

# **MEN'S HEALTH IN MASSACHUSETTS**

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# INTRODUCTION

Over the past two centuries, Western medicine has primarily addressed health issues common to all demographic groups. These common issues include infectious diseases, cancer, and problems affecting the heart, lungs, skin, circulatory, excretory, and digestive systems. Since the early 1980s, however, some groups have fought for establishment of health policies and services that address their own, unique characteristics and needs. Prominent examples of these movements include efforts to improve health care for older adults, people with HIV/AIDS, and women.

Much less attention has been paid to the health needs of men, especially men within diverse communities such as African-Americans, Hispanics/Latinos, Asian-Americans, American Indians, men from low-income backgrounds, gay and bisexual men, and men with disabilities. It is true that until recently, most medical research in the United States has used males as the “human model” for problems such as heart disease and cancer. At the same time, compared to women:

- men have much higher mortality rates for most leading causes of death;
- men know less about health, take less responsibility for household health care decisions, and take less responsibility for their own health; and
- men are less likely than women to view themselves as susceptible to injury or illness, even in instances in which they are significantly more vulnerable than women or are uniquely affected (as with prostate or testicular cancer).

Men have a higher probability of developing cancer, and do not survive as long as women do after diagnosis. Men are more likely than women to die from strokes, obstructive lung disease, pneumonia, influenza, diabetes, chronic liver disease, and cirrhosis. Young men (ages 17 to 44) are more likely than women in this age cohort to sustain serious injuries during sports activities, they account for most traumatic spinal cord injuries, and are more likely to die from accidents such as drowning or motor vehicle crashes. Nine out of ten cases of HIV infection involve men.

Many, if not all of these problems are preventable or can be managed effectively with good-quality health care. Even problems unique to men, such as prostate cancer, testicular cancer, and impotence, can be treated successfully, provided men are willing to obtain primary health care on a regular basis and take responsibility for healthful behavior.

This study, commissioned by the Massachusetts Department of Public Health, was designed to examine men’s health from the perspective of social marketing—that is, our goals were: (1) to collect and analyze secondary information on what is known about men’s health nationally and in Massachusetts; (2) to gather specific information from men in Massachusetts about their attitudes toward health and what might motivate them to take better care of themselves with respect to primary care; and (3) to fine-tune and pilot-test a media campaign developed specifically to inform and educate men about their health risks, and to motivate men to see a doctor on a regular basis for primary care.

This report presents the findings from an extensive review of secondary research regarding men's health and from focus groups conducted with men, their spouses and partners, and health care providers across the state. These findings will be utilized to develop a media campaign and related strategies to promote awareness of men's health issues and use of preventative care.

## **METHODOLOGY**

This study was designed to provide a thorough review of secondary information regarding men's health issues, men's attitudes toward health, and campaigns addressing men's health problems; and to gather qualitative data from men around the state regarding their attitudes toward their own health, their knowledge of preventative health guidelines, their use of health care services, and sources of information regarding health issues. Market Street Research, Inc. and *causemedia, inc.* began this study by meeting with representatives of the Massachusetts Department of Public Health (MDPH) to identify important background information and determine the specific research questions that needed to be answered in order to develop an effective media campaign. Market Street Research, *causemedia*, and MDPH agreed that a methodology combining secondary research and a qualitative study regarding men's attitudes toward their health care would meet the objectives for this study.

### **Phase 1: Secondary Research**

In April and May 2000, Market Street Research and *causemedia* conducted an extensive reviewing of existing literature and databases regarding:

- demographic trends among men in Massachusetts;
- health status indicators among men in Massachusetts;
- men's attitudes toward their health status and health services;
- existing men's health initiatives; and
- lessons learned from health initiatives targeting other populations.

The findings presented in this report represent a wide range of research and news sources. Market Street Research makes every attempt to verify findings by consulting multiple sources. In all cases, we provide a full citation to which the reader can refer for more detailed information. In addition, Appendix A presents an extensive bibliography of literature relating to men's health.

### **Phase 2: Qualitative Study**

In order to better understand the attitudes of men in Massachusetts toward their own health status and toward health services, we conducted a series of focus groups with men, their spouses or partners, and health care providers around the state. Market Street Research, *causemedia*, and MDPH developed a plan to target lower- and moderate-income men between the ages of 25 and 45, representing various racial and ethnic groups, and covering the entire state. Appendix B provides a complete description of each of the groups held.

Market Street Research and *causemedia* worked with a number of community agencies and research recruitment firms to identify and screen eligible participants for the focus groups. Participants were recruited using advertisements in local papers, flyers posted at community agencies, outreach by community agency workers, and telephone calls using targeted lists of households meeting the group criteria. Market Street Research and *causemedia* developed participant screeners used to identify eligible participants for each of the focus groups. Each group was designed to target a specific ethnic or racial population. In order to be eligible for this study, men had to:

- be between the ages of 25 and 45;
- represent a range of incomes (for the white, black, and Hispanic groups this included some men with annual household incomes under \$20,000, some with incomes between \$20,000 and \$40,000, and limited representation of more affluent men); and
- be from the designated racial or ethnic group, either white or Caucasian, black or African-American, Hispanic or Latino, Cape Verdean, Cambodian, Vietnamese, or Chinese.

In addition, we screened out men who themselves work in or who have a family member who works in health care or health education. Within each group, we tried to have a mix of men with private and publicly-funded insurance and those with no health insurance. The groups were conducted in Boston, other eastern Massachusetts cities, central Massachusetts, and western Massachusetts. Appendix C provides the screeners used for the groups with white, black, and Hispanic men.

Culturally-appropriate agencies recruited and organized the focus groups with Cambodian, Cape Verdean, Chinese, and Vietnamese men. For these groups, we had the agencies use their judgment in terms of the appropriate make-up of the group, given that we were looking to include lower- and moderate-income men between the ages of 25 and 45. These groups did not have a formal screener.

In addition to the focus groups with men, we conducted two additional groups. One group targeted the female spouses or partners of men meeting the above criteria. This group was held in Boston and represented families in the greater Boston area. We also conducted a focus group with health care and social services professionals who work in the greater Boston area with lower-income men and men from various ethnic and racial backgrounds.

Market Street Research and *causemedia* developed three distinct Moderator Guides: one that could be used for each of the focus groups of men, one for the focus group with spouses, and one for the group with health care professionals. MDPH and *causemedia* reviewed drafts of the Moderator's Guides, which were revised and finalized by Market Street Research. Appendix D presents the final Moderator's Guides.

The focus groups were conducted during April, May, and June 2000. This report provides a summary of the background research and the focus groups. Findings from the groups with spouses, health care professionals, and black, white, and Hispanic men are presented in the main body of the report. Findings from the groups with Cape Verdean, Cambodian, Chinese, and Vietnamese men are presented in the appendices at the end of this report.

## EXECUTIVE SUMMARY

Recent trends in public health in the United States have led to initiatives that focus on specific sub-populations that are either disproportionately affected by certain illnesses or that historically have been underserved. For example, women's health initiatives have received a great deal of funding and public attention with their focus on educating women regarding health issues, expanding coverage for women's health, and designing research that focuses on women's health. Similarly, other major initiatives have targeted older people, people with HIV/AIDS, rural and urban populations, and children. However, there have been few public health initiatives targeting men, particularly younger men. The Massachusetts Department of Public Health (MDPH) is interested in developing a campaign to educate this population, particularly lower-income and minority men, regarding some of the major illnesses and causes of death among men, including cardiovascular disease, diabetes, prostate cancer, and colorectal cancer. If young men can be educated to seek preventative care and routine screenings at an early age, early detection is likely to reduce the severity of illness and decrease mortality among men due to these diseases.

To support MDPH's efforts, Market Street Research and *causemedia* conducted a study to develop a better understanding of men's attitudes toward health, their use of health services, and their sources of information about health. This report provides the findings from an analysis of existing research regarding men's health issues and a qualitative study conducted by Market Street Research and *causemedia* with men ages 25 to 45 across the state, men's wives and partners, and health care providers.

### Summary of Findings

One of the major reasons young men have not been targeted in most public health campaigns is that, compared to other sub-populations, **young men are a relatively healthy group**. Those public health efforts that have targeted this group tend to focus on specific risks young men face, particularly lower-income and minority men, such as risky behaviors, including drug use and drinking and driving; accidents; and violence. Because there has been little education of younger men regarding major illnesses, such as cardiovascular disease and diabetes, men often are not accessing routine screening and preventative care for these diseases at an early age.

In fact, **the major causes of death among men of all ages are heart disease and cancer**, and this is consistent among white, African-American, and Hispanic men. Even among the 25 to 44 year old population, these are two of the major causes of death, along with accidents, suicide, homicide, and AIDS. For older men, those between 45 and 64, heart disease and cancer are by far the major causes of death. The major forms of cancer affecting men in all age groups are lung, prostate, and colorectal. With early detection and treatment, cardiovascular illness and many cancers can be managed and potentially eliminated.

However, the major obstacle a men's health campaign faces in targeting younger men is that **most perceive themselves to be fairly healthy and are unlikely to seek medical care** except for trauma, acute illness, or chronic conditions for which they are being treated. In fact, according to a survey of adult men in Massachusetts, about nine

out of ten rate their health status as good to excellent.<sup>1</sup> This was clearly borne out in focus group discussions with young men across the state, representing white, black, and Hispanic populations. Almost all men, except those diagnosed with a serious illness or disability, think of themselves as generally healthy. As long as men are sleeping, eating, walking, and working, they tend to see themselves as healthy, although many acknowledge that they have some unhealthy habits, such as smoking, poor diets, and lack of exercise.

Given this positive perception of their health status, **most men do not seek routine or preventative health care.** Rather, they will visit a physician for sudden illness or injury. Even in these cases, many men and their spouses indicate that men are likely to avoid seeking health care, unless the problem is very severe. Because men typically see health care providers for urgent care issues, providers are not able to provide information and conduct routine screenings at these appointments. Providers indicate that it is very difficult to get men to come back for follow-up appointments or routine care.

However, **men who have been diagnosed with serious illnesses, such as heart disease, diabetes, or HIV/AIDS, and those who have suffered serious injuries, are much more likely than other men to regularly seek medical care.** These men are frequently somewhat older—in their late 30s or older—and tend to be better educated and informed about their health risks. These men also tend to have more confidence in the value of medical care and routine screenings for early detection and treatment of medical problems.

The goal for MDPH is to reach **those men who are not currently accessing health care.** These tend to be younger men, those without insurance, less affluent men, those with little history of illness, and men from minority groups, particularly recent immigrants and those who do not speak English.

There are a wide variety of reasons men do not seek health care, primary among them are men's attitudes toward their own health and toward health care in general. These attitudinal barriers include:

- **a general belief that they are fit and healthy** and therefore do not need any type of health care;
- a sense that **men are supposed to be strong**, and that a concern with one's health would reveal weakness;
- **fear that screening would uncover a serious illness**, with many men clearly not ready to face that reality and not able to imagine themselves as a "sick" or "weakened" person; and
- **discomfort with health care providers** based on prior experiences, in which men feel they have been treated disrespectfully or are uncomfortable with the power imbalance between patient and physician.

In addition, many men are **uncomfortable with health care systems in general.** In particular, lower-income men and those without health insurance have a

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<sup>1</sup> *Massachusetts Department of Public Health, Chronic Disease Surveillance Program. Health Risks and Preventive Behavior Among Massachusetts Adults. Results from the Behavioral Risk Factor Surveillance System, June, 1999.*

very negative image of the health care services available to them. Men confirm each other's stories of great difficulty accessing care at all, long waits for care in clinics and emergency rooms, and little or no personal attention or respect. Further, men in recent immigrant populations often have little information about how to access services. These men also routinely face language and cultural barriers in accessing and utilizing health care services.

Given men's general avoidance of health care as an issue and health care services, men have a **fair level of knowledge of many health concerns affecting men**. Many African-American and Hispanic men are able to identify diseases that disproportionately affect men of their ethnic background. Many men are aware of the importance of routine screenings for hypertension, high cholesterol, and prostate and colorectal cancer. The **chief sources of health information for men** include:

- television advertising and news stories, particularly when major public figures are diagnosed with a serious illness;
- other men, particularly somewhat older men, including family members, colleagues, and friends, many of whom have experienced some of these problems;
- community centers and community events that provide easy access to health information for men in some communities; and
- mothers, wives, and girlfriends who often urge men to seek health care for specific problems or relate information they have recently heard.

Despite men's general level of awareness of many health issues, **few men can recall information providing specific guidelines for routine screenings**. Most importantly, despite this level of awareness, **few men between the ages of 25 and 45 are routinely being screened and followed up with for illnesses** such as heart disease, diabetes, and cancer. On the positive side, many men report having had their blood pressure and/or cholesterol checked in the past year, although many assume this has happened when they have visited a doctor for urgent care. Others report having been checked at community events or at the supermarket, for example, for a blood pressure check. These very visible screening tools have clearly made men more aware of the importance of having their blood pressure and cholesterol checked, although it is unclear that men do anything with their results or that there is any follow-up in terms of behavioral change or treatment.

In addition, **few men who participated had ever had a prostate or colorectal exam**. While many were too young for routine screening, there was a clear sense among all men who do not have a primary care physician that these types of screenings are something they are unlikely to seek out in the near future.

For men who have made significant changes in terms of health-related behaviors or the extent to which they access health care, there are a **few key factors that commonly motivate these types of changes**. The most effective motivator is when men experience a **health or health-related crisis**, such as a severe injury or accident, diagnosis with a serious illness, or "*hitting the bottom*" with drug use. These men frequently become regular users of medical care and change risky behaviors. Other factors that have somewhat less influence on men's behavior include: knowing another man (usually an immediate family member or friend) who has experienced a serious

health problem; getting insurance coverage and feeling more able to access health care; and having children, which often coincides with getting somewhat older, beginning to realize one's mortality, and having a strong motivation to stay alive to watch one's children grow and take care of them.

## Recommendations

These findings clearly demonstrate the significant challenge MDPH faces in motivating young, relatively healthy men to seek preventative health care. Changing men's behavior will require far more than a simple educational campaign regarding preventative health guidelines. It will also require social marketing to influence men's attitudes, as well as changes in how health care services are delivered, particularly to lower-income men. MDPH faces even greater challenges in developing initiatives that target minority populations, particularly recent immigrant groups, such as Cambodian and Cape Verdean men. In addition to a general lack of interest in routine health care, these groups face diverse cultural and language barriers that further impede their access to care.

Men's health campaigns should draw on lessons learned from other widespread initiatives, particularly women's health efforts over the past 30 years. These initiatives have clearly demonstrated the value of:

- attacking a problem at every level, including consumer education, health care delivery systems, health care and consumer research, and policymaking;
- using every possible media to bring attention to an issue, including advertising, community forums, and national publicity regarding key public figures; and
- maintaining momentum over an extended period of time to see the process through, from initially getting an idea out, to affecting social change that supports men in changing the way they see themselves.

In terms of consumer education, initial efforts should utilize major media, including **television and radio news stories and public services announcements**. MDPH should use radio and cable stations that target specific sub-populations to reach minority groups, such as Latinos or Cape Verdeans. Men and health care providers also indicate the value of getting **information out into community settings**, such as community events, shopping centers, churches, and supermarkets. MDPH will also want to consider ways to **take advantage of major news stories about health issues affecting well-known public figures**, such as Magic Johnson, Rudolph Giuliani, and Darryl Strawberry. Men become sensitive to key health issues from these stories, but rarely learn relevant information affecting their own attitudes or health behavior. A men's health campaign should also develop **innovative strategies to support dialogue among groups of men and between men and their families** regarding important health issues affecting men.

In terms of the message, MDPH needs to develop a variety of messages that work with the diverse population of men in Massachusetts. First and foremost, all messages need to be **linguistically and culturally appropriate** and provided by someone from the targeted community. Men need to be able to easily identify with the spokesperson or they will not respond. Men need **basic information about symptoms to be aware of, immediate action they can take, and the value of early detection—**

all provided in easy-to-understand language. Men need to be able to clearly see and strongly feel the immediate connection to their own lives in order to absorb health-related information.

In addition, MDPH will want to try **multiple strategies for motivating men** to seek preventative health care. Three suggestions include:

- having **men educate and motivate each other**. Men in the focus groups indicated that they are most likely to identify with and respond to a message if they see and hear stories from other men—from their own community, in their general age range, and with a similar background—who felt they were perfectly healthy, but were diagnosed with a specific illness. However, these messages also need to clearly convey to men that early detection is the key to avoiding negative outcomes. Otherwise, men will avoid health care, thinking they can avoid the prognosis and outcome;
- using **men’s perceptions of themselves as providers for their family** to help men change their behavior. Many men, their wives, and health care providers suggested that men are most likely to change behaviors in order to maintain their own health for their children’s sake and to support their children’s healthy behaviors; and
- **helping men move from a fear of routine screening**, thinking it will result in a poor prognosis, **to an attitude that routine screening will help them stay strong and healthy**, so that they can continue to provide for their family and not become a burden on their wives, children, or parents.

In addition, MDPH needs to address the issue of **health care access and quality of the health care experience**, particularly for lower-income and minority men. Men are more likely to seek health care if they have health care coverage or if it is low-cost. Many men have very negative associations with their current options for health care, such as emergency rooms and neighborhood clinics, at which they have experienced problems getting to see a provider, long waits for care, impersonal and disrespectful treatment, and providers that are too rushed to respond to questions or address anything other than urgent issues. Providers reported success in getting men to return for repeat visits and preventative health screenings when they have culturally-appropriate outreach staff to assist with intakes, education, and follow-up with men who come in for urgent care services.

Finally, to improve access to health care and to promote widespread education, MDPH will want to consider strategies of **providing care in community settings**, including community centers, malls, and community events. Men currently do not prioritize their own health care, but if a routine screening service is conveniently placed right in their path, there is a greater chance they will utilize it. These screenings need to include information and follow-up services.

Clearly, changing men’s attitudes and health behaviors will require a comprehensive, long-term strategy that includes education, social marketing, health care delivery initiatives, and social change. Just as in the women’s health movement, every effort that makes men a little bit more familiar with a health issue is a step toward educating men in how to take better care of themselves. As men are surrounded with messages—in the media, from their family, and in work and community settings—they will become more comfortable with this information and more likely to act upon it.

**PHASE I:**  
**SECONDARY RESEARCH**

## DEMOGRAPHIC PROFILE OF MEN IN MASSACHUSETTS

Massachusetts is a small New England commonwealth with an estimated 2000 population of about 6.3 million. About 47% of the resident population, or about 3 million, are male (see Table 1). The majority of Massachusetts' male residents are white (91.4%), with small but growing populations of African-Americans (5.2%), Hispanic/Latinos<sup>2</sup> (5.4%), Asian-Americans (2.9%), and American Indians (0.3%).<sup>3</sup> According to 1997 projections prepared by the Massachusetts Institute for Social and Economic Research, within the state there are approximately:

- **162,757 African-American males**, with significant communities<sup>4</sup> in Amherst, Boston, Brockton, Chelsea, Cambridge, Framingham, Harvard, Holyoke, Lawrence, Lynn, Medford, Malden, Lowell, New Bedford, Newton, Randolph, Pittsfield, Springfield, Waltham, and Worcester;
- **169,676 Hispanic/Latino males**, the majority of whom are of Puerto Rican, Dominican, or Cuban origins. Cities and towns with significant Hispanic/Latino communities include Boston, Lawrence, Springfield, Worcester, Holyoke, Lowell, Chelsea, Cambridge, Lynn, Somerville, Framingham, New Bedford, Brockton, Waltham, Fitchburg, Leominster, and Salem;
- **88,569 Asian-American males**, the majority of whom are of Chinese, Cambodian, or Vietnamese descent. Cities and towns with significant Asian-American communities include Amherst, Boston, Brookline, Cambridge, Framingham, Lowell, Lynn, Malden, Newton, Quincy, Somerville, Springfield, Waltham, and Worcester; and
- **7,721 American Indian males** representing many different tribes. American Indians in Massachusetts live throughout the state, without the degree of geographic concentration common to the African-American and Hispanic/Latino communities.

Figure A presents a detailed **age breakdown** for Massachusetts males for 1997, based on projections from the 1990 *U.S. Census*. The largest cohort of males in Massachusetts consists of baby-boom generation adults and generation X'ers, ages roughly 20 to 54 years. As these men age, their need for appropriate health care

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<sup>2</sup> *“Hispanic” and “Latino” are used variously to refer to persons of Puerto Rican, Cuban, Mexican, Central and South American, Spanish, and in some cases, Portuguese origins. Many Puerto Rican and Cuban men in New England prefer “Latino,” but others, particularly Mexican-American men, prefer the term “Hispanic” or in some cases, “Chicano.” In this report we use the combined term, Hispanic/Latino, to reflect the considerable diversity of this group in Massachusetts, representatives of whom may be of any race—for example, in 1990, more than 1,600 Hispanics/Latinos were of American Indian, Eskimo, or Aleut descent; more than 3,000 were of Asian or Pacific Island descent; about 26,000 were African-American; and the remaining 125,000 described themselves as white.*

<sup>3</sup> *Massachusetts Department of Public Health, MassCHIP data, August, 1999; and Massachusetts Institute for Social & Economic Research (MISER), unpublished data.*

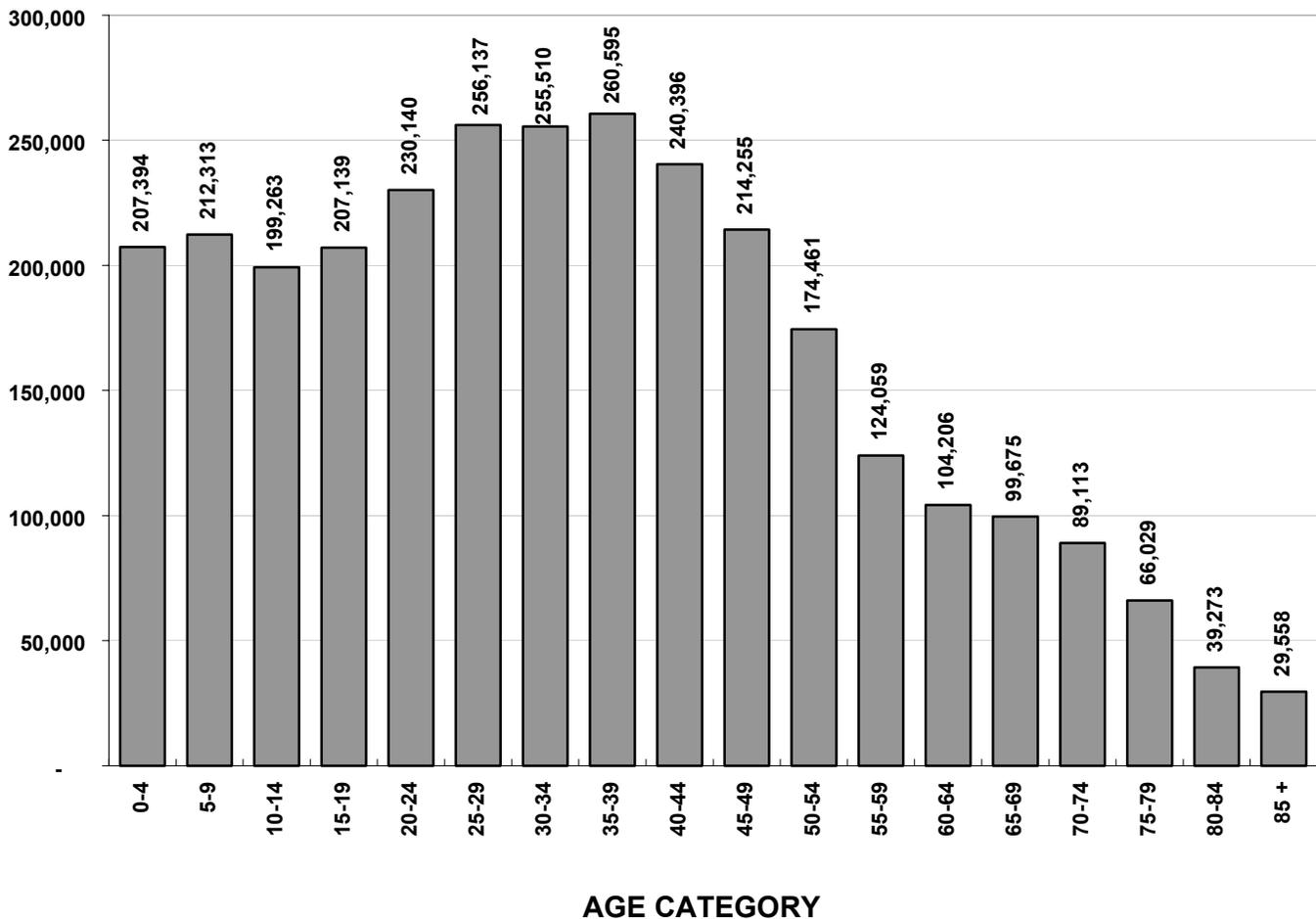
<sup>4</sup> *Defined as cities and towns with at least 800 African-American men. We used the same threshold for Hispanic/Latino and Asian-American communities.*

services will increase, as will their likelihood of contracting various illnesses that occur most often in men over age 50. The next largest cohort of males in Massachusetts includes children, teenagers, and young adults, ages 0 to 19, and the smallest cohort includes men ages 55 and older.

Table 2 presents a general demographic and socioeconomic breakdown for men in Massachusetts, broken down by region (e.g., Western Mass, Southeast, Northeast, Central, and Greater Boston areas). As is clear, the greatest number of men in Massachusetts live in the Greater Boston, Northeast, and Southeast regions.

**FIGURE A**

**Population Breakdown By Age, Males,  
Massachusetts, 1997 Projection**



*Source: Massachusetts Institute for Social and Economic Research (MISER), projections based on 1990 U.S. Census totals for Massachusetts.*

**TABLE 1**

**Age and Racial/Ethnic Profile of Males  
in Massachusetts, 1997 Projection**

| Age Cohort         | TOTAL All Males  | Percent of Total ↓ | Age Breakdown for Males by Racial and Ethnic Group: |                  |                 |                 |                   |
|--------------------|------------------|--------------------|---|------------------|-----------------|-----------------|-------------------|
|                    |                  |                    | White   | African-American | Asian-American* | American Indian | Hispanic/Latino** |
| 0-4                | 207,394          | 6.9%               | 180,117   | 18,216           | 8,410           | 651             | 21,678            |
| 5-9                | 212,313          | 7.1%               | 188,002   | 16,385           | 7,307           | 619             | 19,187            |
| 10-14              | 199,263          | 6.6%               | 179,212   | 12,760           | 6,633           | 658             | 15,087            |
| 15-19              | 207,139          | 6.9%               | 186,012   | 13,231           | 7,301           | 595             | 14,676            |
| 20-24              | 230,140          | 7.6%               | 207,274   | 14,395           | 7,870           | 601             | 15,597            |
| 25-29              | 256,137          | 8.5%               | 230,920   | 15,801           | 8,779           | 637             | 17,256            |
| 30-34              | 255,510          | 8.5%               | 230,833   | 14,943           | 9,119           | 615             | 16,411            |
| 35-39              | 260,595          | 8.7%               | 237,402   | 13,824           | 8,675           | 694             | 13,792            |
| 40-44              | 240,396          | 8.0%               | 221,383   | 11,380           | 6,930           | 703             | 10,282            |
| 45-49              | 214,255          | 7.1%               | 199,444   | 8,757            | 5,518           | 536             | 7,526             |
| 50-54              | 174,461          | 5.8%               | 164,035   | 6,465            | 3,583           | 378             | 5,492             |
| 55-59              | 124,059          | 4.1%               | 116,358   | 4,699            | 2,699           | 303             | 3,749             |
| 60-64              | 104,206          | 3.5%               | 98,596  | 3,439            | 1,941           | 230             | 2,755             |
| 65-69              | 99,675           | 3.3%               | 95,260  | 2,881            | 1,359           | 175             | 2,069             |
| 70-74              | 89,113           | 3.0%               | 85,449  | 2,458            | 1,056           | 150             | 1,606             |
| 75-79              | 66,029           | 2.2%               | 63,688  | 1,584            | 686             | 71              | 1,074             |
| 80-84              | 39,273           | 1.3%               | 38,013  | 812              | 400             | 48              | 667               |
| 85+                | 29,558           | 1.0%               | 28,471  | 727              | 303             | 57              | 772               |
| <b>All ages</b>    | <b>3,009,516</b> | <b>100.0%</b>      | <b>2,750,469</b>                                    | <b>162,757</b>   | <b>88,569</b>   | <b>7,721</b>    | <b>169,676</b>    |
| Percent of Total → |                  |                    | 91.4%   | 5.4%             | 2.9%            | 0.3%            | 5.6%              |

\* Includes Asian-American and Pacific Islanders.

\*\* Hispanics/Latinos may be of any race.

**Source:** Massachusetts Institute for Social and Economic Research (MISER), projections based on 1990 U.S. Census of Population statistics.

**TABLE 2****Age by Sex Forecast, Males, 1990-2004  
For Massachusetts Regions**

| <b>Geographic Area:</b>   | <b>1990 Census</b> | <b>1999 Estimate</b> | <b>2004 Projection</b> |
|---|--------------------|----------------------|------------------------|
| <b>Western Region (Hampshire, Hampden, Franklin, and Berkshire Counties)</b>        |                    |                      |                        |
| Total population (male and female)  | 812,322            | 791,998              | 782,712                |
| Total males   | 386,839            | 379,482              | 375,083                |
| Median age, males   | 32.1 years         | 35.1 years           | 36.1 years             |
| Median household income   | \$31,366           | \$36,976             | \$44,387               |
| <b>Central Region (Worcester County, Framingham, and Adjoining Towns)</b>           |                    |                      |                        |
| Total population (male and female)  | 709,705            | 737,466              | 764,969                |
| Total males   | 345,722            | 359,957              | 373,499                |
| Median age, males   | 31.9 years         | 34.8 years           | 35.7 years             |
| Median household income   | \$35,774           | \$43,652             | \$53,631               |
| <b>Southeast Region (New Bedford and Towns South of Boston, Including Cape Cod)</b> |                    |                      |                        |
| Total population (male and female)  | 1,128,206          | 1,204,215            | 1,257,278              |
| Total males   | 542,523            | 581,258              | 607,373                |
| Median age, males   | 33.0 years         | 36.2 years           | 37.5 years             |
| Median household income   | \$34,840           | \$43,429             | \$53,090               |
| <b>Northeast Region (Lawrence, Lowell, and Towns North of Boston)</b>               |                    |                      |                        |
| Total population (male and female)  | 1,219,932          | 1,280,297            | 1,327,602              |
| Total males   | 590,068            | 622,219              | 645,099                |
| Median age, males   | 32.6 years         | 35.4 years           | 36.5 years             |
| Median household income   | \$41,498           | \$50,328             | \$58,167               |
| <b>Greater Boston Area (Boston, Cambridge, and Boston Suburbs)</b>                  |                    |                      |                        |
| Total population (male and female)  | 2,077,151          | 2,095,611            | 2,126,527              |
| Total males   | 989,964            | 1,002,366            | 1,016,267              |
| Median age, males   | 31.8 years         | 34.7 years           | 35.6 years             |
| Median household income   | \$38,736           | \$48,326             | \$55,625               |

**Sources:** CACI, Inc.; 1990 Census of Population, STF 1 and 3; and Massachusetts Institute for Social and Economic Research (MISER).

## HEALTH STATUS INDICATORS FOR MEN

Most men believe they are basically healthy (see Table 3). According to the most recent data available, nearly nine-tenths (89.3%) of adult men in Massachusetts rated their general health as “*excellent*,” “*very good*,” or “*good*,” and only 2.3% rated their health as “*poor*.” Men and women are equally likely to say they are healthy, both in Massachusetts and in the United States. While these are heartening statistics, men are at risk of a number of health problems, in part due to the inevitable tendency of humans to get sick from time to time, and in part due to self-perpetuated, risky behaviors such as smoking, not exercising, and failure to maintain a healthy weight.

### Overall Morbidity and Behavioral Risk Factors

According to the Centers for Disease Control and Prevention, more than one-fourth (27.3%) of adult men in Massachusetts experience some form of illness at least once a month. Massachusetts men’s rate of illness during a typical month is nearly identical to the national average, but is slightly lower than the rate for women in Massachusetts (32.1%). About one-fourth (26.1%) of Massachusetts men also experience at least one day per month in which they feel their mental health is not good, compared with 33.2% of women. Most men in Massachusetts (88.4%) have some form of health insurance coverage, although about one-tenth (8.8%) could not afford to see a doctor in 1998. Insured rates and the ability to pay for doctor visits when needed are about the same for men and women, both in Massachusetts and nationwide.

While men believe they are basically healthy, nearly 30% of adult men in Massachusetts did not have a routine check-up in 1998. This is considerably higher than the 15% of adult women who neglected to obtain primary health care that year. Furthermore, among Massachusetts men:

- 31% are at risk of health problems because they are **overweight** (although only 12% remember being told at some point by a health care provider that they should lose weight);
- 77% are at risk of health problems because they **do not exercise** regularly; and
- 22% are **current smokers** (smoke daily or almost every day), and are at risk of many smoking-related problems such as asthma, lung problems and diseases, heart disease, and a wide variety of cancers.

In the United States, life expectancy is 73.1 years for men born in 1996 and 79.1 years for women born in 1996, a difference of six years. Life expectancy for African-American men born in 1996 is even lower, at 66.1 years.<sup>5</sup> In fact, for nearly every major health problem affecting the nation’s citizens, men’s morbidity and mortality rates are higher than rates for women—yet men are much less likely than women to admit they may have health problems and are much less proactive in seeking the care they need.

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<sup>5</sup> Peters, K.; K. Kochanek; and S. Murphy. “Final Data for 1996.” *National Center for Health Statistics. National Vital Statistics Reports*, 1998, 47(9), p. 22.

**TABLE 3**

**Health Risk Factors for Adult Men and Women  
in Massachusetts and the United States, 1998**

| Health Problem or Risk Factor                         | Massachusetts |       | United States |       |
|---|---------------|-------|---------------|-------|
|   | Men           | Women | Men           | Women |
| General health “excellent,” “very good,” or “good”    | 89.3%         | 89.0% | 86.3%         | 85.5% |
| Physical health not good at least 1 day in past month | 27.3%         | 32.1% | 27.9%         | 34.9% |
| Mental health not good at least 1 day in past month   | 26.1%         | 33.2% | 26.0%         | 34.8% |
| Participated in physical activities in past month     | 76.3%         | 73.2% | 74.3%         | 70.1% |
| Has health care coverage                              | 88.4%         | 93.4% | 85.7%         | 88.4% |
| Could not afford doctor visit in past year            | 8.8%          | 7.3%  | 7.8%          | 11.2% |
| Had routine check-up in past year                     | 70.1%         | 84.6% | 62.0%         | 78.5% |
| Current smoker  | 22.5%         | 19.5% | 25.3%         | 20.9% |
| At risk of health problems due to lack of exercise    | 77.5%         | 78.5% | 78.2%         | 80.5% |
| At risk of health problems due to obesity             | 30.9%         | 23.0% | 33.3%         | 31.4% |
| Told by provider to lose weight                       | 12.0%         | 11.4% | 9.4%          | 12.1% |
| Told by doctor has diabetes                           | 4.7%          | 3.1%  | 5.2%          | 5.3%  |
| Tested for HIV in past year                           | 26.6%         | 34.2% | 33.5%         | 34.1% |

*Source: 1998 Behavioral Risk Factor Surveillance System.*

**Men and Chronic Health Problems:** Men of all racial and ethnic backgrounds suffer from a variety of chronic physical and health problems, many of which are preventable and/or treatable with regular primary care. Common chronic health problems among men range from skeletal, skin, and musculoskeletal disorders to various physical impairments, digestive disorders, and conditions affecting the nervous, genitourinary, endocrine, metabolic, and blood-related systems. Men’s experiences with chronic health problems vary significantly between age groups—based on the self-reported rate per 1,000 adult men in the United States, the most prevalent chronic conditions are as follows.<sup>6</sup>

- **males under age 45:** chronic sinusitis, allergic rhinitis (hay fever), orthopedic problems (such as chronic lower back pain), asthma, hearing impairments, high blood pressure, dermatitis, visual impairments, acne, indigestion, heart disease, migraine headache, and hemorrhoids. For men under age 45, the prevalence of each of these chronic health problems ranges from less than 1 to around 115 per 1,000 men;

<sup>6</sup> Benson, V. and M. Marano. “Current Estimates from the National Health Interview Survey, 1995.” National Center for Health Statistics. *Vital Health Stat*, 1998, 10(199), pp. 79-80.

- **males ages 45 to 64:** hypertension, hearing impairments, orthopedic problems, arthritis, heart disease, chronic sinusitis, allergic rhinitis, tinnitus, hemorrhoids, diabetes, visual disorders, and vertebral disk disorders. For men ages 45 to 64, the prevalence of each of these chronic health problems ranges from less than 1 to around 234 per 1,000 men; and
- **males ages 65 and over:** arthritis, hearing impairments, heart disease, hypertension, orthopedic problems, chronic sinusitis, cataracts, diabetes, prostate disease, visual impairment, tinnitus, cerebrovascular disease, hernia, emphysema, bursitis, and gout. For men ages 65 and older, the prevalence of each of these chronic health problems ranges from about 3 to 405 per 1,000 men.

Most chronic health conditions become increasingly prevalent as men age—a good example is arthritis, which is rare for men under 45 but more prevalent than any other chronic problem for men over age 65. There are some chronic conditions that do not follow this pattern; for example, acne and sebaceous skin cysts primarily affect young men, and there are several conditions which primarily, although not exclusively, affect elderly men (such as arthritis, hearing problems, cerebrovascular disease, cataracts, and gout). Men of all ages can have heart disease, but among younger men, these problems typically involve relatively benign heart rhythm disorders (such as heart murmurs). As men age, the rate of more serious, ischemic heart disease increases.

Men ages 45 to 64 are an interesting group, as there are chronic conditions which affect this age group that are relatively uncommon for younger and older men. These problems are mainly associated with **aggressive physical activity** (bursitis and orthopedic impairments affecting the back and lower extremities are most common among these men), and **stress** (ulcers, enteritis, colitis, migraine headache, and spastic colon). These men are in their “prime earning years,” and this cohort also includes members of the baby-boom generation, who are beginning to experience chronic health problems associated with job stress and over-exercising.

**Men and Hypertension:** Hypertension is a significant problem for men, although the rate of hypertension among men has declined since the mid-1980s. In 1960-1962, two-fifths (40.0%) of men in the United States ages 20 to 74 had hypertension, for example. By 1988-1991 this percentage had dropped to about one-fourth (26.4%). White and Hispanic/Latino men have roughly the same rate of hypertension (25.1% and 26.7%), while African-American men have a much higher rate (37.4%). Hypertension is rare among young men, but the risk of acquiring this condition increases significantly over the life span—by the time men reach age 75, more than two-thirds (64.4%) have hypertension.<sup>7</sup>

**Men and Cholesterol:** Many men have high cholesterol on a chronic basis, a condition which contributes to cardiovascular disease—strokes, heart attacks, and the like. The average, serum total cholesterol among males ages four and older in the United States is 191. The average increases gradually as men age, from 180 for men in their twenties to 201-217 for men over age sixty.<sup>8</sup> Cholesterol levels are comparable among men of different racial and ethnic backgrounds.

<sup>7</sup> National Center for Health Statistics. *Health, United States, 1995*, Hyattsville, MD: Public Health Service, 1996, p. 181. Hypertension is defined as having elevated blood pressure (e.g., systolic pressure of at least 140 mmHg or diastolic pressure of at least 90 mmHg), or having normal blood pressure due to antihypertensive medication.

<sup>8</sup> Centers for Disease Control and Prevention. *NHANES III, 1988-1994*.

**Men and Obesity:** The more overweight a man is, the more likely he is to suffer from problems such as high cholesterol, high blood pressure, and adult-onset diabetes.<sup>9</sup> Table 4 presents the proportion of adult men who suffer from various health problems, broken down by weight. For men, **overweight** is defined as having a body mass index (BMI) above 25 kg/m<sup>2</sup>, and **obese** is defined as having a BMI above 30 kg/m<sup>2</sup>.

About 10% to 20% of adult men in the United States are obese under these definitions, with the percentage varying depending on how men are surveyed.<sup>10</sup> The rate of obesity is somewhat higher for women (15%-25%). Men are most likely to be obese in their forties, fifties, and sixties, although even among men in their twenties, 9% are considered obese and almost 40% are considered overweight. Men of Cuban and Mexican-American origins are more likely than any other racial/ethnic group to be obese (13% and 15%, respectively). Overweight and obese men are at much greater risk than normal-weight men of having high cholesterol, high blood pressure, and adult-onset diabetes. Underweight men, interestingly, have an elevated risk of coronary heart disease and adult-onset diabetes when compared with normal-weight men.

At any given time, roughly 20% of men ages 18 to 65 describe themselves as being on diets, and 40% have been on a diet at some point in their lives. Men diet and exercise for many reasons—about half do so to lose or maintain weight, the majority also want to “*stay healthy*” by exercising and controlling their eating, and many exercise to preserve a sense of well-being, control stress, to “*look their best*,” or for personal enjoyment.<sup>11</sup>

**TABLE 4**

**Percent of Adult Men With Selected Health Problems,  
Based on Weight (United States, 1999)**

| Health Problem:                  | Underweight | Normal Weight | Overweight |
|----------------------------------|-------------|---------------|------------|
| Coronary Heart Disease           | 12.5%       | 8.9%          | 9.6%       |
| High Cholesterol ( total > 240 ) | 6.7%        | 26.7%         | 35.7%      |
| High Blood pressure ( > 140/90 ) | 23.4%       | 23.5%         | 34.2%      |
| Adult-Onset Diabetes             | 4.7%        | 2.0%          | 4.9%       |

*Source: U.S. Department of Food and Agriculture.*

<sup>9</sup> Winslow, R. “Health and Medicine Overview: Why Fitness Matters.” *Wall Street Journal*, May 1, 2000, p. R4.

<sup>10</sup> These estimates are from NHES I; NHANES I; NHANES II; and NHANES III; which are nationwide surveys sponsored by the Centers for Disease Control and Prevention. Results from all four surveys can be viewed at the National Center for Health Statistics web site, [www.cdc.gov/nchs](http://www.cdc.gov/nchs).

<sup>11</sup> “Survey Reveals Why Men Diet.” *Jet*, 90(26), November 11, 1996, p. 47.

In general, men ages 25 to 50 eat 76% of the recommended number of servings of grains, 86% of the recommended servings of vegetables, and 81% of the recommended servings of milk, but only 35% of the recommended servings of fruit. Diets low in fruits, vegetables, and fiber, and high in fat tend to cause obesity, and are widely viewed as a contributing cause of colorectal cancer in men, particularly among African-American men.<sup>12</sup>

## Overall Mortality Rates

Mortality rates for men are much higher than for women in the United States (see Figure B). As of 1996, the crude death rate for women was 381 per 100,000 population, compared with 623 per 100,000 for men.<sup>13</sup> African-American men have the highest annual mortality rate of any racial or ethnic group in this country—the rate was 967 per 100,000 in 1996. The top ten causes of mortality among men in the United States are **heart disease, cancer, cerebrovascular disease, lung disease, pneumonia and influenza, accidents, diabetes, liver disease, suicide, and homicide** (see Table 5).<sup>14</sup>

The main causes of mortality among men vary by age. For young boys (ages 0-15), accidents, congenital abnormalities, homicide, and cancer account for the largest proportions of deaths. For teenagers and young adults (ages 16-25), accidents, homicide, suicide, and cancer account for the largest proportion. The mortality profile changes after age 25—among younger baby-boomers<sup>15</sup> and generation X'ers (ages 26-44), accidents, heart disease, cancer, suicide, and HIV/AIDS account for the largest proportion of deaths.

For older baby-boomers and men approaching retirement (ages 45-64), heart disease and cancer are by far the most significant causes of death, followed to a lesser extent by accidents, cerebrovascular disease, liver disease, pulmonary disease, diabetes, and suicide. Among male seniors (ages 65+), heart disease, cancer, cerebrovascular disease, lung disease, pneumonia and influenza, and diabetes account for the largest proportion of deaths, although accidents, liver diseases, septicemia, and Alzheimer's also kill significant numbers of men. Age-related mortality trends for men in Massachusetts closely mirror trends for the United States as a whole.

Between ages 40 and 50, mortality among men due to illness (such as heart disease, cancer, diabetes, etc.) increases significantly, while the rate of death due to other public health problems (such as accidents, homicide, or suicide) decreases. Age 50 is critical for men, as the overall mortality rate for men younger than 50 is much lower than for men older than 50. At age 50, most health practitioners and researchers recommend that men begin having annual check-ups as well as regular tests for diseases for which early detection and treatment helps reduce mortality, such as heart disease, prostate cancer, colorectal cancer, diabetes, and cerebrovascular disease.

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<sup>12</sup> Sullivan, A. "Health & Medicine, Food & Fitness: Fill 'Er Up." *Wall Street Journal*, May 1, 2000 p. R6. These figures are based on data provided by the U.S. Department of Food and Agriculture.

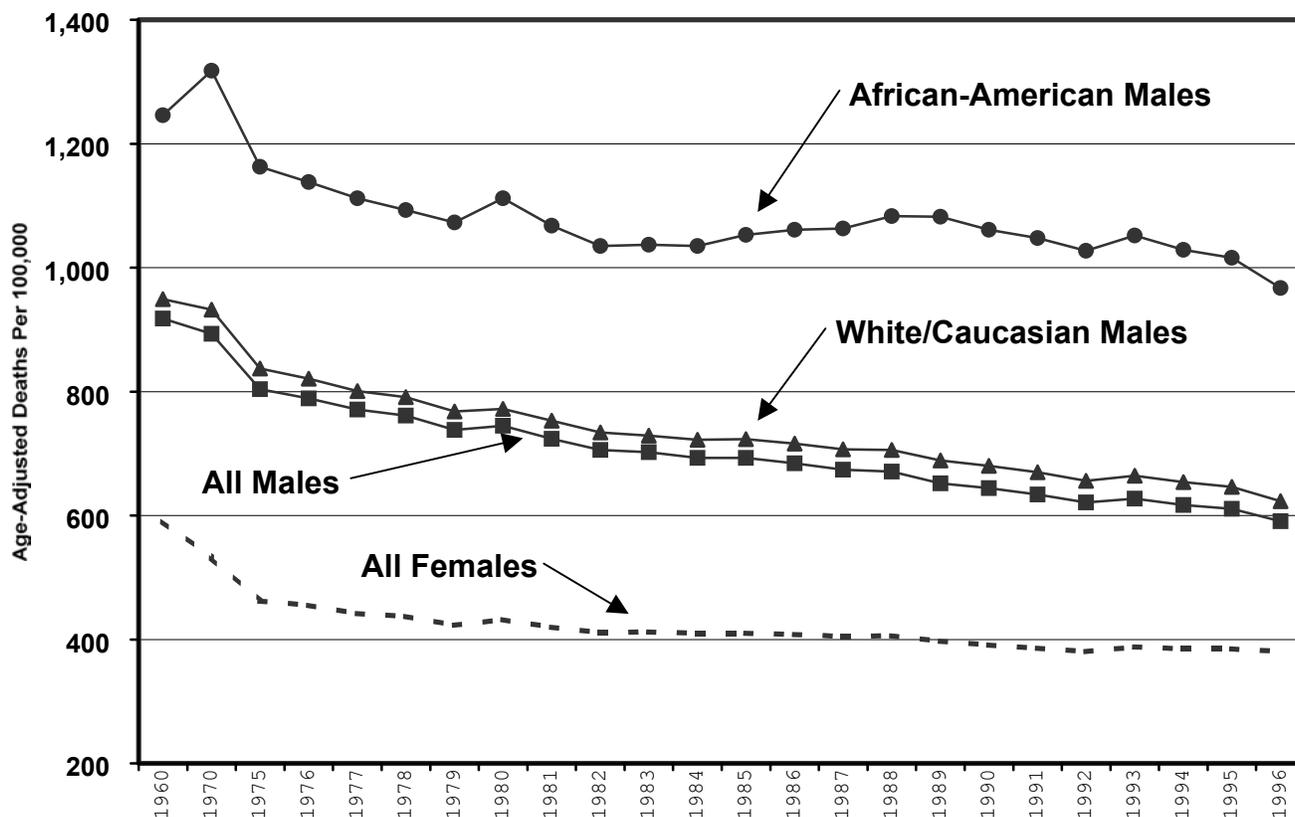
<sup>13</sup> Peters, K.; K. Kochanek; and S. Murphy. "Deaths: Final Data for 1996." *National Vital Statistics Report*, 47(9), Hyattsville, MD: National Center for Health Statistics, 1998, p. 16.

<sup>14</sup> Centers for Disease Control and Prevention. *National Vital Statistics Reports*, 47(19), June 30, 1999, pp. 27-50 (see Table 5).

<sup>15</sup> The baby-boom generation is generally defined as people born from 1945 to 1960.

**FIGURE B**

**Crude Age-Adjusted Death Rates  
Per 100,000 Population, United States, 1960-1996**



*Note: Data are crude annual rates, as of April 1<sup>st</sup> for U.S. Census years and July 1<sup>st</sup> for all other years. Beginning in 1970, death rates exclude deaths of U.S. citizens who are non-residents. Because of inconsistencies in the ways "race" and "ethnicity" are reported on death certificates from region to region, specific data for Hispanic/Latino, Asian-American, and American Indian/Alaska Native males are not included in this figure. All data are for civilians. Age-adjusted to 1940 standard U.S. population.*

**Source:** National Center for Health Statistics.

**Racial, Ethnic, and Cultural Differences in Mortality:** The main causes of mortality among men in the United States vary not only by age, but also between white, African-American, and Hispanic/Latino men. Figure C presents the top causes of mortality among men of various ages, broken down into these three racial and ethnic categories (data for other groups are unavailable). Among men of all ages:

- **illnesses**, such as heart disease, cancer, and cerebrovascular disease, are most likely to kill white men; and
- while illnesses are among the top causes of death among African-American and Hispanic/Latino men, **accidents and homicide** are also critical public health problems for these groups—more so than for white men.

Accidents, homicide, suicide, and HIV/AIDS cause more deaths among African-American and Hispanic/Latino men than among white men. This is true for all age groups except seniors. HIV/AIDS mainly kills men ages 25 to 64, and African-Americans and Hispanics/Latinos bear the brunt of this disease despite recent advances in prevention and treatment.

**TABLE 5**  
**Causes of Mortality Among Men By Age:**  
**Rate per 100,000 Population, United States, 1997**

| Cause of Mortality                  | Males All Ages | Rate per 100,000 Population by Age Cohort, Males, United States |            |             |             |             |              |
|-------------------------------------|----------------|---|------------|-------------|-------------|-------------|--------------|
|                                     |                | 1-4 Years   | 5-14 Years | 15-24 Years | 25-44 Years | 45-64 Years | 65+ Years    |
| <b>All men, all causes of death</b> | <b>880</b>     | <b>40</b>   | <b>24</b>  | <b>124</b>  | <b>215</b>  | <b>855</b>  | <b>5,621</b> |
| Heart disease                       | 272            | 2   | 1          | 4           | 28          | 265         | 1,944        |
| Malignant neoplasms (cancer)        | 214            | 3   | 3          | 5           | 24          | 260         | 1,425        |
| Cerebrovascular disease             | 48             | 1   | 1          | 1           | 4           | 32          | 371          |
| Pulmonary (lung) diseases           | 43             |   | 1          | 1           |             | 25          | 346          |
| Pneumonia & influenza               | 30             | 1   | 1          | 1           | 3           | 13          | 243          |
| Motor vehicle accidents             | 22             | 5   | 6          | 38          | 24          | 20          | 32           |
| All other accidents                 | 25             | 9   | 5          | 14          | 25          | 26          | 79           |
| Diabetes mellitus                   | 22             |   |            |             | 4           | 25          | 143          |
| Suicide                             | 19             |   | 1          | 19          | 24          | 23          |              |
| Chronic liver disease/cirrhosis     | 12             |   |            |             | 7           | 29          |              |
| Homicide/legal intervention         | 12             | 3   | 2          | 28          | 16          |             |              |
| Congenital abnormalities            |                | 4   | 1          | 1           |             |             |              |
| Septicemia                          |                | 1   |            |             |             |             | 9            |
| Perinatal conditions                |                | 1   |            |             |             |             |              |
| Benign neoplasms                    |                | 1   |            |             |             |             |              |
| Kidney disease                      |                |   |            |             |             |             | 10           |
| HIV/AIDS                            |                |   | 1          | 1           | 21          | 14          |              |
| All other causes                    | 162            | 10  | 5          | 12          | 37          | 123         | 164          |

 *Shaded areas indicate rates are below 1 per 100,000 men.*

*Source: Centers for Disease Control and Prevention, National Vital Statistics Reports.*

**FIGURE C: Causes of Mortality Among Men by Age and Race/Ethnicity, Based on Rate per 100,000 Population, U.S., 1997**

| <b>White Males, All Ages</b>   | <b>African-American Males, All Ages</b>  | <b>Hispanic/Latino Males, All Ages</b>  |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Heart disease</li> <li>• Cancer</li> <li>• Cerebrovascular disease</li> <li>• Pulmonary disease</li> <li>• Accidents</li> </ul>           | <ul style="list-style-type: none"> <li>• Heart disease</li> <li>• Cancer</li> <li>• Accidents</li> <li>• Cerebrovascular disease</li> <li>• Homicide</li> </ul>                    | <ul style="list-style-type: none"> <li>• Heart disease</li> <li>• Cancer</li> <li>• Accidents</li> <li>• Homicide</li> <li>• Cerebrovascular disease</li> </ul>           |
| <b>Boys (ages 0-15)</b>  |  |   |
| <ul style="list-style-type: none"> <li>• Accidents</li> <li>• Congenital abnormalities</li> <li>• Cancer</li> </ul>  | <ul style="list-style-type: none"> <li>• Accidents</li> <li>• Homicide</li> <li>• Congenital abnormalities</li> </ul>  | <ul style="list-style-type: none"> <li>• Accidents</li> <li>• Congenital abnormalities</li> <li>• Cancer</li> </ul>   |
| <b>Teens &amp; Young Adults (ages 16-25)</b>   |  |   |
| <ul style="list-style-type: none"> <li>• Accidents, especially auto</li> <li>• Suicide</li> <li>• Homicide</li> </ul>  | <ul style="list-style-type: none"> <li>• Homicide</li> <li>• Accidents</li> <li>• Suicide</li> <li>• Cancer</li> </ul>   | <ul style="list-style-type: none"> <li>• Accidents</li> <li>• Cancer</li> <li>• Homicide</li> <li>• Suicide</li> </ul>  |
| <b>Younger Baby-Boomers &amp; Generation X'ers (ages 26-44)</b>  |  |   |
| <ul style="list-style-type: none"> <li>• Accidents</li> <li>• Suicide</li> <li>• Heart disease</li> <li>• Cancer</li> <li>• HIV/AIDS</li> </ul>                                    | <ul style="list-style-type: none"> <li>• HIV/AIDS</li> <li>• Homicide</li> <li>• Accidents</li> <li>• Heart disease</li> <li>• Cancer</li> </ul>                                   | <ul style="list-style-type: none"> <li>• Accidents</li> <li>• HIV/AIDS</li> <li>• Homicide</li> <li>• Cancer</li> </ul>   |
| <b>Older Baby-Boomers and Men Approaching Retirement (ages 45-64)</b>  |  |   |
| <ul style="list-style-type: none"> <li>• Heart disease</li> <li>• Cancer</li> <li>• Accidents</li> <li>• Liver disease</li> </ul>  | <ul style="list-style-type: none"> <li>• Heart disease</li> <li>• Cancer</li> <li>• Cerebrovascular disease</li> <li>• Accidents</li> <li>• HIV/AIDS</li> </ul>                    | <ul style="list-style-type: none"> <li>• Heart disease</li> <li>• Cancer</li> <li>• Liver disease</li> <li>• Accidents</li> <li>• Diabetes</li> </ul>                     |
| <b>Senior Men (ages 65 and older)</b>  |  |   |
| <ul style="list-style-type: none"> <li>• Heart disease</li> <li>• Cancer</li> <li>• Cerebrovascular disease</li> <li>• Pulmonary disease</li> <li>• Pneumonia/influenza</li> </ul> | <ul style="list-style-type: none"> <li>• Heart disease</li> <li>• Cancer</li> <li>• Cerebrovascular disease</li> <li>• Pulmonary disease</li> <li>• Pneumonia/influenza</li> </ul> | <ul style="list-style-type: none"> <li>• Heart disease</li> <li>• Cancer</li> <li>• Cerebrovascular disease</li> <li>• Diabetes</li> <li>• Pneumonia/influenza</li> </ul> |

*Source: Centers for Disease Control and Prevention.*

## Cardiovascular Disease

Cardiovascular diseases are a top cause of death and disability among men in the United States and in Massachusetts.<sup>16</sup> These diseases include coronary heart disease, congestive heart failure, angina pectoris, stroke, hypertension (high blood pressure), cardiac arrhythmia, rheumatic heart disease, and various other, rare problems such as cardiomyopathy and congenital cardiac defects. According to the American Heart Association, roughly one-third of men can expect to develop some form of significant cardiovascular disease before they reach age 60, compared with one-tenth of women.<sup>17</sup>

Improvements in the treatment of risk factors for heart disease over the past decade have reduced deaths due to cardiovascular disease particularly among African-American men, but the problem remains serious in the United States. Factors contributing to cardiovascular disease include:

- tobacco use;
- lack of physical activity;
- poor nutrition;
- being overweight or obese;
- hypertension;
- high blood cholesterol levels; and
- diabetes.<sup>18</sup>

**Coronary Heart Disease:** Most coronary heart disease (85%) occurs in people over the age of 65, and men are more likely than women to have this disease. About 50% of men who die suddenly of coronary heart disease have no symptoms before they succumb. White, non-Hispanic men are at greatest risk. Massachusetts' mortality rate for coronary heart disease overall (males and females) is lower than the national average (see Table 6), although the state ranks 21<sup>st</sup> out of all states in this respect (with 1<sup>st</sup> being the lowest mortality rate in the United States, which happens to occur in New Mexico). **Angina pectoris** affects about 27% of men who have had a confirmed heart attack, with Mexican-Americans having the highest rate of angina.<sup>19</sup>

**Congestive Heart Failure:** Congestive heart failure is a major, chronic disease for older men, and the prognosis for men covered by Medicare is very poor—worse, in fact, than the prognosis for most types of cancer for these men.<sup>20</sup> In general, men are more likely than women to suffer from congestive heart failure, and men's five year survival rate is lower than for women.

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<sup>16</sup> Centers for Disease Control and Prevention; Office of Communications and Media Relations. *Deaths from Heart Failure, United States, 1980-1995*. [www.cdc.gov/od/oc/media/fact/heartdea.htm](http://www.cdc.gov/od/oc/media/fact/heartdea.htm), July, 1998.

<sup>17</sup> American Heart Association. *Cardiovascular Diseases*, [www.americanheart.org/statistics](http://www.americanheart.org/statistics), 2000.

<sup>18</sup> Centers for Disease Control and Prevention; National Center for Chronic Disease Prevention and Health Promotion; Cardiovascular Health. *Preventing Cardiovascular Disease: Addressing the Nation's Leading Killer, At-A-Glance 2000*. [www.cdc.gov/hccdphp/cvd/cvdaag.htm](http://www.cdc.gov/hccdphp/cvd/cvdaag.htm), March, 2000.

<sup>19</sup> American Heart Association. *2000 Heart and Stroke Statistical Update*, [www.americanheart.org](http://www.americanheart.org), 1999.

<sup>20</sup> Centers for Disease Control and Prevention; Office of Communications and Media Relations. *Facts About Heart Failure in Older Adults*, [www.cdc.gov/od/oc/media/fact/f990305.htm](http://www.cdc.gov/od/oc/media/fact/f990305.htm), March, 1999.

**Stroke:** Stroke can affect men at any age, although the largest proportion of stroke victims are affected between the ages of 55 and 66. African-American men, particularly younger African-American men, have two to three times the risk of ischemic stroke than do white men, and African-Americans in general are more likely to die from strokes. Massachusetts' mortality rate due to strokes is one of the lowest in the nation; the state ranks 2<sup>nd</sup> in this respect, with New York ranking 1<sup>st</sup>. Stroke is more common among men with hypertension, which may explain the higher-than-average incidence among African-Americans.<sup>21</sup>

**Hypertension:** On average, until age 55, more women than men have high blood pressure. This trend reverses after age 55, when hypertension among men surpasses the rate for women. African-American males are at very high risk of hypertension, at all ages. In fact, the rate of hypertension among African-American men is among the highest in the world. American Indian, Cuban-American, and white men are less likely than African-American men to have high blood pressure, and the rates for Puerto Ricans and Asian-Americans are among the lowest in the United States. One group that is extraordinarily likely to have high blood pressure is American men of Japanese origins. More than 70% of these men have high blood pressure.

Congestive heart failure is most common among men with diabetes and/or hypertension. Less than 25% of men with hypertension have their blood pressure under control, and the incidence of congestive heart failure is highest among African-American men.

**Other Cardiovascular Diseases:** Most other cardiovascular diseases are relatively rare among men. In general, African-American men are at much higher risk than men from other racial/ethnic groups to suffer from arrhythmia (particularly ventricular fibrillation, which is often fatal); end-stage renal disease; cardiomyopathy; heart problems related to rheumatic fever; and congenital cardiovascular defects such as atrial septal defects, patent ductus arteriosus, and ventricular septal defects. African-American infants also die more often from congenital heart problems. Mexican-American and American Indian men also suffer from higher-than-average rates of end-stage renal disease and rheumatic fever diseases. The rates for Puerto Rican men tend to be lower than average, regardless of the variety of cardiovascular disease in question.

The Centers for Disease Control and Prevention estimate that if all forms of cardiovascular disease were eliminated in this country, life expectancy would rise by almost seven years. The comparable statistic for cancer of all types is a three year gain in life expectancy. The probability at birth of eventually dying from a major cardiovascular disease is around 47%, and from cancer is 22%.

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<sup>21</sup> All findings reported on this page are derived from Centers for Disease Control and Prevention; Office of Communication and Media Relations. Facts About Cardiovascular Disease, [www.cdc.gov/od/oc/media/fact/cardiova.htm](http://www.cdc.gov/od/oc/media/fact/cardiova.htm), June 27, 1997; and American Heart Association.

**TABLE 6**

**Age-Adjusted Death Rates for Cardiovascular Diseases, Coronary Heart Disease, and Stroke, Massachusetts vs. United States, 1994-1996**

| Disease:                      | Massachusetts    |                       | United States Rate Per 100,000 |
|-------------------------------|------------------|-----------------------|--------------------------------|
|                               | Rate Per 100,000 | State Rank (1=Lowest) |                                |
| Total Cardiovascular Diseases | 331.4            | 12 <sup>th</sup>      | 382.2                          |
| Coronary Heart Disease        | 165.9            | 21 <sup>st</sup>      | 192.3                          |
| Stroke                        | 51.4             | 2 <sup>nd</sup>       | 63.4                           |

**Source:** National Center for Health Statistics compressed mortality file (unpublished). Data for 1994-1996 are combined.

**Cancer**

Cancer is the second most common health problem affecting men both nationally and in Massachusetts. Men are affected by the same kinds of cancer as women, with the exception of cancers specific to the male and female reproductive systems.

As of 1997, the annual, age-adjusted **incidence** of all types of cancer among men in Massachusetts was 484.4 per 100,000 men.<sup>22</sup> Males under the age of 20 have about the same annual incidence of cancer as their female counterparts (see Table 7), and men ages 20 to 44 actually have a lower risk of cancer than women of this age. After 45, however, the risk of cancer for men increases dramatically—by the time a man in Massachusetts reaches the age of 75, his risk of cancer is nearly twice that of women the same age. The **most common types of cancer** afflicting the state’s men, in rank order according to risk of mortality, include (see Table 8):

- cancer of the bronchus or lung;
- prostate cancer; and
- colorectal (colon or rectum) cancer.<sup>23</sup>

<sup>22</sup> Massachusetts Department of Public Health; Bureau of Health Statistics, Research, and Evaluation; Massachusetts Cancer Registry. Cancer Incidence and Mortality in Massachusetts, 1993-1997: Statewide Report, Appendix IV, March, 2000.

<sup>23</sup> *Ibid.*, Appendix III. Rates are age-adjusted to the 1970 U.S. Standard Population.

**TABLE 7****Age-Specific Annual Incidence of Cancer,  
Massachusetts Residents, 1993-1997**

| Age Group          | Males    | Females  | Total    |
|--------------------|----------|----------|----------|
| 19 years and under | 18.30    | 16.30    | 17.32    |
| 20-44 years        | 77.25    | 123.76   | 100.62   |
| 45-64 years        | 727.34   | 699.12   | 712.70   |
| 65-74 years        | 2,708.62 | 1,546.71 | 2,052.55 |
| 75-84 years        | 3,122.76 | 1,833.85 | 2,306.11 |
| 85 years and older | 3,046.65 | 1,595.07 | 1,946.36 |

*Source: Massachusetts Cancer Registry.*

**Cancer of the Lung and Bronchus:** Lung cancer is the most common killer of men in Massachusetts. The mortality rate for lung diseases of all types is significantly higher for men than women, both statewide and in the United States (see Table 9). For lung cancer specifically, the age-adjusted mortality rate is 45.4 per 100,000 men, compared with 28.9 per 100,000 for women.<sup>24</sup> Mortality rates are about the same for African-Americans and whites for cancers of the lung and bronchus.

For the most part, lung cancer is caused by cigarette smoking, and is thus preventable. Massachusetts has an aggressive Tobacco Control Program operated by the state's Department of Public Health, which operates a number of initiatives aimed at reducing tobacco use. From 1992 to 1998, per-capita purchases of cigarettes in Massachusetts declined by 30%, and smoking rates among adolescent and young men declined slightly. Although a definite link cannot be proven, the incidence of bronchus and lung cancer declined from 81.3 to 76.7 cases per 100,000 males in Massachusetts, or by about 6%, during roughly the same time period (1993-1997).<sup>25</sup>

<sup>24</sup> American Lung Association, Epidemiology and Statistics Unit. *Lung Disease, State By State*, [www.lungusa.org/data/state/state.pdf](http://www.lungusa.org/data/state/state.pdf), February, 2000.

<sup>25</sup> Hamilton, W. and G. Norton. *Independent Evaluation of the Massachusetts Tobacco Control Program, Fifth Annual Report: January 1994-1998*, Cambridge, MA: Abt Associates, Inc. and Boston, MA: Massachusetts Department of Public Health, [www.state.ma.us/dph/mtcp/report/abtrep.htm](http://www.state.ma.us/dph/mtcp/report/abtrep.htm), June, 1998.

**TABLE 8****Annual Age-Adjusted Cancer Incidence and Mortality Rates  
Per 100,000 Males, Massachusetts, 1993-1997**

| <b>Morbidity (Incidence) Rate:</b> | <b>1993</b>  | <b>1994</b>  | <b>1995</b>  | <b>1996</b>  | <b>1997</b>  |
|------------------------------------|--------------|--------------|--------------|--------------|--------------|
| <b>All Cancers</b>                 | <b>493.3</b> | <b>469.8</b> | <b>472.1</b> | <b>478.1</b> | <b>484.4</b> |
| Prostate                           | 152.8        | 138.4        | 144.6        | 145.4        | 150.2        |
| Bronchus & Lung                    | 81.3         | 79.3         | 74.8         | 74.0         | 76.7         |
| Colon & Rectum                     | 62.7         | 61.7         | 57.3         | 59.7         | 58.3         |
| Urinary Bladder                    | 23.8         | 21.2         | 23.6         | 24.6         | 24.9         |
| Non-Hodgkin's Lymphoma             | 17.9         | 17.7         | 19.1         | 19.7         | 18.6         |
| Melanoma of Skin                   | 12.9         | 12.3         | 13.8         | 14.9         | 15.6         |
| Kidney & Renal Pelvis              | 13.7         | 14.2         | 14.5         | 13.1         | 14.1         |
| Oral Cavity & Pharynx              | 16.8         | 16.4         | 15.4         | 16.0         | 14.0         |
| Pancreas                           | 9.2          | 8.3          | 8.5          | 8.5          | 11.2         |
| Leukemia                           | 10.5         | 9.4          | 10.1         | 11.2         | 10.9         |
| Stomach                            | 10.8         | 9.8          | 10.3         | 9.6          | 10.8         |
| Larynx                             | 9.3          | 7.5          | 8.9          | 8.6          | 8.6          |
| Brain & Central Nervous System     | 7.9          | 9.7          | 7.1          | 7.2          | 8.3          |
| Esophagus                          | 7.9          | 9.5          | 9.7          | 8.6          | 8.3          |
| Liver & Intrahepatic Bile Ducts    | 4.6          | 4.3          | 4.3          | 4.9          | 5.9          |
| Multiple Myeloma                   | 4.2          | 4.0          | 4.7          | 4.7          | 4.4          |
| Testis                             | 4.6          | 5.4          | 5.4          | 4.7          | 4.2          |
| Hodgkin's Disease                  | 4.3          | 3.9          | 3.6          | 4.4          | 3.2          |
| Thyroid                            | 2.5          | 2.2          | 2.8          | 3.4          | 2.7          |
| Breast                             | 1.4          | 1.5          | 1.3          | 1.9          | 1.5          |
| <b>Mortality (Death) Rate:</b>     | <b>1993</b>  | <b>1994</b>  | <b>1995</b>  | <b>1996</b>  | <b>1997</b>  |
| <b>All Cancers</b>                 | <b>222.9</b> | <b>221.8</b> | <b>220.5</b> | <b>217.2</b> | <b>207.1</b> |
| Bronchus & Lung                    | 65.6         | 67.5         | 66.8         | 64.3         | 61.8         |
| Prostate                           | 26.0         | 25.4         | 23.6         | 24.3         | 22.6         |
| Colon & Rectum                     | 25.8         | 25.2         | 24.8         | 23.0         | 22.3         |
| Pancreas                           | 10.2         | 10.4         | 10.0         | 10.1         | 10.2         |
| Non-Hodgkin's Lymphoma             | 8.2          | 8.9          | 9.2          | 10.1         | 8.7          |
| Esophagus                          | 6.3          | 7.1          | 8.0          | 7.4          | 7.4          |
| Leukemia                           | 8.8          | 7.4          | 8.3          | 8.3          | 7.3          |
| Urinary Bladder                    | 6.3          | 6.5          | 6.3          | 7.3          | 6.8          |
| Liver & Intrahepatic Bile Ducts    | 4.6          | 5.3          | 5.9          | 5.9          | 6.1          |
| Stomach                            | 6.8          | 7.1          | 7.1          | 7.0          | 6.1          |
| Kidney & Renal Pelvis              | 5.6          | 4.8          | 5.2          | 5.2          | 5.2          |
| Brain & Central Nervous System     | 5.4          | 4.9          | 4.7          | 5.6          | 4.3          |
| Melanoma of Skin                   | 3.9          | 3.9          | 2.7          | 3.7          | 3.8          |
| Oral Cavity & Pharynx              | 4.5          | 4.2          | 4.7          | 3.5          | 3.8          |
| Multiple Myeloma                   | 3.6          | 4.2          | 3.7          | 3.6          | 3.7          |
| Larynx                             | 3.1          | 2.6          | 2.4          | 2.7          | 2.3          |
| Thyroid                            | 0.4          | 0.4          | 0.4          | 0.3          | 0.5          |
| Breast                             | 0.2          | 0.4          | 0.3          | 0.3          | 0.3          |
| Hodgkin's Disease                  | 0.7          | 0.6          | 0.6          | 0.8          | 0.3          |
| Testis                             | 0.1          | 0.2          | 0.3          | 0.4          | 0.3          |

**Source:** Massachusetts Cancer Registry.

**TABLE 9**  
**Age-Adjusted Mortality Rates Per 100,000 Population**  
**Due to Lung Diseases, Massachusetts, 1997**

| Rate per 100,000 For:   | Massachusetts |       |       |       | United States |       |       |       |
|-------------------------|---------------|-------|-------|-------|---------------|-------|-------|-------|
|                         | Men           | Women | Black | White | Men           | Women | Black | White |
| Total All Lung Diseases | 84.9          | 56.0  | 66.7  | 68.3  | 93.3          | 55.4  | 81.0  | 71.6  |
| Lung Cancer             | 45.4          | 28.9  | 37.9  | 36.4  | 50.5          | 27.0  | 45.3  | 37.1  |
| Pneumonia/Influenza     | 18.0          | 11.1  | 16.2  | 13.8  | 16.3          | 10.6  | 17.0  | 12.6  |
| COPD**                  | 20.2          | 14.0  | 7.4   | 16.9  | 24.8          | 16.1  | 13.8  | 20.6  |

\* Age-adjusted to the 1940 U.S. civilian non-institutionalized population.

\*\* Chronic obstructive pulmonary disease (excludes asthma, which is reported separately. Asthma kills less than 40 men in Massachusetts each year).

**Source:** CDC WONDER: State Specific Mortality Data (unpublished), 1997. This information can be viewed at [www.lungusa.org/data/state/state.pdf](http://www.lungusa.org/data/state/state.pdf).

**Prostate Disease and Prostate Cancer:** The prostate is a walnut-sized organ responsible for producing the fluid component of sperm. The gland surrounds the urethra and lies immediately below the urinary bladder. Nearly all men will experience prostate enlargement in their lifetimes, and prostate cancer is the most commonly diagnosed form of cancer in the United States other than skin cancer.<sup>26</sup> Prostate cancer is the second most prevalent cause of mortality in men, and the disease is most common among men over age 65. For reasons that have not yet been determined, prostate cancer is much more common among African-American men than white men. Many men also experience **benign** prostate problems, which include:

- **acute or chronic prostatitis** (bacterial infections of the prostate); and
- **benign prostatic hypertrophy** or BPH (non-cancerous enlargement of the prostate, common in older men—roughly half of men in their 60s, and most men ages 70 and over, have BPH).<sup>27</sup>

Prostatitis is most often treated with antibiotics. BPH is often left alone in cases in which men are not bothered by symptoms. In men who do experience symptoms, a variety of medications can be used to treat the problem, including alpha blockers (e.g., doxazosin or prazosin) or finasteride (blocks action of male hormones). In troublesome cases, surgery can be used to relieve BPH symptoms. Such surgery might include transurethral resection, transurethral incision, or open surgery, if the gland is very large.

<sup>26</sup> Centers for Disease Control and Prevention; National Center for Chronic Disease Prevention and Health Promotion; Cancer Prevention and Control. *Prostate Cancer: Can We Reduce Deaths and Preserve Quality of Life? At-A-Glance 2000*, [www.cdc.gov/cancer/prostate/prostate.htm](http://www.cdc.gov/cancer/prostate/prostate.htm), 2000.

<sup>27</sup> National Institute on Aging. *Age Page: Prostate Problems*, [www.aoa.dhhs.gov/aoa/pages/agepages/prostate.html](http://www.aoa.dhhs.gov/aoa/pages/agepages/prostate.html).

Prostate cancer has been correlated with a high-fat diet in white, African-American, and Asian-American men.<sup>28</sup> There are two tests for prostate cancer that men should receive annually after age 50: (1) digital rectal examinations, which can detect gross tumors; and (2) prostate-specific antigen or PSA test, a blood test that detects both benign and cancerous problems with the prostate. PSA tests cannot determine whether a prostate problem is cancerous (only whether the gland is enlarged); thus men with a positive result often undergo biopsies to determine whether a problematic prostate is cancerous. Treatment for prostate cancer, which is usually slow-growing, ranges from:

- **waiting** to see if the cancer progresses or causes more symptoms;
- **radical prostatectomy** (surgical removal of the prostate, a procedure that in the past usually caused impotence. Surgeons are now increasingly able to avoid the nerves leading to the penis, thus impotence is now less common);
- **transurethral resection** (surgical removal of the cancer but not the entire prostate);
- **radiation therapy** (usually external, although a new procedure injects radioactive, titanium-encased pellets directly into the prostate<sup>29</sup>); and
- **hormone therapy** (used to treat prostate cancer that has spread to other parts of the body, and to prevent cancer from growing).

Men at highest risk for prostate cancer include **those who have more than one close relative with the disease, and African-American men**. The American Cancer Society estimates that in 2000, roughly 4,200 men in Massachusetts will be diagnosed with prostate cancer, and roughly 700 will die from the disease.<sup>30</sup> Table 10 presents age-adjusted mortality rates for prostate cancer for Massachusetts and the United States, broken down by race/ethnicity. Two trends are significant. First, the mortality rate for African-American men in Massachusetts is lower than the national average (46.2 vs. 54.8 deaths per 100,000 men), and the rate for Asian-American and Pacific Islanders is higher than average in Massachusetts (17.0 vs. 10.8 per 100,000).

From 1993 to 1997, the incidence of prostate cancer in Massachusetts declined slightly (by about 2%). The incidence rate is now about 150 per 100,000 men, and the decline was observed both in Massachusetts and nationally. Some researchers believe the decline has to do with changes in the provision of health care services to men, in that an increasing number of men are tested and treated for prostate disease in outpatient settings, and these cases are not always reported to cancer registries.<sup>31</sup>

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<sup>28</sup> Whittemore, A.; L. Kolonel; A. Wu; E. John; et al. "Prostate Cancer in Relation to Diet, Physical Activity, and Body Size in Blacks, Whites, and Asians in the United States and Canada." *Journal of the National Cancer Institute*, 87, 1995, pp. 652-661.

<sup>29</sup> Groopman, J. "Annals of Medicine: The Prostate Paradox, Computers vs. Cancer." *The New Yorker*, May 29, 2000, pp. 52-64.

<sup>30</sup> American Cancer Society. *Massachusetts Cancer Burden, Facts & Figures 2000*.

<sup>31</sup> Massachusetts Department of Public Health; Bureau of Health Statistics, Research, and Evaluation; Massachusetts Cancer Registry. *Cancer Incidence and Mortality in Massachusetts, 1993-1997: Statewide Report, Appendix IV, March, 2000*.

**TABLE 10**

**Age-Adjusted Mortality Rates for Prostate Cancer, Massachusetts and United States, Projected 2000**

| <b>Deaths Per 100,000 Males:</b>      | <b>Massachusetts</b> | <b>United States</b> |
|---------------------------------------|----------------------|----------------------|
| <b>All Males (Overall Rate)</b>       | <b>24.8</b>          | <b>25.6</b>          |
| White                                 | 24.3                 | 23.4                 |
| African-American                      | 46.2                 | 54.8                 |
| Hispanic/Latino                       | 10.8                 | 16.6                 |
| Asian/Pacific Islander                | 17.0                 | 10.8                 |
| <b>Estimated # New Cases for 2000</b> | <b>4,200</b>         | <b>180,400</b>       |
| <b>Estimated # Deaths in 2000</b>     | <b>700</b>           | <b>31,900</b>        |

**Source:** American Cancer Society web site. Data are age-adjusted to the 1940 standard U.S. population.

**Colorectal Cancer:** Cancers of the colon and rectum are the third major cause of cancer-related mortality among Massachusetts men. Men are much more likely than women to contract colorectal cancer, and to die from the disease. The mortality rate for colorectal cancer among men in Massachusetts is almost the same as for prostate cancer (22.3 vs. 22.6 per 100,000 men, age-adjusted). Colorectal cancers are easily treated, with good success, if the disease is caught early. Groups at greatest risk of colorectal cancer include:

- all men over age 50, since 93% of cases occur after age 50;
- African-American men;
- men with a history of inflammatory bowel disease, ulcerative colitis or colorectal polyps;
- men with family members who have had or died from cancers of the colon, rectum, or female reproductive organs, and men with a family history of colorectal polyps;
- men with poor lifestyle habits, such as lack of exercise; a diet low in fruits, vegetables, and fiber and high in fat; and alcohol consumption; and
- men with certain genetic markers for colon or rectal cancer.<sup>32</sup>

<sup>32</sup> Centers for Disease Control and Prevention; National Center for Chronic Disease, Prevention and Health Promotion; Cancer Prevention and Control. *Colorectal Cancer: The Importance of Prevention and Early Detection: At-A-Glance 2000*, [www.cdc.gov/cancer/colorct/colorect.htm](http://www.cdc.gov/cancer/colorct/colorect.htm), 2000.

There are two tests commonly used to detect colorectal cancer: (1) **fecal occult blood test** (FOBT), which can be done by men at home with a special kit, or by a physician during a routine digital rectal exam; and (2) **flexible sigmoidoscopy**, a procedure in which a flexible, tube-like instrument is inserted in the rectum, so all areas of the rectum and colon can be observed by a physician.<sup>33</sup> Variations of sigmoidoscopy include proctoscopy and colonoscopy. Treatment for colorectal cancer often includes surgery, radiation therapy, chemotherapy, or biological response modifier (BRM) therapy, which is sometimes referred to as immunotherapy.<sup>34</sup>

While screening for colorectal cancer is critical in terms of reducing the risk of dying from the disease, men do not tend to get these tests on a regular basis which may in part explain their greater likelihood of late detection of the disease. About 20% of men ages 50 and over in the United States had had a FOBT done in 1997, with lower rates for Asian-American and Hispanic-Latino men. About 35% of men ages 50 or over have had a sigmoidoscopy or proctoscopy (a similar procedure) during the past five years, again, with lower rates for Asian-American men. In total, only 41% of men ages 50 and older have had either a FOBT or flexible sigmoidoscopy.<sup>35</sup>

Medicare expanded coverage in 1998 to cover colorectal screening in men. Massachusetts residents in general (both sexes, ages 50 and older) are more likely than the nationwide average to have had FOBT tests done recently (28.1% vs. 19.8%), but are comparable in terms of sigmoidoscopy. From 1993 to 1997, colorectal cancer declined by 7% among men in Massachusetts, from 62.7 to 58.3 cases per 100,000 men. Researchers believe the decline is due to better screening, resulting in earlier detection.<sup>36</sup>

## Diabetes

Diabetes mellitus is a potentially fatal disorder caused by a deficiency of the hormone insulin, which is secreted by the pancreas. There are two varieties, Type 1 (insulin-dependent), which tends to occur during childhood or adolescence, and Type 2 (non-insulin-dependent), a more common disorder, which usually occurs after age 40. Type 1 diabetes is more common among white males, while Type 2 is much more prevalent among African-American males. Untreated diabetes often leads to debilitating complications, such as blindness, amputation of the lower extremities, diabetic ketoacidosis, and end-stage renal disease (kidney failure requiring dialysis or kidney transplant).<sup>37</sup>

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<sup>33</sup> Centers for Disease Control and Prevention. "Screening for Colorectal Cancer—United States, 1997," *Morbidity & Mortality Weekly Report*, 48(6), January 19, 1999, pp. 116-121.

<sup>34</sup> National Cancer Institute. "Colon Cancer (PDQ®)." *CancerNet*, [www.cancernet.nci.nih.gov](http://www.cancernet.nci.nih.gov), 2000.

<sup>35</sup> Centers for Disease Control and Prevention; Office of Communication and Media Relations. *Colorectal Cancer and Early Detection*, [www.cdc.gov/od/oc/media/fact/colorect.htm](http://www.cdc.gov/od/oc/media/fact/colorect.htm), February, 1999.

<sup>36</sup> Massachusetts Department of Public Health; Bureau of Health Statistics, Research, and Evaluation; Massachusetts Cancer Registry. *Cancer Incidence and Mortality in Massachusetts, 1993-1997: Statewide Report*, Appendix IV, March, 2000.

<sup>37</sup> American Diabetes Association. *Surveillance Report: The Public Health of Diabetes Mellitus in the United States*, Chapter 1, [www.diabetes.org](http://www.diabetes.org), 2000.

About 5.7% of men in Massachusetts have been told at some point by a health care professional that they had diabetes, compared with 5.2% nationally.<sup>38</sup> Overall, 8.2% of men in the United States have diabetes, although roughly one-third are unaware of this fact. Diabetes in men is accompanied by the same range of complications as is true for women, but the disease can also cause impotence in men. As many as 60% of men over age 50 who have diabetes suffer from some degree of impotence. Other risks specific to men with diabetes include:

- a much greater risk of retinopathy among men whose diabetes is diagnosed before age 30, as compared with women with diabetes;
- a greater risk of coronary heart disease, cardiac failure, and peripheral vascular disease; and
- higher likelihood of having a lower extremity amputated, such as a foot or leg (1.4 to 2.7 times higher in men than women).<sup>39</sup>

**Diabetes and African-American Men:** Roughly 25% of African-American men between the ages of 65 and 75 have diabetes. African-American men with diabetes experience serious complications more often than white men with diabetes, and are more likely to become blind, have lower limbs amputated, and suffer from kidney failure.

**Diabetes and Hispanic/Latino Men:** Hispanic/Latino men are more likely than white men to have Type 2 diabetes, and the prevalence of diabetes is highest among Mexican-Americans (24%) and Puerto Ricans (26%) who are between the ages of 45 and 74. The rate for Cuban-Americans is lower than for other Hispanic/Latino groups (16%). Mexican-Americans who have diabetes are highly likely to develop diabetic retinopathy which often leads to blindness; their rate is as high as 40% for this complication. Mexican-Americans with diabetes are also five to seven times as likely as other diabetics to suffer from end-stage renal disease.

**Diabetes and American Indians:** Diabetes is considered by many researchers to be an epidemic among American Indians and Alaska Natives. While the American Indian population in Massachusetts is small, an estimated 12% of those over age 19 have diabetes. One tribe in Arizona has the highest rate of diabetes in the world—about 50% of this tribe's members who are ages 30 to 64 have diabetes. The rate of diabetic end-stage renal disease among American Indians with diabetes is around six times as high as the rate among other groups in the United States; the rate of amputation is three to four times higher; and the rate of diabetic retinopathy is also higher than average, particularly among Pima and Oklahoma Indians.

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<sup>38</sup> Centers for Disease Control and Prevention; National Center for Chronic Disease Prevention and Health Promotion; Behavioral Risk Factor Surveillance System. *Prevalence Data*, [www2.cdc.gov/nccdphp/brfss](http://www2.cdc.gov/nccdphp/brfss), 1999.

<sup>39</sup> American Diabetes Association. *Diabetic Facts and Figures*, [www.diabetes.org](http://www.diabetes.org), 2000.

## Accidents and Violence

Nationally, men are at greater risk than women of being involved in auto crashes or workplace accidents, of being physically assaulted by strangers or murdered on the streets or at their jobs, and of committing suicide. These forms of violence affect men of all racial and ethnic backgrounds, but African-American men—especially younger men—are most vulnerable to violent crime. Accidents, homicide, and suicide are major causes of morbidity and mortality among men in Massachusetts, especially among teenagers and young adults. For these reasons, violence is arguably one of the greatest public health problems affecting men both statewide and nationally.

**Men and Accidents:** The main cause of accident-related mortality among men in Massachusetts is motor vehicle crashes, a problem that is particularly acute among teenagers and young adult males. Unintentional injuries are the next most prevalent variety of fatal accident among men.

Men are more likely than women to engage in risk-taking behaviors that often lead to accidents. For example, in Massachusetts, the majority of **binge drinkers** are white men ages 18 to 24, men are much more likely than women to **drive while intoxicated**, and men are less likely than women to wear seatbelts.<sup>40</sup> Another example: boys account for 86% of hospital emergency room visits relating to **BB and pellet gun injuries and accidents** among children and teenagers in the United States, with males ages 10-19 at greatest risk.<sup>41</sup>

The annual rate of **occupational injury** in Massachusetts is 2.2 deaths per 100,000 workers. In 1995, almost all (97%) of the fatal occupational injuries in the state involved male victims, most of whom were in the prime of their working years. The primary causes of occupational fatality in Massachusetts are falls off scaffolding and ladders, highway traffic injuries, homicide, and injuries caused by vehicles or mobile equipment striking pedestrians. The two industries accounting for the largest proportion of occupational fatalities in Massachusetts are construction and retail trade.<sup>42</sup>

**Men and Homicide:** For a variety of complex reasons not all of which are clearly understood, crime in Massachusetts has declined over the past decade, as well as recently, by about 4.8% from 1997 to 1998. Crime rates for murder, rape, robbery, and aggravated assault have all declined in Massachusetts, by about 16% since 1991. Men are both the main perpetrators of violent crime in Massachusetts, as well as the main victims, particularly of fatal and potentially fatal violence. Among the state's convicted homicide **offenders**:<sup>43</sup>

- 91% are men;

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<sup>40</sup> Massachusetts Department of Public Health, Chronic Disease Surveillance Program. *Health Risks and Preventive Behavior Among Massachusetts Adults, 1997: Results from the Behavioral Risk Factor Surveillance System*, June, 1999.

<sup>41</sup> Centers for Disease Control and Prevention. "BB and Pellet Gun-Related Injuries—United States, June 1992-May 1994." *Morbidity and Mortality Weekly Report*, 44(49), December 15, 1995, pp. 909-913 (see Table 1).

<sup>42</sup> Massachusetts Department of Public Health, Occupational Health and Safety. *Overview of Fatal Injuries at Work in 1995*, 1998.

<sup>43</sup> Massachusetts State Police, Crime Reporting Unit, Research and Development Section. *Preliminary Annual Crime Report, 1997-1998*, January, 1999.

- 47% commit murder within the City of Boston;
- most use firearms, handguns, knives, or blunt objects to kill; and
- 65% are white, and 33% are African-American.

Most homicide **victims** in Massachusetts are people ages 14 to 44 years who live in either Boston, Springfield, Lowell, or Lynn, with the greatest risk of victimization among African-American men, particularly in Boston. About three-fourths (74%) of homicide victims in Massachusetts in 1995 were men, about 52% of whom were African-American and 45% were white.<sup>44</sup>

**Men and Physical Violence:** In terms of violence resulting in injury (but not death), in 1996 there were nearly 600 reports from hospital emergency rooms in Massachusetts of men who had sustained violence-related injuries, and another 1,566 men who received sharp instrument wounds. The majority of gun assaults affect African-American youth, and the majority of stabbings occur among African-American and Hispanic/Latino youth. Rates in Massachusetts for both gun assaults and stabbings have declined substantially over the past five years, mirroring national trends.<sup>45</sup>

Men also suffer from **sexual assault**, although this topic has not been addressed to any great extent in Massachusetts, probably because women substantially outnumber men in the use of rape crisis centers, and these centers provide most of the state's data on sexual crimes. The most recent Behavioral Risk Factor Surveillance System (BRFSS) survey only asks women ages 18 to 59 whether they have ever had sexual contact against their will, even though this problem does affect some men.<sup>46</sup> In fact, between 1995 and 1997, there were 179 reported cases of men who had been raped, 15 cases of men who had experienced an attempted rape, and 106 cases of sexual assault of men in Massachusetts. It is highly likely that the actual number of men who were sexually assaulted or raped during that time period is larger than the reported statistics suggest.<sup>47</sup>

Existing data for Massachusetts suggest that, among males in general, boys under age 12 are most likely to receive treatment for rape, attempted rape, and other sexual assaults. Once boys reach adolescence, however, the proportion who seek help drops significantly—among all adolescents ages 13-19 who sought help in rape crisis centers, only 4% were male. This does not necessarily mean that teenage boys, or adult men, for that matter, are less likely than young boys to be sexually assaulted. It simply means they tend not to report such crimes, or seek help.

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<sup>44</sup> Massachusetts State Police, *Crime Reporting Unit, Research and Development Section. Homicide in Massachusetts, 1995*, [www.magnet.state.ma.us/msp/cru/spresrch.htm](http://www.magnet.state.ma.us/msp/cru/spresrch.htm), October, 1996.

<sup>45</sup> Massachusetts Department of Public Health; Bureau of Health Statistics, Research, and Evaluation. *Weapon Injury Update: News from the Weapon-Related Injury Surveillance System (WRISS)*, April, 1997.

<sup>46</sup> Massachusetts Department of Public Health, *Chronic Disease Surveillance Program. 1999 Behavioral Risk Factor Surveillance System Questionnaire*.

<sup>47</sup> Massachusetts Department of Public Health. *Sexual Assault in Massachusetts 1988-1997: Findings from Publicly-Funded Rape Crisis Centers and the Behavioral Risk Factor Surveillance System*, November, 1999.

In Massachusetts, men are by far more likely than women to commit sexual crimes. Of the 25,759 assailants documented from 1988 to 1997, nearly nine-tenths (89%) were male. Males assaulted or raped between 1995 and 1997 in Massachusetts were for the most part assaulted or raped by other men.

**Men and Suicide:** Suicide rates among teenagers and young men have more than tripled over the past four decades. Among 15 to 19 year-old males in the United States, the suicide rate in 1960 was 5.6 per 100,000 males. By 1990, this rate had increased to 18.1 per 100,000 males. A similar increase occurred for men ages 20 to 24 (11.5 to 25.7 per 100,000). Although women make more suicide attempts, young men are far more likely than young women to succeed in committing suicide, in part because they tend to use more dangerous methods, such as a gunshot to the head.<sup>48</sup>

## Substance Abuse

In Massachusetts, adult men are significantly more likely than adult women to drink alcohol and to “binge” drink, which means consuming five or more alcoholic beverages in one sitting (see Table 11). Men are also slightly more likely than women to smoke cigarettes (21.8% vs. 19.2%). Nationally, males are more likely than females to use almost every kind of illicit drug, and this is true for both adults and high school students.

Substance abuse is a major health problem for many men, in part because alcohol, cigarettes, and illegal drugs can be addictive, and for some men, use of these substances may lead to risk-taking behavior with resulting accidents and fatalities. For example, men who die in motor vehicle crashes are almost twice as likely as women drivers to be legally drunk (defined as a blood alcohol concentration of 0.10 g/dL or greater).<sup>49</sup>

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<sup>48</sup> Centers for Disease Control and Prevention. “Programs for Prevention of Suicide Among Adolescents and Young Adults.” *Morbidity and Mortality Weekly Report*, 43(RR-6), April 22, 1994, pp. 1-7 (see Table 1).

<sup>49</sup> Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Impaired Driving Fact Sheet*, [www.cdc.gov/ncipc/factsheets/driving.html](http://www.cdc.gov/ncipc/factsheets/driving.html), 2000.

**TABLE 11**

**Substance Use Among Men, 1997-1998**

| Substance or Behavior                              | Massachusetts:  |         | U.S. Males |  |  |
|--|-----------------|---------|------------|--|--|
|  | Males           | Females |            |  |  |
| <b>Alcohol</b>                                     |                 |         |            |  |  |
| Drank at all in the past month                     | 71.8%           | 58.6%   | 62.0%      |  |  |
| Drank 5 or more at least once in past month        | 38.6%           | 16.1%   | 37.6%      |  |  |
| Drove while drunk                                  | 3.1%            | 2.3%    | 5.5%       |  |  |
| <b>Tobacco</b>                                     |                 |         |            |  |  |
| Current smoker                                     | 21.8%           | 19.2%   | 25.4%      |  |  |
| <b>Illicit Drug Use, Adult Males</b>               |                 |         |            |  |  |
| Any illicit drugs                                  | (Not Available) |         | 8.1%       |  |  |
| Marijuana  |                 |         | 6.7%       |  |  |
| Cocaine  |                 |         | 1.1%       |  |  |
| <b>Illicit Drug Use, Male High School Students</b> |                 |         |            |  |  |
| Marijuana  |                 |         | 50.7%      |  |  |
| Cocaine  |                 |         | 9.1%       |  |  |
| Crack  |                 |         | 5.2%       |  |  |
| Illegal steroids                                   |                 |         | 4.1%       |  |  |
| Injection drugs                                    |                 |         | 2.6%       |  |  |

Sources: Centers for Disease Control and Prevention, *1997 Behavioral Risk Factor Surveillance System*; U.S. Health and Human Services Administration, *Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, 1998 National Household Survey on Drug Use*; and Centers for Disease Control and Prevention, *1997 Youth Risk Behavior Surveillance System* (Links to these data bases can be found at [www.fedstats.gov](http://www.fedstats.gov)).

## Other Health Problems Unique to Men

Two other health problems that are unique to men include testicular cancer and erectile dysfunction. **Testicular cancer** is very rare, affecting less than five men per 100,000 in Massachusetts (refer to Table 8). The disease is most prevalent among men ages 15 to 35 and among men with undescended testicles, even if surgically corrected during childhood.<sup>50</sup> Surgery, radiation therapy, chemotherapy, and bone marrow transplant are treatment options. If detected and treated early, testicular cancer is often curable. If caught in later stages, the disease is difficult to treat and often fatal.<sup>51</sup>

**Erectile dysfunction** (impotence) is often defined as the *“inability to obtain an erection rigid enough to penetrate the vagina and then stay rigid long enough to complete intercourse during at least 75% of attempts.”*<sup>52</sup> The problem can occur at any age and is often confused with premature or delayed ejaculation, low sexual desire, and a lengthened period of time after ejaculation, during which it is not possible for men to ejaculate again.

Erectile dysfunction is most common among men ages 40 and older, and it can be caused by physical abnormalities, medical problems, and psychosocial difficulties. With men under age 50, the cause is most often psychological. For men over age 50, the cause is often organic and is much more difficult to treat, although there have been recent developments in this respect, such as effective medications for erectile dysfunction. Risk factors range from diabetes to atherosclerosis, hypertension, use of certain medications (particularly for cardiovascular disease), cigarette smoking, alcohol use, and pelvic surgery. Men who have endocrinopathy, obstructive sleep apnea syndrome, or who have experienced trauma to the pelvic region as a result of accidents or other causes may also experience erectile dysfunction.

## Men and Diseases Commonly Attributed to Women

While breast cancer, osteoporosis, and eating disorders are commonly thought of as *“women’s health concerns,”* men do suffer from these diseases (albeit in much smaller numbers than women), and are often not treated because of the belief that only women get them.<sup>53</sup> Men and health providers who treat men may fail to recognize important warning symptoms, or may not believe that breast cancer, osteoporosis, or eating disorders affect both genders. Men face several obstacles in dealing with these health problems:

- they may believe that these disorders are *“not masculine,”* or that it is inappropriate for men to have or be treated for problems that mostly affect women;

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<sup>50</sup> National Cancer Institute, CancerNet. *Testicular Cancer (PDQ®)*. [cancer.net.nci.nih.gov](http://cancer.net.nci.nih.gov).

<sup>51</sup> Henkel, J. *Testicular Cancer: Survival High with Early Treatment*, U.S. Food and Drug Administration, [www.fda.gov/fdac/features/196test.html](http://www.fda.gov/fdac/features/196test.html), 2000.

<sup>52</sup> “Erectile Dysfunction.” *Digital Urology Journal*, [www.duj.com/erectile.html](http://www.duj.com/erectile.html), 2000.

<sup>53</sup> Henkel, J. *Conditions Men Get Too*, U.S. Food and Drug Administration, [www.fda.gov/fdac/features/695\\_men.html](http://www.fda.gov/fdac/features/695_men.html), 2000.

- they may feel embarrassment, shame, and fear about getting a “*woman’s disease*,” particularly when it involves the breasts; and
- they may be frustrated in trying to get gender-appropriate information and treatment (for example, young men often do not stay in group treatment for anorexia or bulimia, because these groups are usually dominated by women).

**Men and Osteoporosis:** Roughly five million men in the United States have osteoporosis, which is a condition characterized by weakened bones caused by a deficiency in calcium. Women are about four times as likely to suffer from osteoporosis, theoretically because men have greater bone mass than women on average, and bone loss begins later in men’s lives. There are few gender-specific treatments for men with osteoporosis, and some of the more recent drugs developed for osteoporosis in women (such as calcitonin) have not been approved by the FDA for use in men. Like women, men with osteoporosis are treated with calcium supplements, sodium fluoride, vitamin D, and calcitonin, and some also receive testosterone injections. Factors contributing to osteoporosis include an inactive lifestyle, cigarette smoking, and drinking alcohol.<sup>54</sup>

**Men and Eating Disorders:** Eating disorders include such conditions as anorexia nervosa (purposeful starvation) and bulimia nervosa (binging followed by self-induced vomiting or laxative use). Men make up roughly 13% of people in the United States who have eating disorders, about 10% of people who seek professional help for eating disorders are male,<sup>55</sup> and 6% of men with these problems die as a result. Eating disorders in men tend to surface during adolescence, and many men refuse or fail to seek treatment. Unlike women, men are often medically obese when they first exhibit eating disorders, and they feel pressure to be thin, which prompts the disorder and/or a related problem, compulsive exercising.

**Men and Breast Cancer:** Breast cancer is rare among men, both in Massachusetts and nationally, although men do get this disease and, in fact, are about as likely to die from breast cancer as they are from testicular cancer. Men rarely perform breast self-examinations and, for the most part, are not examined by physicians for breast-related problems during routine physicals. Men with hyperestrogenism (abnormal secretion of estrogen in the blood), Klinefelter’s syndrome (which often causes enlarged breasts in afflicted men), and gynecomastia (other enlargement of the breasts) are at greater risk of breast cancer. Men with testicular problems are also at higher risk. Unfortunately, men are often diagnosed after breast cancer has spread, because they are hesitant to report symptoms of the disease.<sup>56</sup>

**Men and “Menopause:”** Most people associate menopause strictly with women—the term is almost never used in connection with men. There is evidence, however, that while the process is much more gradual, men do experience changes in hormonal activity as they age that may lead to declines in testosterone levels, erectile dysfunction, and increased risk of osteoporosis.<sup>57</sup> The issue has not been widely researched, but the popular media (particularly web sites on general health issues, such as *drkoop.com*) has started mentioning “male menopause” as a concern.

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<sup>54</sup> Henkel, J. *Conditions Men Get Too*. U.S. Food and Drug Administration, [www.fda.gov/fdac/features/695\\_men.html](http://www.fda.gov/fdac/features/695_men.html), 2000.

<sup>55</sup> *Eating Disorders Awareness and Prevention, Inc. (EDAP). Men and Eating Disorders: The Latest Facts*, [www.edap.org/men.html](http://www.edap.org/men.html).

<sup>56</sup> Henkel, *Ibid*.

<sup>57</sup> *Male Menopause—Fact or Fiction?*, [www.drkoop.com](http://www.drkoop.com), March 26, 2000.

## MEN'S ATTITUDES TOWARD HEALTH

Overall, most research on men's health indicates that men are not only less likely than women to seek medical care, but are also less proactive with respect to maintaining and monitoring their health. More often than not, men put off seeing a doctor when they have medical problems, especially problems affecting the reproductive system. Men tend to rate themselves as "healthy" even when they are overweight, have high blood pressure or cholesterol, consume alcohol or drugs in unhealthy amounts, or regularly engage in risky behaviors, such as driving while intoxicated, not wearing helmets while riding motorcycles, and so on. The most important issues with respect to men's attitudes toward health are as follows:

- men fail to obtain primary health care on a regular basis;
- men prefer to view themselves as healthy, often ignore warning signs and symptoms of disease, and avoid seeing a doctor until the problem is advanced (and often more difficult to treat). Furthermore, views about gender roles strongly influence men's attitudes about health, making it less likely that they will admit they are sick and subsequently see a doctor; and
- these gender-stereotyped attitudes toward health are perpetuated to some extent by organizations that conduct research on health, and in men's experiences with the health care system.

**Avoiding Primary Health Care:** With the exception of the very young and very old, throughout the life span men make fewer visits than women on an annual basis to primary care physicians and outpatient health care providers.<sup>58</sup> Despite the fact that men are more often affected by accidents and certain forms of violent assault, men are also slightly less likely than women to visit emergency rooms over the course of a typical year. This is especially evident for men ages 15 to 24, who are most likely to engage in risky behavior that leads to accidents. When surveyed, anywhere from 55% to 70% of men will claim they have had a physical exam in the past year,<sup>59</sup> but the proportion drops significantly for men under the age of 50. In general, men account for only 40% of visits to physicians in the United States.<sup>60</sup> Many men go for ten years or more without seeing a doctor of any kind.<sup>61</sup>

Men are also significantly less likely than women to understand that **regular medical care is important for good health** (50% of men recognize this fact, compared with 68% of women). The majority of men say they are concerned about prostate cancer, but only about 35% overall have actually been tested for the disease, and less than half (48%) of men ages 55 to 64, the ages when prostate cancer risk rises dramatically, have been tested.<sup>62</sup>

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<sup>58</sup> National Center for Health Statistics. *Visit Rates (NAMCS)*, [www.cdc.gov/nchs/dataawh/statab/pubd/vrn.htm](http://www.cdc.gov/nchs/dataawh/statab/pubd/vrn.htm), March, 1999.

<sup>59</sup> "CNN/Men's Health Magazine: Most Men Say They Are Healthy." *American Health Line*, Focus on Men's Health Week, June 15, 1999.

<sup>60</sup> Lipsyte, R. "Don't Take Your Medicine Like a Man; As Patients, Men Are Impatient, or Uneasy, or Both. They Need to Get a Grip, Like Women." *New York Times*, February 17, 1999, p. G-1.

<sup>61</sup> Reuters Health. "Men More Likely to Neglect Health." *HealthCentral.com News*, June, 1998.

<sup>62</sup> National Center for Health Statistics, *Ibid.*

Some researchers believe men fail to get primary health care because “men’s health” is not a major theme for the general public or within the health care industry, and there are no kinds of physicians for men that are comparable to those available specifically for women, such as gynecologists or obstetricians.<sup>63</sup> Most surveys of men suggest, however, that traditional views about maleness and men’s role in society and in their families in large part drive their reluctance to schedule regular check-ups.<sup>64</sup>

**TABLE 12**

**1999 Guidelines for Health Screening in Men**

| Age   | Annual  | Every 1-3 Years   | Every 3-5 Years                        | Every 5-10 Years   |
|-------|---|---|--|--|
| 18-39 | Basic physical*<br>Dental exam  | Blood pressure check  | Cholesterol check                      | Tetanus booster  |
| 40-65 | Basic physical*<br>Dental exam<br>Blood pressure check<br>FOBT**<br>PSA***                      | Vision & glaucoma tests   | Blood sugar check<br>Cholesterol check | Flexible sigmoidoscopy<br>Colonoscopy<br>DC barium enema<br>Tetanus booster    |
| 65+   | Basic physical*<br>Dental exam<br>Blood pressure check<br>FOBT**<br>PSA***<br>Influenza vaccine | Thyroid hormone check<br>Complete blood count<br>Cholesterol check<br>Blood sugar check<br>Hearing test<br>Vision & glaucoma tests<br>Urine-lab tests | Flexible sigmoidoscopy                 | Colonoscopy<br>DC barium enema<br>Pneumonia vaccine (at 65)<br>Tetanus booster |

\* Physical exam to screen for cancers of the thyroid, lymph nodes, skin, and testes.

\*\* Fecal occult blood test (FOBT) for colorectal cancer.

\*\*\* Prostate-specific antigen (PSA) test for prostate cancer.

**Source:** Based on guidelines developed by the American Academy of Family Physicians and U.S. Preventive Health Task Force; see DeRoin, D. “Routine Health Care for Men.” *Clinical Reference Systems*, July 1, 1999, pp. 1277.

<sup>63</sup> Lipsyte, R. “Don’t Take Your Medicine Like a Man; As Patients, Men Are Impatient, or Uneasy, or Both. They Need to Get a Grip, Like Women.” *New York Times*, February 17, 1999, p. G-1.

<sup>64</sup> Centers for Disease Control and Prevention; National Center for Chronic Disease, Prevention, and Health Promotion; Cancer Prevention and Control. *Colorectal Cancer: The Importance of Prevention and Early Detection: At-A-Glance 2000*, [www.cdc.gov/cancer/colorctl/colorect.htm](http://www.cdc.gov/cancer/colorctl/colorect.htm), 2000.

These gender-related attitudes generally fall into three categories:

- **men are too busy with jobs and supporting families**—they have no time, have too many responsibilities, do not have enough financial resources to seek care, or they believe it “*costs too much*” to have a check-up.<sup>65</sup> Men in their 20’s have no time to spend on doctor visits, and men in their 40’s are afraid they will find out something is wrong with them if they have a check-up;
- **men are not supposed to get sick**—only sick people go to the doctor, and men do not believe they get sick or think they should be strong, stoic, and silent about illness or injury. Men have a much more difficult time than women in discussing health matters, especially when they involve aging, hormones, or reproductive health, and they may not admit they are sick to avoid frightening their partners or children;<sup>66</sup> and
- **doctors are not to be trusted**—if a man had something seriously wrong with him, doctors would not be able to cure the problem. An alternative argument is that men feel ashamed to ask for help from a doctor, are terrified that certain procedures will be painful or embarrassing, or are “*squeamish about doctors poking around their lower anatomy.*”<sup>67</sup>

Even when men do get primary health care, they often fail to discuss any symptoms they may be having with their doctors. Men often lack a vocabulary for discussing health matters, tend not to be involved in health care decisions for their families, and lack experiences with the health care system, so they tend not to think of going to the doctor as an option if they are experiencing pain or feel sick. The consensus among providers is that men are “*out of touch with their bodies*” and are taught to ignore symptoms and not discuss those symptoms until they are desperate.

**Socialization to be Good Patients:** Men are often described by providers as “good patients,” in that they tend not to ask questions about their symptoms and are often stoic in the face of pain or illness. Some believe they are not allowed to manifest illness until the symptoms are obvious or overt, and thus delay treatment until their conditions are advanced (and as a result, much harder to treat). Men are also less predictable than women in terms of following treatment regimens, and often claim that they are not interested in improving their health and fitness.<sup>68</sup> Men’s outward excuses for avoiding health care may mask feelings of self-doubt and/or pressure to conform to societal norms about men’s behavior. As one researcher explained:

- “***I’m too busy***” might mean “*It looks bad if I take time off work to see a doctor. My co-workers might think I’m weak, lazy, or getting old;*”

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<sup>65</sup> “CNN/Men’s Health Magazine: Most Men Say They Are Healthy.” *American Health Line*, Focus on Men’s Health Week, June 15, 1999.

<sup>66</sup> “Barriers to Care: Why Do Men Have Fewer Doctor Visits?” *American Health Line*, Focus on Men’s Health Week, June 15, 1995.

<sup>67</sup> Gallo, N. “Real Men Go to Doctors.” *Better Homes and Gardens*, October, 1996, 74(10), pp. 54-59.

<sup>68</sup> Brody, J. “Giving Men Directions to the Road to Better Health.” *New York Times*, Science Desk/Health Page, August 4, 1998, p. F-7. See [www.nytimes.com](http://www.nytimes.com).

- **“I don’t trust doctors”** might mean *“I don’t like giving up control;”*
- **“I don’t want to make a big deal out of it”** might mean *“I’m afraid of bad news;”*
- **“I already know what they’ll say”** might mean *“The doctor will tell me to change my lifestyle, and I don’t want to hear any more about exercise, stress, or eating better;”* and
- **“I can’t talk to my doctor”** might mean *“I’m too embarrassed to discuss what’s wrong. I don’t know very much about common health conditions and will feel foolish if I ask questions.”*<sup>69</sup>

Part of the problem lies in the ways men are raised in this country—boys are conditioned to *“tough things out”* and endure pain at all costs, or until they have finished whatever task or project they are working on. Men also tend to think that symptoms are only important if they are drastic, cause physical collapse, or are extremely painful. A good example is men’s attitudes toward *Viagra*,<sup>70</sup> a medication that is effective in helping many men with erectile dysfunction. A 1999 survey of men ages 45 and older conducted by the American Association of Retired Persons (AARP) indicated that only 25% of men with at least some degree of erectile dysfunction take this medication, even though it has been widely publicized.

Unfortunately, men who exhibit signs of social dominance, are highly competitive, or try hard to take control of situations are at much greater risk of dying than men who are less aggressive in these respects.<sup>71</sup> Men’s tendency to ignore symptoms and wait to see if illness improves without treatment is one reason why many health campaigns aimed at men have targeted the women in men’s lives, because these women can sometimes get men to pay attention to their health and/or seek help when they need it.

**Perpetuation of Men’s Health as a “Non-Issue:”** In some ways, stereotypes about men and health are augmented by their experiences with the health care industry. Doctors are under great pressure to treat patients quickly, and patients who do not ask many questions may be viewed more positively than those who are aggressive in seeking treatment. Men also face the same variety of institutional barriers to health care as women, such as lack of insurance, inconvenient doctors’ office hours, and for some men, inability to get to a doctor’s office due to lack of transportation.<sup>72</sup>

<sup>69</sup> Gallo, N. “Real Men Go to Doctors.” *Better Homes and Gardens*, 74(10), October, 1996, pp. 54-59.

<sup>70</sup> **Viagra** (sildenafil citrate) is a prescription medication manufactured by Pfizer, Inc. that improves erections in men with erectile dysfunction (impotence). The medication is most effective in men whose erectile difficulties are not due to vascular problems. *Viagra works by relaxing the blood vessels in the penis, allowing an inflow of blood and subsequent erection. The drug interacts with nitrates causing serious falls in blood pressure, thus men who take medications for angina, and men who use “poppers” (amyl nitrates) as a recreational drug are warned not to take Viagra.*

<sup>71</sup> Godbey, S.; R. Chillot; and S. Stocker. “Back Off Jack: Dominance May Do You In.” *Prevention*, 49(6), June, 1997, pp. 24-26.

<sup>72</sup> “Barriers to Care: Why Do Men Have Fewer Doctor Visits?” *American Health Line, Focus on Men’s Health Week*, June 15, 1995.

Popular health-related media perpetuate the problems men have in getting themselves to accept and access health care, by not reporting on the issue. One example: the Internet data base *Medline* has listed nearly 4,400 entries for women's health over the past 40 years, compared with 94 on men's health topics.<sup>73</sup>

Health care researchers have followed this general pattern. For example, the National Committee for Quality Assurance (NCQA)'s widely used *HEDIS* survey has almost no questions about men's health, although women's health is covered in detail. The Centers for Disease Control and Prevention's *Behavioral Risk Factor Surveillance System* survey has no questions about issues specific to men's health, although women's use of primary care services (such as mammograms, Pap smears, etc.) are covered in detail. When the draft of *Healthy People 2010* was released in September of 1998, almost nothing was mentioned about men's health, and women were identified as the main at-risk group in the United States with respect to health.<sup>74</sup> The document contained 37 health objectives for women, and 2 for men.<sup>75</sup>

Even the language used to describe health care tends to exclude or alienate men. Some practitioners recommend changing the basic terms or using concepts such as "tune-up" rather than "care" to describe primary health care, and/or promoting overall health as something connected to sexual functioning, rather than overall wellness.

## HEALTH INITIATIVES TARGETING MEN

While men's health has increasingly been recognized as an important issue in this country, there are relatively few examples of broad-based campaigns aimed at getting men to seek health care and take better care of their health. The most visible effort to date is the Men's Health Network (MHN), an educational campaign organized in the early 1990s to address men's health on a national level.<sup>76</sup> MHN's goals are to reduce mortality among men and boys, improve men's physical and mental health, and reduce violent and addictive behaviors among men. The organization is using a variety of tactics to further the goal of improving men's health, including media campaigns, coalition-building, networking, policy and program development, and political organizing. MHN has five major projects under development or in-progress:

- men's disease awareness and prevention project;
- men's therapy project;
- youth project;
- veteran support project; and
- father's project.

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<sup>73</sup> Lipsyte, R. "Don't Take Your Medicine Like a Man; As Patients, Men Are Impatient, or Uneasy, or Both. They Need to Get a Grip, Like Women." *New York Times*, February 17, 1999, p. G-1. See [www.nytimes.com](http://www.nytimes.com).

<sup>74</sup> Hubert Humphrey Institute of Public Affairs. *Health Policy Issues*, [www.next.hhh.umn.edu/pubpol/pubpol-1/199812/0008.html](http://www.next.hhh.umn.edu/pubpol/pubpol-1/199812/0008.html).

<sup>75</sup> The federal government publishes a comprehensive health plan every ten years that is referred to as the "Healthy People" book. The most recent version, *Healthy People 2010*, has been in development over the past two years.

<sup>76</sup> Men's Health Network. *The Men's Health Network: A National Education Campaign to Significantly Improve Male Health and Longevity*, Washington, DC (see [www.menshealthnetwork.org](http://www.menshealthnetwork.org)).

MHN has established connections with a wide variety of organizations that either work with men or are in regular contact with them, such as veterans' groups, public and private schools, governmental health agencies, private mental health care providers, law enforcement agencies, businesses and corporations, and legislators. Recent activities sponsored by MHN include:

- development of a “**men’s hotline**” (toll-free number) for men to call if they have health-related questions or need information;
- congressional passage of **National Men’s Health Week**, which was signed into law by President Clinton in May, 1994. The week includes Father’s Day. In 1998, MHN offered health screenings for House and Senate members as a way to promote legislators’ awareness of men’s health as an issue;
- **National Prostate Cancer Coalition** and **Prostate Cancer Awareness Week** (MHN also worked with the U.S. Postal Service to develop a prostate awareness stamp, which is currently available); and
- **Father’s Connection**, a free counseling program currently offered in Austin, Texas, Sacramento, California, and Galveston, Texas, for fathers and other men who are experiencing family-related stress. MHN also established a father’s hotline for men in crisis.

MHN has also sponsored national conferences and policymaking forums on men’s health, family violence, and other issues affecting men, and has conducted men’s health-related surveys. These efforts, disappointingly, have not reached minority men effectively. African-American men, for example, have not participated in major Prostate Cancer Awareness Week events, although Harry Bellafonte (who was diagnosed with prostate cancer in the mid-1990s) agreed to act as a spokesperson in the 1997 effort.<sup>77</sup>

The American Foundation for Urologic Disease launched a National Educational Outreach program targeting prostate cancer, in 1999.<sup>78</sup> The project includes Prostate Cancer Awareness Week (September 20-24), and Benign Prostatic Hyperplasia Week (September 13-17) as part of an overall, National Prostate Health Month. The campaign includes national public service announcements via television, newspaper, and print media. In another example of national coverage of a men’s health issue, *Today Show* anchor Katie Couric recently testified to Congress about her husband’s death to colon cancer,<sup>79</sup> in the hope of raising awareness of this disease in U.S. men.

The Massachusetts Department of Public Health’s Division of Community Health Promotion has sponsored a Prostate Disease and Cancer Awareness Project targeting older men and African-American men. The project provides materials and education programs to raise awareness about early detection, screening, and treatment of these diseases.<sup>80</sup>

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<sup>77</sup> *Men’s Health Network. The Men’s Health Network: A National Education Campaign to Significantly Improve Male Health and Longevity, Washington, DC (see [www.menshealthnetwork.org](http://www.menshealthnetwork.org)).*

<sup>78</sup> *American Foundation for Urologic Disease. Prostate Health Month, [www.afud.org](http://www.afud.org).*

<sup>79</sup> “Couric Highlights Need for Colorectal Screening.” *HealthCentral*, March 7, 2000, [www.healthcentral.com/news](http://www.healthcentral.com/news).

<sup>80</sup> *Massachusetts Department of Public Health, Division of Community Health Promotion. Prostate Disease and Cancer Awareness Project, Elder Health Programs, [www.state.ma.us/dph/prosaw.htm](http://www.state.ma.us/dph/prosaw.htm).*

None of the national and statewide campaigns aimed at men's health have been evaluated, to date, in terms of their effectiveness at reaching men and motivating men to change their behavior. There is some evidence that comprehensive campaigns that combine coalition-building, policymaking, and mass media approaches are helpful at increasing public awareness of health issues, but this has not been proven for men's health.<sup>81</sup>

## LESSONS LEARNED FROM OTHER HEALTH CAMPAIGNS

At present, the United States is the only industrialized nation in the world that does not have a national health care policy.<sup>82</sup> An offshoot of the lack of national health policymaking is the tendency in this country to deal with health issues on a piecemeal basis—for example, by focusing on particular populations (such as women), on specific conditions (such as cancer, diabetes, heart disease, or HIV/AIDS), or on specific unhealthy behaviors (such as driving while intoxicated or eating a high-fat diet). We tend to view health as an individual, rather than collective, responsibility, and illness as a sign of moral failure and/or public ignorance. Many large-scale public health campaigns are aimed at particular problems—for example, we have programs aimed at immunizing children and reducing breast cancer—but campaigns that address broader factors that affect people's health, such as poverty, are less common.

At present, no consensus exists as to the best way of providing people with information about health issues and health risks. Approaches that present statistical information about a health problem, such as the probability of it occurring within a population, have some benefits in terms of raising people's awareness levels; but efforts that provide people with a **context in which to understand their own, individual risks** seem to be more effective.<sup>83</sup> The lay public does not understand or believe probability statistics. Giving people information about who is at risk, along with vivid, graphic details about the consequences of a health condition, and how to prevent and treat the problem, does seem to affect people's behavior over the long run.

Massachusetts has had good experience with several key public health campaigns that utilize a broad-based, social marketing approach to reducing certain health problems and/or encouraging healthy behavior. Three recent examples include:

- the **Massachusetts Tobacco Control Program's** efforts to reduce tobacco use among state residents—this campaign has included legislation, coalition-building, research studies, support for community-based programs, and advertising campaigns. Cigarette smoking has declined by 31% since the program was initiated;

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<sup>81</sup> Bellicha, T. and J. McGrath. "Mass Media Approaches to Reducing Cardiovascular Disease Risk." *Public Health Reports*, U.S. Department of Health and Human Services, 105, May/June 1990, pp. 245-252.

<sup>82</sup> Jimenez, M. "Concepts of Health and National Health Care Policy: A View from American History." *Social Service Review*, 71(1), March, 1997, pp. 34-51.

<sup>83</sup> Rothman, A. and M. Kiviniemi. "Treating People With Information: An Analysis and Review of Approaches to Communicating Health Risk Information." *Journal of the National Cancer Institute*, 25, January 1, 1999, pp. 44-51.

- the **HIV Drug Assistance program** distributes HIV medications to underinsured and uninsured individuals with HIV/AIDS in Massachusetts. From 1995 to 1997, AIDS-related mortality within the state decreased by 71%; and
- the **Women's Health Network** provided free screenings and diagnostic tests for breast and cervical cancer to more than 41,000 women from 1993 to 1998, detecting 273 cases of breast cancer and 286 cases of cervical problems in Massachusetts women who might not otherwise have been tested for these diseases.<sup>84</sup>

There are several large-scale, national, comprehensive health campaigns that are similar to what the Massachusetts Department of Public Health is considering for men's health and have been effective. The most relevant example, perhaps, is **women's health**, a multi-faceted series of initiatives that began reaching women in large numbers in the early 1970s, in part due to publication of the now famous *Our Bodies, Ourselves*. Key aspects of these campaigns have included:

- **using many venues for raising awareness and educating women about women's health**, such as large-scale media campaigns and charity events like the "Walk for the Cure";<sup>85</sup> creation of a *Breast Cancer Awareness Stamp* by the U.S. Postal Service;<sup>86</sup> using innovative, local, community-based strategies for reaching women (e.g., hair salons);<sup>87</sup> creating Internet web sites where women can get health information;<sup>88</sup> and using a variety of techniques to address public stereotypes about diseases affecting women;<sup>89</sup>
- **creating centers for women's health** to provide comprehensive, integrated health services for women within a supportive environment,<sup>90</sup> as well as local health networks,<sup>91</sup> and

<sup>84</sup> Massachusetts Department of Public Health. *Recent Advances in Public Health*, [www.magnet.state.ma.us/dph/comm/advance.htm](http://www.magnet.state.ma.us/dph/comm/advance.htm).

<sup>85</sup> "National Breast Cancer Awareness Month." *Women's Sports and Fitness*, 12(6), September, 1999, p. 40.

<sup>86</sup> "Breast Cancer Awareness Stamp Slated for June." *Stamps*, 255(1), March 30, 1996, pp. 1-2. The stamp went into circulation in June of 1996 as part of a four-month public service campaign sponsored by the U.S. Postal Service, YWCA of the United States, American Cancer Society, Lifetime Television, and a variety of national and regional breast cancer groups.

<sup>87</sup> "Trip to Beauty Parlor Means More than Haircut." *Cancer Weekly Plus*, October 28, 1996, p. 7.

<sup>88</sup> "First Internet-Based Cervical Cancer Public Education Campaign Launched." *Cancer Weekly*, January 25, 2000.

<sup>89</sup> National Council on the Aging. "Assessing the Odds." *The Lancet*, 350(9091), November 29, 1997, p. 1563.

<sup>90</sup> A good example is the Center for Women's Health at Monroe in Philadelphia, which provides both health care services as well as teaching opportunities for health professionals affiliated with the Hahnemann School of Medicine. See *Institute for Women's Health*, [www.auhs.edu/institutes/iwh/cwh.htm](http://www.auhs.edu/institutes/iwh/cwh.htm).

<sup>91</sup> Massachusetts Department of Public Health, Bureau of Family and Community Health, Division of Community Health Promotion. *Massachusetts Women's Health Network*, [www.state.ma.us/dph/whn/whn.htm](http://www.state.ma.us/dph/whn/whn.htm).

- **promoting research specifically on women's health,**<sup>92</sup> including creating professional associations;<sup>93</sup> developing training programs for health professionals;<sup>94</sup> creating medical libraries and other repositories of information about women's health;<sup>95</sup> and conducting comprehensive, longitudinal, medical research on women's health.<sup>96</sup>

Many of the women's health initiatives in the United States have recognized that socio-cultural factors are critical in terms of reaching underserved populations. In other words, campaigns that work well with one population often do not work as well with other populations.<sup>97</sup> For example, with Hispanic/Latino women, individualistic approaches to health are not as effective as those that emphasize the cultural values of familialism, collectivism, *simpatia*, *personalismo*, and *respeto*. Researchers have used segmentation strategies to reach different audiences of women,<sup>98</sup> have studied the readability and understandability of health literature for different groups of women,<sup>99</sup> and have recognized that women's health care needs change over the life span.<sup>100</sup>

In another example involving changing people's behavior, Mothers Against Drunk Driving (MADD) has had significant success at using media to reduce alcohol-impaired driving in this country.<sup>101</sup> MADD has used advertising, public service announcements, news, public interest stories, and the entertainment media (such as talk shows) to promote its agenda, and has also worked to promote appropriate legislation, such as administrative license revocation for drunk drivers.<sup>102</sup> MADD has also had success in involving the entertainment industry in its efforts.<sup>103</sup> This kind of multi-faceted effort has also been effective at reducing tobacco use nationwide.<sup>104</sup>

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<sup>92</sup> For example, see *Women's Health Research Coalition*, [www.womens-health.org/steering.html](http://www.womens-health.org/steering.html).

<sup>93</sup> For example, see *American Medical Women's Association*, [www.amwa-doc.org](http://www.amwa-doc.org).

<sup>94</sup> American Medical Student Association. *Women's Health*, [www.amsa.org/programs/gpit/women.html](http://www.amsa.org/programs/gpit/women.html).

<sup>95</sup> "National Alliance of Breast Cancer Organizations." *Library Journal*, 122(16), October 1, 1997, pp. S-20-21.

<sup>96</sup> "The Women's Health Initiative Underway." *Nurse Week/Health Week*, [www.healthweek.com/features/meno-sb2.htm](http://www.healthweek.com/features/meno-sb2.htm).

<sup>97</sup> Marcus, A. "New Directions for Risk Communication Research: A Discussion With Additional Suggestions." *Journal of the National Cancer Institute*, 25, January 1, 1999, pp. 35-42.

<sup>98</sup> LaFleur, E. and S. Taylor. "Women's Health Centers and Specialized Services: Segmentation Strategies Can Be Effective in Targeting Some Female Health Care Consumers." *Journal of Health Care Marketing*, 16(3), Fall, 1996, pp. 16-24.

<sup>99</sup> Behan, B. and A. Reynolds. "Readability of Breast Self-Exam Literature." *The Nurse Practitioner*, 22(6), June, 1997, pp. 12-17.

<sup>100</sup> "Women's Health Initiative Seeks Women 60-79." *Menopause News*, 7(4), July-August 1997, p. 4.

<sup>101</sup> Price, E. "The 1992 National City Challenge to Stop Drunk Driving." *Nation's Cities Weekly*, 15(33), August 17, 1999, p. 7.

<sup>102</sup> Russell, A.; R. Voas; W. DeJong; and M. Chaloupka. "MADD Rates the States: A Media Advocacy Event to Advance the Agenda Against Alcohol-Impaired Driving." *Public Health Reports*, U.S. Department of Health and Human Services, 110(3), May/June 1995, pp. 240-246.

<sup>103</sup> Koltnow, B. "TBS' 'Hollywood Gets MADD' Shows How Attitudes Have Changed on DUI." *Knight-Ridder/Tribune News Service*, November 5, 1999, p. 11.

<sup>104</sup> Erickson, A.; J. McKenna; and R. Romano. "Past Lessons and New Uses of the Mass Media in Reducing Tobacco Consumption." *Public Health Reports*, U.S. Department of Health and Human Services, 105, May/June 1990, pp. 239-244.

Most of these kinds of health campaigns use **marketing research** as a tool for understanding how people think about health and how they are likely to react to a specific strategy. For example, a study on teenagers and smoking showed that advertisements exposing the marketing techniques of the tobacco industry confused teenagers—they interpreted the advertisements as promoting, rather than discouraging, cigarette smoking.<sup>105</sup>

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<sup>105</sup> McKenna, J. and K. Williams. "Crafting Effective Tobacco Counteradvertisements: Lessons from a Failed Campaign Directed at Teenagers." *Public Health Reports, U.S. Department of Health and Human Services*, 108, 1993, pp. 85-89.

**PHASE II:**

**QUALITATIVE RESEARCH  
TARGETING MEN IN MASSACHUSETTS:**

**MEN'S ATTITUDES TOWARD HEALTH, HEALTH CARE,  
AND HEALTH INFORMATION**

## OVERVIEW

The qualitative segment of this study was designed to assess the attitudes of 25 to 45 year old men toward their health and toward preventative health care. Market Street Research and *causemedia* conducted focus groups with white, black, and Hispanic men in this age group, as well as their spouses and health care providers, in order to develop an understanding of men's:

- perceptions of their current health status;
- awareness of preventative health guidelines;
- patterns of use of health services; and
- sources of information regarding health issues.

The findings from our qualitative research confirm findings from other studies done with men in general. That is, men frequently take little interest in preventative health care and are more likely to seek health care when they face acute health problems. This is consistent among the different ethnic groups we surveyed. However, there are critical differences among men depending on their history of health care use and their experience with the health care system; socioeconomic, educational, and insurance status; and cultural beliefs relating to health care. The following sections examine men's attitudes overall and consider differences between these important subgroups. In addition, Market Street Research and *causemedia* will provide additional reports based on focus groups being conducted with Cambodian, Cape Verdean, Chinese, and Vietnamese men in Massachusetts (see Appendices E-H).

## MEN'S PERCEPTIONS OF THEIR HEALTH STATUS

As suggested in national studies, men tend not to think or talk about their health very much. This was clearly indicated in each of the focus group discussions in terms of the obvious novelty for participants of having a group discussion on the subject of men's health. For example, an exchange in one of the groups of white men indicated that men feel they are not supposed to think or worry about health issues. One man explained, *"But I think some of our own male intelligence tells us, you know, men aren't supposed to talk about that. That's how we were brought up, what we learned in society."* Another agreed, *"Men can't cry, men aren't supposed to show emotions,"* suggesting that men tend to equate concerns about health with weakness. This theme came up consistently among all ethnic groups, with many men indicating that women are the ones who take care of health issues for the family.

However, focus group discussions indicated that health is an area about which men would like to talk more and be better informed. Focus group participants almost all seemed to appreciate the focus group discussion as a unique opportunity to sit down with other men and talk about health issues. Many were interested in staying after groups ended to continue discussions, and some said they would be interested in coming to another group even without the financial compensation for their time. These findings are very positive in that they indicate men's openness to thinking about these issues. However, much of the discussions clearly demonstrated the significant obstacles social marketers face in terms of changing men's attitudes toward health and health behaviors.

## Overall Health Status

Men who participated in the focus groups represented a range of health experience. Many have never had any major health problems. Others have experienced chronic illness, including cardiovascular disease, diabetes, debilitating injuries, drug addiction, and AIDS. There are some clear differences among ethnic and socioeconomic groups, in that men from poorer backgrounds and those who have experienced institutionalized racism are more likely to have experienced socio-cultural risk factors, such as violence, drug use, and stress.

Despite these differences, across socioeconomic and ethnic groups, 25 to 45 year old men tend to fall into one of two categories in terms of how they perceive of their health:

- (1) **those who have not had any major health problems tend to see themselves as in generally good health**, with some acknowledging they have some weaknesses such as being overweight, smoking or drinking regularly, or not getting enough exercise; and
- (2) **those who have a serious or chronic illness, such as diabetes, heart disease, or AIDS, tend to be very concerned about their health status**, and more aware of the various risks and health challenges they face.

Men in the former group are frequently younger men, in their 20s or early 30s, who are less likely to have experienced any major health issues themselves or in their peer group. These men typically describe their health as *“good to excellent,”* noting that they may have some somewhat unhealthy habits, but that they feel healthy. For example, one Hispanic man summarized his sense of how most of the group felt, *“We all feel good, I also feel good, maybe because of our age. We are still young, but the truth is that I feel good, I always try to get some kind of exercise, and I believe that also helps.”*

The younger men and those who are single tend to be more concerned with sexually transmitted diseases and exercise habits than with health issues such as cardiovascular disease or cancer. For example, one Hispanic man described, *“I feel pretty good about my health. When I was a little bit younger, I was in high school sports and I used to do a lot of distance running and swimming. . . . For ten years now, I have not made any exercise or anything like that, and I still feel good but I think that I should start doing something pretty soon cause I’m beginning to feel tired, and I’m also working harder, but I think I need more exercise right now. I don’t think I do enough.”*

Similarly, in the spouse group, one woman indicated her and her partner’s sense of his health: *“Overall, he is in good health. He is muscular, he does a strenuous job, he eats whatever he likes, like salt and things that are good for you, and all things that are bad for you like chocolate and cake. You know, he keeps swallowing it and he never gains a pound.”* Another spouse described her husband as, *“He thinks that he is the Rock of Gibraltar.”* Many men, their spouses, and health care professionals likened this attitude to that typically attributed to teen-agers, a sense that they are immortal and do not have to worry about illness, injury, or death. For example, one health care professional explained, *“I think that [when] they are getting older, they are kind of*

*realizing their mortality. I think that the young guy is kind of like, . . . 'I'm 30 years old—I can't get sick.'"*

Health history and concurrent perceptions of their health status are important indicators of the extent to which men even think about their own health or health issues in general. For example, men who see themselves as in fairly good health tend not to spend much time thinking or talking about health problems and few are familiar with specific conditions. One Hispanic man explained, *"I mean, I don't want to stress myself at my age on issues that might bother me when I'm 60."*

In contrast, those in the second group—men who have experienced serious illness themselves—tend to be much more familiar with their own health risks and men's health issues in general. These men and their partners seem genuinely concerned about their health status, take their illnesses seriously, and are aware of related conditions for which they are at risk. In addition, many of these men recognize that their current problems relate to unhealthy habits they have had for years, and many wish they could have been more aware years ago. For example, one white man described his health as follows: *"I had a heart problem last October and I realized when I had this they put a stent in my heart and they said the cholesterol buildup goes all the way back to almost 20 years old so food issues and exercise. . . . But it really affected even my memory, the diabetes, mini-strokes and I had to get one of these just to remember anything for a while. I'm doing a lot better. The doctor's got me on 2,000 units of niacin every day now and I was even taking Viagra, on that for a month so I'm doing better."*

Similarly, many men in one of the groups with Hispanic men described how they have changed their habits significantly since they were younger, frequently due to traumatic injuries or illnesses. For example, one man explained, *"I've endured a lot of past health issues. . . . I'm taking care of myself better now as far as eating. I'm not involved in a lot of negative [habits], because I believe a lot of your health has to do with the way you carry yourself, the way you take care of yourself. . . . I know that I have to realize now that I'm over 30, I have to take care of my body even more. More than when I did when I was in my teens and 20's, because I'm a high risk. I've gotten through a lot of stuff, man, I had a lot of liver problems."*

Men from moderate-income and wealthier family backgrounds are more likely to make regular visits to physicians and also tend to be more aware of preventative health guidelines and the importance of routine physicals and screenings. Men in poverty are more likely to recognize the health problems they face, the abuse their body has sustained, and their immediate health care needs, but are not likely to be regularly seeking preventative care.

In addition to these two general groups of men, a few men indicated that while they feel in generally good health, they do have concerns relating to family history or workplace risks, including having physically demanding jobs and jobs that expose them to toxic fumes or chemicals. They have generally experienced some health problems related to the risks they face or have seen close family members experience serious health problems. One African-American man described, *"I've been standing 10 to 12 hours a day for 12 years and sometimes my knees pop, I mean, you know, like probably that comes from the profession I chose. But I've been thinking that maybe some day, something is going to be wrong with my legs or something. I had seen a guy that was a barber for 20 something years, and I seen all the veins and stuff in his legs and no, just*

*really, just my knees pop sometimes. I just be standing and just pop, pop.”* Others described their experience with family members’ illnesses, recognizing that they are also at risk. However, overall, if men are not feeling any immediate and severe symptoms, they tend to think of themselves as in generally good health.

## **Health-Related Behaviors**

Despite a general sense of sound health, men clearly recognize that many of their behaviors are not healthy. Men frequently mention smoking, drinking, poor diets, and lack of exercise as unhealthy habits. In addition, several men had previously been or were currently using addictive drugs. Some of the single men felt that their greatest health risk was in having multiple sexual partners. Men at the focus groups represented a wide range in terms of health-related behaviors. Some indicated that they generally lead very healthy lives, with a balanced diet and regular exercise. Others feel they are generally healthy, but acknowledged that many of their habits are not good for their health. Others described lifestyles that are replete with health risks, frequently involving extreme poverty, poor diets, heavy smoking, and intravenous drug use.

**While most men recognize that some of their behaviors are not good for their health, few are seriously concerned about any of them,** certainly not to the extent of being motivated to change these behaviors. For example, talking about diet, many explained that while they know they should be eating more salads and healthy foods, they are most likely to eat whatever is convenient and food they like, which often includes fried foods, fast food, and heavy meals their family has traditionally served. One man described, *“And I really don’t look at the oil contents, cholesterol, sugars, but I think I try to keep it at a minimum. When I’m out there, it’s Burger King, McDonalds, Kentucky Fried Chicken, other sandwiches. Things like that.”*

Many men believe that they are likely to feel the impact of their behavior when they are older, but that does not affect how they feel today. For example, one of the groups with African-American men had this exchange about the effects of their moderate and heavy drinking habits:

*--I just can’t see it. It probably does, but I just can’t see it.*

*--You’re right. Exactly, exactly.*

*--I’m pretty sure it is.*

*--It’s taking its toll.*

*--Somewhere, somewhere.*

*--I seen my old man die from it, so I don’t like it.*

*--I may not recognize it right now, but somewhere along the line, I know it’s got to be taking its toll.*

Similarly, men recognize that smoking is not good for them, but only a few have seriously tried to quit, and even fewer have been successful. For example, two men in one focus group with white men had this exchange with lots of agreement around the group:

-- I don't really think about it affecting me later. As far as physically, I think, 'Yeah, cause I'm still active right now and stuff, and I still play basketball, and all these things.' I don't really think about later.

--Well it's also human nature—as long as it's not bothering me, I'm not going to stop. Why should I stop? But then if you should develop lung cancer, then you'll stop smoking. It's like human nature, as long as it's not bothering me, well, let's just do it.

## Motivation to Change Health-Related Behaviors

Unless men feel an immediate and fairly severe health impact, they are unlikely to feel motivated to change. Therefore, we see somewhat of an **attitudinal shift among somewhat older men (those in their mid to late 30s and 40s)**, who are more likely to experience health repercussions or to have seen friends and relatives have serious health problems related to these behaviors. For example, one Hispanic man described, *"I've been pretty healthy and this year I'll be 46, and I think that is the time when I've got to start taking care as to some of the stuff that I eat, some of the stuff that I do because like Johnny was saying, I start feeling tired, you know, and things that before I was able to go the distance and sometimes I find myself a little [tired], so I'm now going to be a little careful."* Another explained, *"One day, I was playing with my son, and he ran and I chased him, I mean like from here to the door; and I felt like I was going to die, from here to the door like [gasping sound], . . . and I said, 'This is no good; this is no good.' And I stopped [smoking]."*

However, **most men need to feel much more severe effects before they think about changing behaviors.** As many indicated, by the time they are truly motivated to change, it is too late. One health care provider explained, *"Talking about prevention, people with osteoporosis, they, usually they are older people, much older, and they ask questions [like], what can I do, can I drink more milk or can [I] eat dairy, and this and that. . . . You have to do it, you know, sixty years ago when you were teenagers and going through your growth spurts. So you can convey the idea, that they can pass to their grandchildren, but for them by then, it is already a little bit too late."*

In fact, many of the men who participated in the discussions and made behavior changes regretted that they had not thought more about what they were doing when they were younger. Many changed their behaviors when they were really forced to by their health conditions. Having learned from this experience, these men are more likely to monitor their health behaviors now. For example, one Hispanic man described, *"You know, you lose a lot. You had so much going for you at a young age. We as male adults, we don't know how to appreciate things when we have them and then when we lose them. As we look back. and we say, 'Wow!' You know what I mean? Why couldn't we take things slower when we were there? And we blew a lot of things. We all get involved in street violence, we all get involved in using drugs, we all get involved in doing crazy . . . things of life. But as you get older, you say to yourself, 'Wow, now it's time for me to take it easy.' Right now, my health to me is like an up and down scale."* Another participant agreed, *"My health is not bad, but then again, I try to take care of myself more now, because I'm dealing with issues that [result from] when I was younger, I'm dealing with those things now. So what I try to do now, I don't drink and smoke now. So I'm trying to watch what I do better to help better take care of my health."*

Several men indicated that aside from severe health impacts, **family was a major motivating factor for them in improving their health-related behavior.** This has a number of components:

- Some change their behavior so as not to affect their children's health. For example, one African-American man explained, *"I have kids and it's crazy. There's smoke all through the house. I want to stop smoking."*
- Many explained that they wanted to make sure they would be around to see their children grow up. For example, one group had the following exchange:
  - I have two little girls too, so the three of them kind of motivate me to try to take better care of myself from a health point [of view].*
  - It's something to live for. You want to live longer.*
  - Having kids wipes out that sense of immortality. Definitely. . . . It's not like it's just us anymore. We've got these two little beans and they are dependent on us.*
- Others were concerned about becoming a burden on their family should they have severe health problems. A white man explained, *"We don't want to be a burden on the wife and kids, if something ever happened and you became sickly. You know what I mean? Sure, they'd stand by you but think about it. Has anybody ever had a grandparent come into their household? Do you know what I'm saying? . . . You do what you have to do . . . so that you can continue to do what you're doing to provide, that's probably the biggest incentive."*
- Others felt it was important to teach their children healthy habits. For example, one Hispanic man explained, *"Our hope is how to raise our kids. How important it is to every six months take our kids for a physical, to teach them and guide them, you got to take care of yourself, you have to eat right, you have to exercise and as I think about this, these are some of the things we didn't have as we were kids. They would just sit us there, 'Eat, go ahead, eat.' We wasn't taught, 'Go exercise.' Because our parents weren't taught those things so they weren't able to teach us those things, you know what I'm saying? But now we are in a situation that we can teach our kids how to take care of themselves, how to take care of their bodies so 20 years from the time they are ten or 15 they won't have to go through issues of paying back for the things that they did when they were younger."*

The discussion in one group of Hispanic men clearly indicated that **religion or a strong sense of God was a major contributor in men's ability to change their behaviors.** Many expressed thanks to God that they were no longer practicing some of their former behaviors. For example, one man explained, *"I'm going to be 32 May 24th. And I'm in better shape than I've ever been in my life. Because of the habits that I left behind. I used to be a pot head. . . . I used to drink. I used to be in clubs. . . . I had girls here and there. But when I decided to change my life, this should have been a focus group on Christianity or whatever, 'cause everybody is giving God thanks and it's funny for me, it's awesome."*

Men who are trying or have been successful at changing habits, such as smoking, generally see the **motivation coming from within**, and their effectiveness completely based on their own will and strength. Few would consider seeing a physician regarding any of the habits they are interested in changing. To quit smoking, some have tried the patch, prescription medication, and group efforts. However, most said that when the time came to quit, they just did it. For example, one man described his experience: *“Nobody at home smokes, so I didn’t feel comfortable. So I came home, and I just gave myself [the] order that I won’t smoke no more.”*

## **KNOWLEDGE OF HEALTH RISKS AND PREVENTATIVE CARE GUIDELINES**

Across socioeconomic, educational, and ethnic groups, there is a general level of awareness of some of the critical health issues facing men. Many men indicated specific risks they face because of a family history or personal risk factors. Most men, particularly those in their 30s and 40s agree on the importance of regular check-ups to monitor one’s health status. However, the focus group discussions clearly indicated that almost no one has been well-educated in terms of the guidelines for specific types of screenings (e.g., blood pressure, cholesterol, colorectal, or prostate), nor do many men have a clear sense of how frequently they themselves should be visiting a doctor given their own health risks. In addition, it is important to note that while many men have a sense of the importance of regular health check-ups, few men act on this knowledge. For example, when asked about how frequently a man should have a physical one man explained, *“Twice a year at least. But I don’t practice what I preach.”*

### **Perceptions of Preventative Care Guidelines**

In terms of the **recommended frequency of regular physicals**, across groups, most men agreed that they should be getting an exam every six months to a year, with younger men (those in their 20s or early 30s) less likely to have thought about it. Men generally feel that beginning in one’s 20s, blood pressure should be checked every three to six months, and even more regularly if one has a history of related problems. Similarly, men feel they should be getting regular cholesterol checks, beginning in their 20s or early 30s, maybe every six months to a year. Interaction between one of the younger men (mid-20s) and an older man (late 30s) in one of the groups with Hispanic men illustrates how men’s awareness increases somewhat with age:

*--I’m 25, so I’m the baby. Seeing it from his point, yeah, I guess he’s 15 years older, so he’s learning more than I am at this point.*

...

*--I didn’t get to know about any of this stuff that I should be aware of until I got older. Until I got older, until I started hitting in my 30’s was when I finally got to know that I should be looking out for prostate, your counts for your heart and your cholesterol, colon cancer.*

Age is an even greater indicator of knowledge in terms of prostate and colorectal screening recommendations. Younger men tend not to think about this issue at all, thinking of prostate and colorectal illness as something that affects older men. Those in

their late 30s and 40s are more likely to have heard information about these screenings and realize they should be getting them sometime in the near future. While many indicated that routine prostate and colorectal screenings should begin around age 40, few felt any pressing need to ensure they were getting checked out. For example, one man explained, *“I do agree that it’s [prostate and colon screenings] something as you get older, especially my age, 35, there’s things that you should check up on. It’s a logical thing to do, but I’m just not one to really want to worry about some issues. If I have it, I have it. That’s how I feel.”*

Similarly, an exchange in one of the groups with African-American men indicates how ubiquitous this approach is. When the moderator asked when men should start getting their colon tested, men responded:

*--Probably 40s.*

*--40, 45.*

*--Really probably in the 30s, but I’d rather wait until the 70s.*

*--It’s something you don’t really think about. I don’t. It’s something that I don’t think about.*

## **Knowledge of Personal Health Risks**

Men are generally aware of **illnesses they could be at risk of due to a family history**. Many men mentioned that immediate family members had been ill with or died from cancer, heart disease, diabetes, and alcoholism, and realized they themselves were at greater risk of these diseases. For example, one Hispanic man explained, *“My family deals with diabetes, arthritis, so I’m a high risk of being diabetic in my future. So I’m able to, I go to appointments with her [his mother] and I ask the doctors questions and, yes, I know that I have to realize now that I’m over 30, I have to take care of my body even more. More than when I did when I was in my teens and 20s, because I’m a high risk.”* However, many men indicated that they are not aware of extensive family health histories of a certain disease until an immediate family member is in critical condition or dies. Then they learn about their grandparents, aunts and uncles, who had the disease.

Others are aware of family histories, but are unsure as to how that history affects their own risks. For example, one Hispanic man explained, *“I know my grandfather has high blood pressure and . . . I wonder if that’s hereditary or not. And then I know my Mom has, I don’t know what the disease is, but her red blood cells are usually low, so she has to go to the doctor now and then and does check-ups and stuff like that. I’ve never asked her because I guess I’m afraid to find out that she’s really sick, so she looks fine, okay, everything is fine. And those have been two things that have always bugged me. Not knowing, you know, is that stuff that I can eventually have or should I just leave it away. I’m too young to worry about that kind of stuff.”*

Many men are also aware of **their increased health risks among their racial or ethnic group**. This knowledge is frequently related to their own family history. For example, those who have seen lots of diabetes in their immediate and extended family are more likely to be aware that that their ethnic group is actually at higher risk. In terms of specific health risks, African-Americans identified stroke, high blood pressure, stress, and AIDS as particularly high in their communities. Hispanics provided a similar list, including high blood pressure, stress, obesity, heart attacks, diabetes, and AIDS, and at

least one man mentioned prostate cancer as more prevalent in the Hispanic community. White men were less likely to identify specific diseases that are particularly prevalent among Caucasians.

One of the Latino participants clearly indicated that while they frequently see many of these diseases in their community, there is still a lack of information or motivation in the community in terms of preventative measures: *"It is sad to see that the Latino community, in things like diseases and many other things, shows the highest levels, because unfortunately, we lack the right education. Beginning with health issues, we do not like to go to the doctor. We have the highest cholesterol levels, the Latino community shows the highest incidences of cancer, everything. . . . However, we know because they tell us about it all the time, in the news, in the radio, everywhere . . . 'The Latino community this' . . . 'The Latino community that.' But we do not learn, we do not try to be in a lower position in those statistics, to say 'I am going to try and be one less of those numbers. I am going to go to see the doctor and prevent possible diseases.' I do not know what can be done, what I know is that we have a lot of information, in TV, in the radio and everywhere, and there are so many things that they can check for free, but we do not do it. What I know is that we are poorly educated in that sense, we do not pay attention to ourselves, beginning with health issues."*

In fact, despite a fair amount of knowledge regarding health risks and preventative guidelines, men infrequently seek routine health care. Men's use of health care is discussed in the next section, followed by a discussion of the attitudinal and social barriers that impede men's utilization of health care.

## **MEN'S USE OF HEALTH CARE SERVICES**

Men's discussions of the extent to which they use health care clearly conforms with national studies indicating that men do not tend to use routine health care and tend to use health care only for acute or traumatic episodes. We asked men to talk about their use of health care as a child and currently. This section looks at actual utilization patterns, and the next section thoroughly explores men's attitudes that affect the extent to which they utilize health care.

### **Childhood Use**

Men indicated a wide range of experience with health care as a child. Experience seems to be very closely related to socioeconomic status and education levels, as well as insurance coverage. On one end of the spectrum are men who recalled regular visits to private physicians' offices. For example, one white man recalled, *"Well, I have my health book from when I was a child, and I guess my parents brought me relatively regularly. But I can tell you my inch increments at my ages. My mother is a nursing supervisor, . . . now retired nursing supervisor with the VNA . . . and my father is an advanced educated individual. In the same way that, I think, today we as a family care for our children was very much what I was brought up with, with at least annual [exams]. I went to the dentist, the orthodontist, the optometrist."* Another man agreed, *"Oh, yeah, clockwork. Every summer before school, for physicals. All the well*

*babies, all the up through, dentist, it was when you were there you made your next appointment for six months later.”*

In this group and others, however, many men did not recall going to the doctor’s office with any regularity. Many men recalled going when they were sick or for shots. Others recalled getting regular physicals through the school nurse. In addition, it is clear that many men do not have clear recollections of their childhood use of health care services or that they are more likely to remember the traumatic visits than routine well-child check-ups. For example, one participant recalled, *“For me, when I was like seven years old I had an appendectomy. So that was one of my clear memories of going to the doctor. And I hit a tree on a sled when I was young, and I got like a hundred stitches in my head. I remember that—going there and getting stitched up. And then playing hockey, I used to get banged up, lost my teeth and got stitches in the mouth and the eye.”*

At the other end of the spectrum are men, typically from poorer families and communities, who reported that visits to the doctor were incredibly rare and only for emergencies. For example, one group of African-American men had this exchange:

*--I went to the doctor because they had it in school, man.*

*--There wasn’t no doctor, man.*

*--That’s right.*

*--What doctor?*

*...*

*--You’re talking to; I can’t speak for them, but I assume that we are all poor, black males. And when you are poor and you are black, I mean, I don’t have no doctor, . . . and chances are we grew up like that. Most times when we go see the doctors, it’s like school, the physicals; or maybe like my mother was on welfare, and you would go like just because of that.*

*...*

*--My grandmother was our doctor when I was coming up as a kid. The only time I’ve ever had to see a doctor was if I fell down and broke a bone or something like that. My grandmother, you know, would get me to a doctor.*

However, one man in that group noted that his family had insurance, therefore regular health care was the norm for his family: *“As far as them kind of health issues as a kid, I guess I had no worries with that ‘cause my mother worked for the Post Office, so her insurance was covered, so we saw them on the reg.”*

## **Current Use**

Men’s experience with health care as children appears to have minimal impact on their current utilization patterns, aside from the fact that those who had the means and insurance coverage when they were children are more likely to currently have insurance and therefore easier access to care. Even men who had regularly used health care as children, teen-agers, and perhaps in college, reported that when they got into their late teens and 20s and were no longer in family settings or institutions (e.g., college) in which annual physicals were routine, they generally stopped seeing a physician on any regular basis. For example, one woman explained of her partner, *“My boyfriend, I think, grew up going to the doctor on a regular basis, because when I tell him*

*that I am going to go for my doctor's appointment he says, 'You are so good. I haven't done it in so long; I should go.' . . . So he definitely, I think, was brought up that way, since he knows that is really what he should be doing."*

Men in between the ages of 25 and 45 are most likely to use health care for traumatic injuries or acute illness. Many men, their partners, and health care providers indicated that even when in pain, men tend to stay away from doctors. For example, one woman explained of her husband, *"My husband is thirty-four, and he thinks that he is in perfect health. He has had a cough forever, and he won't get it checked."*

As men begin experiencing family medical problems, moderate and severe illnesses, they often begin accessing health care on a regular basis again. For example, one man briefly explained his history of regular health care use: *"Very little when I was a kid, just in the service, just since I was diagnosed HIV. Before that, never."* Others start simply as they get into their 30s, have stable employment and insurance coverage, and begin experiencing minor health problems. For example, another man said about his early adulthood, *"Then for a long time I didn't have anything to do with doctors. And it was only later in life, when I got into my late 30s, that I started seeing doctors again."* Similarly, many of the men who have experienced significant health problems now go to the doctor routinely. However, these visits are often for a specific problem, rather than preventative health exams.

However, a few men, most commonly among those in their late 30s or 40s with health insurance, report more routine use of health care. For example, one Hispanic man described, *"My case is, since 1991, I have been going to the doctor's every six months for physicals. I have been this careful because I have always thought that prevention is very important. Thanks to this I found out, years ago, that my cholesterol was high. . . . And then I knew that my blood pressure was high. . . . I have regularly seen the doctor every six months. I have always been very careful about that, . . . a physical every six months, to check my heart, and everything they could find in the physical."*

This was clearly not the norm. Many fathers in the group noted that, even though they are very aware of the importance of regular check-ups for their children, they do not place the same emphasis on preventative care for themselves. In addition, women noted of their partners that even those who help with their children's health care do not take care of themselves, that they cannot even make their own appointments.

While few men regularly access routine health care, many had recently had their blood pressure and cholesterol checked and had other types of routine screening. Some men have had urgent care visits, at which they assume these routine tests were done. Others use screening services in community settings, such as blood pressure machines in the supermarket or screening booths at community events, to occasionally have these routine tests done.

**Insurance is clearly an important factor affecting use of health services.** Men with health insurance coverage are more likely to be aware of preventative health guidelines and more likely to use health services on a regular basis. For example, one man explained, *"Like for the past year, every time I feel anything with my body that is not normal, I go to the doctor and that's partly because I'm not paying for it out of my pocket."* Those without insurance are likely to cite cost as a major barrier to accessing

care. They certainly would not go for routine care and also put off seeking urgent care unless it is absolutely necessary. For example, another man described, *“Who can afford to go and who can’t. Who has insurance, who doesn’t. I’d probably do a lot more if I had the coverage. . . . You’re in denial. I mean I can’t afford it. So I’m fine and I got nothing hurting me. That’s it.”* Similarly, another participant explained how insurance coverage has affected his decision-making regarding health care: *“I’ve had health insurance for like the last year, so I’ve been trying to be a little bit more regular about it. But before that, when I didn’t have health insurance, I really didn’t even go when I was sick. I went when I was like hurt basically.”*

Insurance clearly affects the extent to which men see cost as a barrier to care. However, **men’s experience with health care is also affected by their insurance status.** For example, men who have not had insurance and are accustomed to using hospital emergency rooms or health clinics frequently report very negative experiences with these health facilities. This experience affects their future use of health care. These types of experiences and men’s attitudes in general will be examined in the next section, which covers attitudinal barriers affecting men’s use of health care.

## **ATTITUDINAL BARRIERS TO ACCESSING HEALTH CARE**

Men clearly indicated extensive knowledge of health risks, an interest in taking better care of their health, and an awareness of some of the health care services available to them; but most men, their partners, and health care professionals emphasized that men simply are not likely to use health care unless they are in extreme pain or have a serious illness. Even men with a clear sense of the importance of check-ups and routine screenings frequently do not utilize these services. For example, one Hispanic man explained, *“I think every person should get a check-up every six months, every six months. I mean, I don’t go. . . . I got the plans; I just don’t do it. It’s like a car, 3,000 miles it needs an oil change. . . . I mean, if you have insurance, you know, why not? Get checked every six months ‘cause they’re willing to find something out that you will find out or, like cancer, it starts growing little by little, and if they catch it when it’s small, they can prevent it from growing or they can give you medicine. And there are so many technologies out there that can prevent so many diseases, you know, like a check-up every six months for man and woman.”*

Throughout each of these groups, men consistently acknowledged that they are unlikely to see a doctor for routine screenings and are often hesitant to go to a physician, even when they are concerned about something. For example, one man expressed what many had been saying throughout the groups: *“I don’t go to the doctor unless I have to go. . . . I usually never go for anything. As far as in the future, don’t know. You just try to stay healthy. That’s it.”* Similarly, one spouse explained, *“But men, for some reason, just want to just push it to the back of their mind and forget about it, and hopefully it will go away.”*

The focus group discussions confirm findings from national studies indicating a variety of attitudinal barriers that affect men’s access to health care. These include:

- the fact that health care is not a priority for men, particularly younger men, who are frequently establishing themselves professionally and beginning to build their own families;
- men's common perception that being concerned about and addressing health issues is a sign of weakness and not appropriate for a man;
- fear of discovering a serious illness or problem, combined with lack of confidence that physicians can help treat many of these problems; and
- negative experiences with health care systems and health care providers, including poor interpersonal interactions and problems accessing care, so that men actively avoid having to face these situations.

### **Health Care is Not a Priority**

Many men ages 25 to 45 simply do not see health care as an important issue for them at this time. They have no pressing health problems and therefore health care does not concern them as much as issues relating to their education, job, family, social life, recreation, etc. For example, one of the younger men explained, *"I'm 25 years old; you know what I mean? I mean, I don't eat that bad. I mean, I stay in pretty good shape. I mean, I'm active. If something hurts, I'll go."* Another Caucasian man explained that health care is something they think about when something goes wrong: *"It was like Dan said, it's like a car, you break down and you go, when something is wrong. That's when I go in."* Similarly, one of the Hispanic participants described, *"In my case, I don't think unless I get like sick now, I would start going more to the doctor, but I think I'm doing fine. I think I'm doing fine right now."*

Some of the men, their spouses, and health care providers linked this indifference to a general cultural attitude that leads men to not think about their health care. For example, one man explained, *"I think society in general, men have always grown up feeling like they're strong. They don't need the doctor. They don't need, men are . . . like mules. They're there to labor and die."*

One health care provider described the difficulty of communicating with men about the importance of routine health care: *"I sometimes think I am just talking to a wall. As much as I say the consequences of their illness, I just don't think that they accept it or understand it until it happens. It has to happen before some of them can accept it or even choose to do anything about it."*

These findings clearly indicate that men are unable to overcome ingrained attitudes toward their health and health services, despite the fact that many recognize the importance of routine health care and early detection of illness. In order to overcome this attitudinal barrier, educational campaigns need to help men who feel strong and healthy clearly see the consequences of not seeking health care. For example, one of the Hispanic participants described a change he has recently experienced, *"Until very recently, if I was not feeling sick, I would not go to the doctor's. I was feeling fine. . . . But now, I am becoming more aware of this, and I think because of the exposure to information. But I think that there are many people, . . . they have to open up . . . and reach more people with this information."*

Educational efforts also have to help men recognize common symptoms and motivate them to seek help. Another Hispanic participant explained, *“Sometimes we won’t go, and it’s because, you know, I think that it is sometimes because of lack of knowledge in certain areas like what [are] the symptoms to high blood pressure? What are the symptoms to diabetes? Sometimes a person might be getting headaches or the symptoms of high blood pressure, and because a person doesn’t know the symptom of this particular area, we won’t go and check ourselves.”*

Men in their 30s and 40s are more likely to have experienced some of these problems and/or known other men who faced serious illness. These men are often more receptive to health messages and more likely to act to prevent illness. For example, one health care professional explained, *“I think the older the guy is, the better I succeed. Well, I think that they are getting older, they are kind of realizing their mortality. I think that the young guy is kind of like, oh you know . . . ‘I’m 30 years old – I can’t get sick.’”* To develop effective strategies to reach the younger segment, MDPH will face the challenge of getting young men to face their mortality, of assisting young men in acknowledging that they will age.

### ***Machismo***

Related to the fact that men simply do not want to think about potential illness is a sense of pride and *machismo*, which takes various forms, but which generally supports a man’s denial of any physical weakness. Men in the groups with Hispanic men frequently came back to the term *machismo*, and men in the other groups, as well as spouses and health care professionals, expressed a similar sense that men are frequently socialized to be macho, stoic, and not reveal any weakness. This deeply ingrained attitude clearly affects men’s ability to worry about their future health, acknowledge that they may be having a health-related problem, and communicate about symptoms or concerns.

One of the Hispanic participants described how this affects his community: *“There are health issues within the Latin community that need to be addressed, and sometimes we, as men, we don’t, our pride won’t allow us to go [to the doctor’s], like, and we won’t go even though we know that something is wrong. Our body is telling us, ‘You’ve got to check yourself.’”*

### **Fear or Not Wanting to Hear Bad News**

Both related to *machismo* and in some ways in opposition to it, many men indicated that they avoid going to the doctor because they do not want to hear any bad news. Clearly, if a man hears a doctor confirm that he has a health problem, it is hard to maintain the attitude that he is strong, healthy, and indefatigable. Men also do not want to face their fears relating to illness and death. Men do not want to be put in the position of the sick person—i.e., someone who is pitied, weak, and can no longer provide for his family. This fear, often presented as complete confidence in one’s own health and strength, helps men procrastinate and completely ignore the need for health care.

Many of the men who participated in the groups were very much in touch with this feeling of fear, openly acknowledging that it kept them from seeking medical care. For example, one man clearly articulated, *“I don’t want to deal with it because I don’t want to find out that I have something wrong. . . . To be honest with you, I don’t want to go find out like prostate, colon. You know what? I’m scared as hell to go check that out, to be honest with you. . . . But I’m going to have to do it. My girlfriend wants me to do it. My parents want me to do it, so I have to do it; but I’m scared as hell. I don’t want to go there to find out, see, if I don’t go I don’t know. . . . Listen, I’m scared as hell. Don’t want to find out that I have it, and they are saying if I go now, it’s treatable.”*

Another man described how scared he had felt while putting off being tested and the resulting relief he felt when he finally got tested for HIV: *“The torture is even more when you . . . know there’s something wrong with you, right? And you’re constantly thinking about it, right? But you’re scared to go to the doctor’s, because you don’t know what it is. But you torture yourself even more, because you just don’t know. For example, in the past I had a problem with drugs. I put myself in a place that I was at high risk of HIV. So for years, I was like, ‘Oh, it was in me.’ You know what I’m saying? Oh, my God! Because, hey, I was there. You know what I’m saying? And then years after I found out that some of the friends that I was with, turned up with HIV. So for two years at least I was just like, but scared, because I thought I might of had it. But the torture was even more just thinking about it. Once I walked in that hospital and I said, I gave my blood. It was over, the pressure was all over.”*

However, in many of the discussions in which fear came up as attitudinal barrier to accessing care, most men were not this candid or even aware of the extent to which it is an issue for them. Men are more likely to present the issue in terms of needing to maintain their health and their strength, so that they can continue to live in their accustomed style and provide for their families. These men see getting tested and potentially diagnosed with a severe illness as a fatal blow. For example, one man described, *“I strongly feel that, I’m not going to go to the doctor’s, because if they check me, and they say I got cancer, I’m going to know I got cancer and I’m going to act like a cancer patient. But if you don’t know, you’re living life fine; or you find out you got something, that’s when you torture yourself, that’s when you start to die.”*

## **Negative Prior Health Care Experiences**

In addition to many of these gender-related issues affecting men’s attitude toward seeking help, acknowledging weakness, or facing illness, many men have often had negative experiences with health care systems or individual providers and want to avoid these situations. For example, many men, particularly those from lower socioeconomic backgrounds, ethnic minorities, and those without insurance coverage have had great difficulty accessing health care and have often encountered disrespectful providers.

One of the critical issues men face is simply access to health care. Many men complained of long waits on hold, long waits to get an appointment, long waits in a clinic or emergency room, and lack of follow-up by medical staff. These men have very clear images of these experiences and certainly do not want to repeat them. In many cases, men will avoid health care altogether unless they are in dire need. Men had numerous stories reflecting the difficulty they have had accessing care. One man described, *“You*

*call and want to make an appointment. You get put on hold. You are sitting there and damn, you could be dead by the time they get you back off of hold, for you to try to see if your doctor is there.”* Another man recounted, *“I know I have to go into the emergency room or whatever to an appointment, and knowing that I have to be there for three hours, four hours, just to be seen and tell me, ‘Hey, here take two and call me in the morning.’ You know what I’m saying?”*

Many of the men, particularly those in the group of African-American men in Springfield, which represented very low-income men, expressed great anger and frustration with the health care system. They have clearly identified this as a class and race issue, in which poor minority men have greater difficulty accessing care. For example, one participant explained, *“That there even goes back to money again. All the places that are around where poor people live, I mean, you wait forever. If you’re real swollen, the swelling may go down by the time they call your name.”*

Men in one of the groups with Hispanic men had a similar discussion about their experience receiving a lower quality of care:

*-- White America, when they go to the doctor, their doctors are, they get treated like real people. Now, Hispanics, they got to go to clinics.  
--Hispanics or blacks.  
--People of color, or even the poor white, the people that are not so fortunate. They have to go to these clinics, where you're just another number. There's no one-to-one. There's no one-to-one with anybody.*

Insurance coverage and level of income clearly affect men’s attitudes toward health care and their ability to access care. It was clear in many of these discussions that education about health care coverage and services may help some of these men access care. In some groups, one participant would try to educate others there about how to access state-funded coverage or get around state and insurance requirements to access care. Even with this knowledge, however, men who have had consistent insurance coverage clearly had had fewer problems accessing care.

Regardless of insurance coverage, men across all the groups complained about **negative experiences with providers who are disrespectful and too rushed to provide thorough care**. These types of interactions clearly reduce men’s likelihood of following up on health care issues or of seeking care the next time a problem arises. Many men expressed a lack of trust in doctors and the health care system in which they have to work. For example, one explained, *“They treat us like we’re idiots. They don’t keep us updated on our own care, because they feel like we wouldn’t understand it. They overcharge us. . . . So, I really don’t trust them. I’m sure there are some good caring doctors out there. I don’t think there’s too many of them, because they’re just burnt out by the system. You know, they’ve got too many patients to care about, you know, things like that.”*

Others similarly articulated that they are uncomfortable with the power imbalance in relations with physicians. One white man described, *“I think there’s also a problem with me going to a doctor in that you really are reduced to a bit of pain. And you have to go to someone [who] is undoubtedly an expert in his or her field, but there is power relationship which is uncomfortable. I mean, everything about a doctor’s office is basically uncomfortable. . . . So for me personally, it’s a power thing.*

Across all ethnic groups, men complained about the **lack of personal attention** they get from physicians, noting that physicians are usually rushed, do not take the time to get to know the patient and his family history, or do not conduct thorough exams and testing. Many men feel physicians are likely to come up with simple answers and solutions, such as recommending a medication to see if a problem goes away. For example, one man described a recent interaction, *“I’ve gone to the doctor, and I’ve brought up, you know, because they’ll ask you, you know, family history, and it’s like, I’ve had, you know, my grandmother, my grandfather, my uncle, three aunts, or great aunts have all died of heart-related injuries. So I sit there and I ask him, ‘You know, is there any testing you can do?’ ‘Oh, that will come up later on in your life.’ And I was like, ‘I don’t want it to come up later on in life, that’s why I’m asking now!’”*

That comment sparked an exchange among other men in the group:

*--I don't trust him [the physician] for shit.*

...

*--I don't trust the doctor at all.*

...

*--You're just like a number.*

...

*--For me, it's not that I don't trust my doctor, even though I know he doesn't know me, but it's the larger system in which the doctor has to make a living. I just don't trust it.*

These types of barriers related to trust and comfort with health care providers are exacerbated for some segments of men. For example, minority groups who have different cultural traditions, interaction styles, health beliefs, and language barriers find it even more difficult to develop a relationship with health care providers. Health care providers described problems they have establishing a positive, trusting relationship with recent immigrants, veterans, and trauma victims, many of whom are even less likely than other men to trust health care professionals and feel comfortable talking about how they are feeling.

## SUGGESTIONS FOR INCREASING USE OF HEALTH SERVICES

Men clearly face significant obstacles to obtaining routine and even urgent care. These include the most common barriers to care, such as cost, time, language, and access to appointments. In addition, attempts to increase the extent to which young men access routine care will have to include social marketing that addresses men's attitudes toward their bodies, their health, and the use of health care. Therefore, MDPH needs to consider a multi-dimensional approach that:

- eases access to care;
- enhances and broadens the typical health care visit; and
- educates and informs men in meaningful ways, so as to overcome their reluctance to seek health care.

Men, their spouses, and health care providers offered many anecdotes describing the difficulty men have had in accessing health care, mostly relating to cost, insurance coverage, and the inflexibility of health care delivery systems. They also offered **suggestions to make it easier for men to access health care**. Many of these suggestions correspond to initiatives undertaken in other health care campaigns to increase utilization of health services by other population segments—for example, women. Specifically:

- expand existing and develop new funding and **insurance coverage initiatives to cover routine screening for men's health issues**. Many participants pointed to the effectiveness of the women's breast health project, which has broadened awareness of the importance of breast cancer screening and increased access to mammograms;
- make **health care delivery systems more user-friendly**, particularly those that provide care to lower-income and ethnic minority groups. Men need to be able to easily schedule appointments, get an appointment within a reasonable period of time, know they will be seen within a reasonable period of time, and have confidence that their concerns will be taken seriously. Men and providers suggested making any changes that make the health visit a more pleasant experience, including having food in the waiting room. Without fundamental changes in how services are delivered, men are unlikely to use health care; and
- make **routine health care more convenient for men in their communities**. Men and health care providers repeatedly emphasized the value of medical care and routine screenings being offered in community settings. For example, many men indicated that their most recent screening had been done in a supermarket or at a community event. One man explained, *"It was one of those mobile vehicles where they have blood pressure and they have some blood tests and sometimes . . . a community endeavor. And I happened to be going to the Postal Office, so I just jump in, pull my arm out and get your [pressure checked]. It was easy, because I was in [the] area, so*

*I was just able to go in, and didn't have to call and make an appointment [and figure out] which doctors and my HMO-PPO and preventive care and go through the whole process.” Similarly, one provider explained, “You almost have to bring health care to the people. You go to the grocery store, you go to different places where people are going, and if you can ask the people, ‘How’s the blood pressure?’ You see it’s a little high, then you give it to them. I think the catch is made a little stronger, they are not just getting it, a piece of paper. They are having somebody say, ‘You know, what your age range for what you do, that is a little bit high. Let me just sit down and have some time to take a look at this. You might want to talk to your doctor, write it down.’”*

In addition, men and health care providers had several suggestions for **improving the quality and content of the visit**. These include:

- having **culture and language-appropriate health care providers** that men from different populations feel comfortable with and trust;
- enhancing delivery systems, so that **providers can take more time with patients**. Both men and health care providers emphasized how short the interaction time is. For example, one man described, *“I will go to a private doctor and what I would ask him, I would tell him exactly what I’m feeling, because I will want him to listen to what’s my problem. I don’t want him to just come and give me one of the over-the-counter diagnostics, ‘Okay, you know, just here, take these pills.’ No, no. I want you to slow down and listen to what my problem is. And sometimes you go to the clinic, and because it’s so crowded, you know, they’re just rushing, you know, it’s kind of hard and I would want somebody that, when I go there for my appointment, I want him to have time for me and find out what my problem is. ‘You’re getting paid for this. Well, I need you to take the time and find out what my problem is.’”* When men come in for urgent care appointments, providers need to be able to take the time to address routine health care issues, knowing that men are not likely to come back for a separate visit;
- developing **staffing patterns to support physicians in encouraging men to access routine care**. For example, one provider described the extensive outreach work her clinic does to ensure that men come back for follow-up appointments; and
- **training providers to take a comprehensive approach to patient care**, to use any appointment as an opportunity to educate and screen men. Providers could also be trained in educational and motivational techniques that work to get men in for return visits. One provider suggested that “scare tactics,” in which she emphasizes the life-threatening risks of not returning, are effective in getting men to return for both follow-up treatment and routine screenings.

Clearly, another major obstacle to overcome is men’s reluctance to seek health care. This will require gradual social change that can be supported by **education and social marketing efforts to overcome men’s attitudinal barriers**. Any education and information campaigns need to address these barriers and help men change the way

they think about their health care. Simply, providing information about health risks, issues, and services will not motivate many men to seek care. Some suggestions include:

- more **public discussion regarding men's health issues**, that include men from all different income levels and racial and ethnic groups. Men were clearly excited by the opportunity to talk about health issues. Publicity regarding these types of forums might help men overcome the sense that health issues are something they are not supposed to talk about;
- having **spokespeople who represent diverse communities**. Men in each of the groups clearly indicated that they are more likely to respond to culturally-appropriate spokespeople addressing health issues. For example, one Hispanic man explained, *"When you talk, don't talk in all these big words, and don't give me . . . a guy with a suit and tie, 'cause I'm not going to relate to that. But if you put the average working Joe or the average Hispanic guy, whether it be with an earring in his ear, chain around his neck, then I can relate and then I say, 'Wait a minute, let me look at that. Is that high blood pressure?'"*;
- taking even **greater advantage of major public figures, particularly athletes**, who have experienced health problems to educate men about the importance of screening and the repercussions of late detection;
- developing campaigns that **help men clearly connect easily-recognizable symptoms** (e.g., recurrent headaches or frequent urination) with simple tests they can have done to prevent major illness; and
- **taking advantage of men's perceptions of themselves as providers**, playing on the importance of men taking care of their own health in order to be able to take care of their family. For example, one man described, *"Because there's nothing I wouldn't want to do just to be, I'll put up with anything even if it's a bag on the side or whatever, just to see my boy grow up and my daughter grow up. That's it. You know, 'til I see that they're on their own, and they're strong, and they can deal with anything that comes their way."*

## SOURCES OF INFORMATION REGARDING HEALTH ISSUES

Men, their spouses, and providers talked about where they typically find information regarding men's health issues and what types of information they find most useful. Men expressed a wide range of opinions on what types of information they are most likely to notice or respond to. For example, many felt that television advertisements during sporting events would effectively reach a lot of men, while others felt that type of message would just annoy them and they would turn it off. These findings clearly suggest that any media and education campaign will have to involve multiple approaches, acknowledging the diversity of the population the state needs to reach.

Off the top of their head, men tend to think of a few **common sources of information relating to health**. These include:

- **news stories on television**, which can be part of the daily news, shows like *Dateline*, or regular short segments shown between shows;
- **widespread publicity regarding well-known public figures**, such as Rudy Giuliani or Darryl Strawberry, who have had major health problems, notably cancer. For example, one man described, *"Whatever is the hot, new thing. There is always something out there that some celebrity died of this, 'Oh my God, everybody have this done.'"*;
- **advertisements** (usually on television) **for specific medications**;
- **community centers** that are well-regarded and frequently used for various community events. For example, the men in the group with African-American men in Springfield continually referred to the Urban League as a central place to get information;
- casual **discussions with other men**, usually family, colleagues, or close friends who spend a fair amount of time together. This is particularly important when one or two older men are beginning to have health problems and introduce younger men to the issues; and
- **wives, partners, mothers, and children**, who often bring home information they have recently learned about various health issues.

Men and health care providers also indicated various other sources of information, including magazines, newspapers, pamphlets, and the Internet, many of which are not very effective in educating men. Health care providers emphasized that they currently rely on pamphlets to provide information that they cannot cover in an appointment, knowing that most pamphlets end up in the trash. However, men and providers both saw this as one means of getting information out there, and emphasized that all literature needs to be competently translated so that men in various language groups have access to information. Similarly, while only a small segment of men would be likely to utilize the Internet for health information, this is an important medium for those men actively looking for specific information.

Men clearly indicated that they see a lot of different health-related messages in their daily life, but that they feel they **pay little attention or do not take much useful information from them**. For example, men clearly were familiar with many celebrities who had recently been publicized with cancer, and many mentioned Katie Couric's show, in which she underwent a colonoscopy on television. However, few men felt any more familiar with the risk factors, warning signs, or screening guidelines for any of these diseases. For example, one man described, *"To me it's only adequate if there's something wrong with me. Then I can identify with what they are telling me. That's it. I see it, but it isn't me. I'm not having that problem. So that's it. If I had them symptoms then. . . ."* This type of publicity is good for bringing specific illnesses to public awareness, increasing recognition of the issue, and helping men see that young, healthy men are susceptible to disease. However, these major news events need to be followed up with extensive education campaigns, so that men become aware of risk factors and the importance of screening in early detection, so that they themselves can avoid the disease.

Men **disagreed on the value of television news shows and advertising** to educate men about health issues. Many indicated that they really do not want to see this type of information, that when health news comes on the television, they frequently change the channel. One man explained, *"I'm being honest 'cause when I see it, it's like, 'Okay, now you have to check this out again, or check this out, check that out.' So you know what, when I see something, Dateline or whatever, and they're talking about health, I turn it off."* However, others feel television is the best medium to reach men, particularly in populations that are unlikely to read information and that have particular shows or channels they are likely to watch. For example, one Hispanic man explained, *"TV is a big deal, especially to Hispanics. . . . A lot of us really don't like to read, not that we're ignorant or you know, but some can't read. There's the language barrier, especially if it is in English, so the TV is a big media for us to learn issues."*

Men, their partners, and health care providers **disagreed on the value of providing information to women**, hoping they can educate and motivate their partners. Many men and women clearly acknowledged that women are likely to be more familiar with health issues and more likely to be responsible for health care decision-making for the family. However, there was little agreement on how effective women were at motivating men to change their behavior. One man described his reaction to his wife's information: *"I haven't had a physical in a long time. I don't remember when. The last time I was at the doctor's, maybe two years ago when I got into an accident. . . . It's been a long time and my wife is always telling me, 'Ed, go get a physical.' And I say, 'Well, you can check my nuts if you want to see if I got a lump.'" Others, however, were much more positive. One man explained, "I think a wife or, you know, should be able to encourage her husband to go. . . . 'Cause men are like, you want to be big, macho, you know, you don't want nothing can hurt you, especially in front of your women. . . . Someone caring helps a lot. If your girl says, 'You know, I wish you would do this,' personally I'd do it just for her sake. Then you have an excuse—she wanted me to do it; okay, I'll do it." Others noted that their mothers have been excellent providers of information, naggers, and motivators.*

Another man in one of the groups with Hispanic men clearly identified **the challenge involved in not only providing information, but actually motivating people to use that information**. He explained, *"The truth is that there is plenty of information. . . . There is a saying, and I think it is very true, that says, 'There is not a*

worse deaf person than the one who does not really want to hear.’ There is information, even in Univision, there is a show on Fridays, I think, where they show very good programs in Spanish, they touch many different subjects, many times related to health issues. However, we do not take our time to sit down and pay attention to what they say, to see if they say something that interests us. I insist on our poor education, we prefer to turn off the TV set, or go to a different channel and wait for the soap operas to start. . . . , but we are not interested at all, we have a bad education, the information is there, through TV, radio, pamphlets, all kinds of things, . . . but we are not interested, we throw it away. We have to create a conscience, or else we will die.”

## SUGGESTIONS FOR EDUCATIONAL CAMPAIGNS

MDPH needs to clearly assess:

- the best way to reach men;
- the type of information to provide to men; and
- the best ways to motivate men to change their health-related behavior.

These are all difficult issues, with no simple answers, particularly given the diversity of the population of men in Massachusetts. Strategies will need to include diverse forums for reaching men; broad-based campaigns to provide men with information regarding basic health issues, risk factors and warning signs, and the availability of routine screening; and innovative initiatives that help men link their knowledge to their actions in order to reduce their health risks.

The first recommendation that clearly comes from men, their partners, and health care providers is to **“get the message out everywhere.”** For example, one provider explained, *“Like health fairs and people are going to pay attention to the media, and like we try to have health fairs in the churches, and, like I said, in the grocery store or something like that, the more we make people aware, like somebody said, you know, bring it to the people, that is where it is going to happen. Like TVs, like in your home, so the same thing, when people get surrounded by this, and time and time again, it finally gets like a broken record, you know, it finally sets in.”*

Just as women’s health initiatives have been very effective in bombarding women with information about menopause and breast cancer, men’s health campaigns will need to use diverse strategies to make men’s health a common topic of conversation about which people have useful information. Men suggested:

- targeted television and radio advertising and news stories;
- information at community centers, community events, churches, grocery stores, and malls;
- information provided through insurance companies;
- mass mailings;

- education provided to children in school, serving two purposes: (1) getting information to parents, and (2) educating children at a young age as to the importance of preventative health care;
- using web sites that are clearly linked to reputable organizations that do not have a profit motive in putting out the information; and
- health care providers taking more time with patients to explain various health issues and screening options.

Health education campaigns also have to **effectively package information so that men can listen to, identify with, and respond to the information**. Given men's reluctance to care about health issues, this is a significant challenge. Campaigns will need to help men make an immediate connection to their own lives. One key suggestion men repeatedly offered was using culturally-appropriate spokespeople to "*bring the message home*" to diverse communities. In addition, education campaign developers should consider:

- using spokespeople with whom men can easily relate—figures who represent older friends, brothers, fathers, who are experiencing illness;
- using clear and direct messages: do not use jargon; and
- developing methods that help men identify their own risk and actions they can immediately take to reduce that risk. For example, present a clear message stating symptoms men might be having, followed with a specific action men can take. Or as one participant suggested, simply state: "*You're a 35 year old Latino, here is what you need to do.*"

Finally, education campaigns need to determine the most effective ways to **motivate men to change behaviors**. The two most common themes coming from the focus groups were to:

- depict **scenarios that men can immediately relate to** and would want to avoid. For example, present a man their age, with their cultural background, who until recently had no reason to be concerned about his health, and explain why he has become concerned. One man explained, "*It's not until it affects somebody in our family, it doesn't touch home, that we really get concerned. . . . I believe that you begin to educate the people as to what to look for, even the older folks, you know, like it's that, you know, give them the symptoms or this is the symptom so that when he is sitting there watching the news or watching sports and they come and say, 'You know, are you experiencing this and this and this and this and this?'*";
- use **commitment to family to motivate men to take care of themselves**. Men and women consistently emphasized that men would change behavior in order to be able to better take care of their family. If campaigns can effectively show that routine screenings make a man a better provider, they are likely to reach family-oriented men; and

- related to men's perceptions of themselves as providers, **address men's fear of becoming ill or incapacitated, of becoming a burden on their family**, to demonstrate that early detection will help them avoid this scenario. Help men move away from a perception that screening leads to a diagnosis of severe and untreatable illness, and help men understand that **with routine screening, they will avoid becoming ill**.

In addition, men, their partners, and health care providers talked about the importance of starting young. While few felt it was too late for the current generation of young men, many felt that education programs should start in elementary school to change boys' concepts of their bodies, their roles, and their health care needs.

The focus group discussions were very important in providing a sense of how men respond to different advertising media and how difficult it is to motivate men to change their behavior. MDPH also has the advantage of learning from numerous other campaigns such as anti-smoking efforts and women's health initiatives that have clearly demonstrated the importance of using diverse approaches to educating populations and supporting people in changing health-related behaviors. Information is clearly not enough. Efforts to increase men's use of routine care will need to include education, changes in health care delivery systems, and fundamental shifts in terms of how we provide health care and how men see themselves in relation to health care.

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## APPENDIX B: SCHEDULE OF FOCUS GROUPS

| Group                                    | Date and Time                        | Location  | Moderator                     | Number of Attendees | Recruitment Methodology   |
|--|--------------------------------------|---|-------------------------------|---------------------|---|
| Spouses/Female Partners                  | Mon., Apr 24 <sup>th</sup> 7:30 PM   | Focus on Boston, Boston                           | Jean Whitworth                | 8                   | Telephone calls to targeted households                                |
| Health Care/Social Service Professionals | Mon., Apr 24 <sup>th</sup> 5:30 PM   | Focus on Boston, Boston                           | Jean Whitworth                | 8                   | Telephone calls to targeted households                                |
| Caucasian Men – Greenfield               | Tues., May 2 <sup>nd</sup> 6:00 PM   | Brickers Restaurant, Greenfield                   | Jeff Bliss                    | 8                   | Telephone calls to targeted households                                |
| African-American Men – Springfield       | Thurs., May 4 <sup>th</sup> 7:30 PM  | Sheraton, Springfield                             | Alan Bell                     | 10                  | Telephone calls to targeted households                                |
| Caucasian Men – New Bedford              | Mon., May 8 <sup>th</sup> 6:00 PM    | Days Inn, New Bedford                             | Jeff Bliss                    | 5                   | Telephone calls to targeted households                                |
| Latino Men – Worcester                   | Mon., May 8 <sup>th</sup> 6:00 PM    | Holiday Inn, Worcester                            | Gilberto Amador               | 4                   | Telephone calls to targeted households                                |
| African-American Men – Worcester         | Tues., May 9 <sup>th</sup> 6:00 PM   | Holiday Inn, Worcester                            | Alan Bell                     | 9                   | Telephone calls to targeted households                                |
| Caucasian Men – Lynn                     | Wed., May 10 <sup>th</sup> 6:00 PM   | The Porthole Restaurant, Lynn                     | Jeff Bliss                    | 8                   | Telephone calls to targeted households                                |
| Latino Men – Holyoke                     | Wed., May 10 <sup>th</sup> 6:00 PM   | Holiday Inn, Holyoke                              | Gilberto Amador               | 8                   | Telephone calls to targeted households                                |
| Latino Men – Lawrence                    | Thurs., May 11 <sup>th</sup> 6:00 PM | Hampton Inn, Lawrence                             | Gilberto Amador               | 7                   | Telephone calls to targeted households                                |
| Cambodian Men                            | Sat., May 13 <sup>th</sup> 9:30 AM   | Cambodian Mutual Assistance Association, Lowell   | Munty Pot                     | 8                   | Flyers, Radio Ads, Personal Outreach                                  |
| Cape Verdean Men                         | Sat., May 20 <sup>th</sup> 11:00 AM  | Cape Verdean Association of Brockton              | Maria Evora-Rosa & Rui Soares | 8                   | Flyers, Personal Outreach   |
| Vietnamese Men                           | Wed., June 7 <sup>th</sup> 5:30 PM   | Vietnamese-American Civic Association, Dorchester | Huon Bui                      | 8                   | Personal Outreach, Telephone calls and Letters to targeted households |
| Chinese Men                              | Mon., June 19 <sup>th</sup> 9:00 AM  | The Asian-American Civic Association, Boston      | Angel Yuen                    | 10                  | Personal Outreach, Flyers, Newspaper Ads                              |

## APPENDIX C: FOCUS GROUP SCREENERS

### FOCUS GROUP SCREENER MEN'S HEALTH ISSUES: GROUP WITH AFRICAN AMERICAN MEN

**RECRUITMENT GOALS:** 2 groups of 8 African American men between the ages of 25-45. One group to be held in the Springfield area (in Springfield) and one group to be held in the Central Mass area (in Worcester). (The quotas described assume you are recruiting 12 people for a group of 8. If you need more than 12 recruits to ensure 8 people show up, adjust all quotas appropriately.)

- Mix of low and moderate household incomes:
  - min of 4 under \$20,000
  - min of 4 \$20,000 to \$40,000
  - max of 2 in \$40,000+--none in this category is fine
- Try for a mix of insured and uninsured
- All participants must have good command of English language and be articulate

#### [RESPONDENT INTRO]

ASK TO SPEAK WITH THE MALE HEAD OF HOUSEHOLD

Hello, my name is \_\_\_\_\_. I'm calling from \_\_\_\_\_. This is not a sales call.

We're conducting a study on health issues relating to men. For the purposes of this study, we are interested in talking to men between the ages of 25 and 45. We are talking to men to get their perspective on important health issues affecting their health, and how to improve health services for men. I would like to ask you a few questions if I may please. First of all...

I would like to ask you a few questions for classification purposes only.

**1. Do you or an immediate family member work as a health care professional or a health education professional?**

Yes ( ) ➔ TERMINATE

No ( )

**2. Are you between the ages of 25 and 45?**

Yes ( )

No ( ) ➔ TERMINATE

**3. Which of the following would you say best describes your race and ethnicity?**

- White, Caucasian ( ) ➡TERMINATE
- African American, Black ( )
- Asian, Pacific Islander ( ) ➡TERMINATE
- Native American ( ) ➡TERMINATE
- Latino, Hispanic ( ) ➡TERMINATE
- Other ( ) ➡TERMINATE

**4. Into which of the following ranges does your household annual income fall?  
(READ LIST AND RECORD BELOW.)**

- Under \$20,000 ( )
- \$20-40,000 ( )
- \$40,000 OR MORE ( )
- Refused ( ) ➡TERMINATE

QUOTA NOTE: Mix of low and moderate. Max of 2 with \$40,000 or higher.

Now I'd like to ask you some health-related questions.

**5. Do you have any form of health insurance coverage?**

- Yes ( )
- No ( )

QUOTA NOTE: Try to get mix of insured and uninsured.

**6. Is this insurance provided through an employer, the state or federal government, or do you pay for your own plan?**

- Self-pay ( )
- Insurance through employer ( )
- State (Medicaid, Mass Health) ( )
- Federal (Medicare, Veterans) ( )
- Other ( )

QUOTA NOTE: Try to get mix of private (employer or self) and public (state or Federal).

IF ELIGIBLE, ARTICULATE, AND WITHIN QUOTAS, PROCEED.

7. As part of this study we are conducting group discussions with men regarding important health issues facing them and how to improve health services for men. The group will be held in \_\_\_\_\_ on April XX at X:XX PM, and will last about an hour and a half. For your time and effort, we'd like to offer you \$50.00, and light refreshments will be served. Will you be able to take part in our discussion group?
8. To confirm, we are holding the group discussion on \_\_\_\_\_ at \_\_\_\_\_. The discussion will last about an hour and a half. We will send you directions to the facility in the mail. Can I please get information as to how to contact you:

**RECORD INFORMATION BELOW:**

NAME: \_\_\_\_\_

PHONE (with area code) : \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY : \_\_\_\_\_

STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_

INTERVIEWER INITIALS: \_\_\_\_\_

**FOCUS GROUP SCREENER  
MEN'S HEALTH ISSUES:  
GROUP WITH CAUCASIAN MEN**

**RECRUITMENT GOALS:** 3 groups of 8 Caucasian men between the ages of 25-45. One group to be held in the Franklin County area (Greenfield), one group to be held in the North Shore area (Lynn), and one group to be held in Southeastern Mass (New Bedford). (The quotas described assume you are recruiting 12 people for a group of 8. If you need more than 12 recruits to ensure 8 people show up, adjust all quotas appropriately.)

- Mix of low and moderate household incomes:
  - min of 4 under \$20,000
  - min of 4 \$20,000 to \$40,000
  - max of 2 in \$40,000+--none in this category is fine
- Try for a mix of insured and uninsured
- All participants must have good command of English language and be articulate

**[RESPONDENT INTRO]**

ASK TO SPEAK WITH THE MALE HEAD OF HOUSEHOLD

Hello, my name is \_\_\_\_\_. I'm calling from \_\_\_\_\_. This is not a sales call.

We're conducting a study on health issues relating to men. For the purposes of this study, we are interested in talking to men between the ages of 25 and 45. We are talking to men to get their perspective on important health issues affecting their health, and how to improve health services for men. I would like to ask you a few questions if I may please. First of all...

I would like to ask you a few questions for classification purposes only.

**9. Do you or an immediate family member work as a health care professional or a health education professional?**

Yes ( ) ➔ TERMINATE

No ( )

**10. Are you between the ages of 25 and 45?**

Yes ( )

No ( ) ➔ TERMINATE

**11. Which of the following would you say best describes your race and ethnicity?**

White, Caucasian ( )

African American, Black ( ) ➔ TERMINATE

Asian, Pacific Islander ( ) ➔ TERMINATE

Native American ( ) ➔ TERMINATE

Latino, Hispanic ( ) ➔ TERMINATE

Other ( ) ➔ TERMINATE

12. Into which of the following ranges does your household annual income fall?  
(READ LIST AND RECORD BELOW.)

- Under \$20,000      ( )
- \$20-40,000      ( )
- \$40,000 OR MORE      ( )
- Refused      ( ) ➡TERMINATE

QUOTA NOTE: Mix of low and moderate. Max of 2 with \$40,000 or higher.

Now I'd like to ask you some health-related questions.

13. Do you have any form of health insurance coverage?

- Yes      ( )
- No      ( )

QUOTA NOTE: Try to get mix of insured and uninsured.

14. Is this insurance provided through an employer, the state or federal government, or do you pay for your own plan?

- Self-pay      ( )
- Insurance through employer      ( )
- State (Medicaid, Mass Health)      ( )
- Federal (Medicare, Veterans)      ( )
- Other      ( )

QUOTA NOTE: Try to get mix of private (employer or self) and public (state or Federal).

IF ELIGIBLE, ARTICULATE, AND WITHIN QUOTAS, PROCEED.

**15. As part of this study we are conducting group discussions with men regarding important health issues facing them and how to improve health services for men. The group will be held in \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_ PM, and will last about an hour and a half. For your time and effort, we'd like to offer you \$50.00, and light refreshments will be served. Will you be able to take part in our discussion group?**

16. To confirm, we are holding the group discussion on \_\_\_\_\_ at \_\_\_\_\_. The discussion will last about an hour and a half. We will send you directions to the facility in the mail. Can I please get information as to how to contact you:

**RECORD INFORMATION BELOW:**

NAME: \_\_\_\_\_

PHONE (with area code) : \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY : \_\_\_\_\_

STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_

INTERVIEWER INITIALS: \_\_\_\_\_

**FOCUS GROUP SCREENER  
MEN'S HEALTH ISSUES:  
GROUP WITH HEALTH AND SOCIAL SERVICE PROFESSIONALS**

**RECRUITMENT GOALS: 1 Group with 8 health and social service (see note below) professionals who work with men between the ages of 25-45**, particularly men in low and moderate income households and men from racial/ethnic minority populations (Latino, African-American, Cambodian, Vietnamese, Chinese). We expect these people to be familiar with men's attitudes toward health care, use of health care services, and barriers to care. Participants might include:

- DPH outreach workers (conduct outreach and education to various populations)
- DSS case workers
- health center/clinic social workers
- community agency staff working with targeted populations
- nurse practitioners and physician assistants working with targeted men in primary care settings

Physicians are not eligible for this study.

All participants must have good command of English language and be articulate.

**(The quotas described assume you are recruiting 12 people for a group of 8. If you need more than 12 recruits to ensure 8 people show up, adjust all quotas appropriately.)**

**[RESPONDENT INTRO]**

Hello, my name is \_\_\_\_\_. I'm calling from \_\_\_\_\_. This is not a sales call.

We're conducting a study on health issues relating to men. For the purposes of this study, we are interested in talking to health and social services professionals who work with men between the ages of 25-45. We are conducting this study to better understand men's perspective on important health issues, the types of services they use, and why they do or don't regularly access health care. I would like to ask you a few questions if I may please. First of all...

**17. Do you regularly work with men between the ages of 25 and 45 in the greater Boston area?**

Yes ( )

No ( ) ➔TERMINATE

**18. Do you regularly work with men in any of the following racial or ethnic groups:**

**[multiple response allowed]**

White, Caucasian ( )

African American, Black ( )

Asian, Pacific Islander ( )

Native American ( )

Latino, Hispanic ( )

Other ( )

QUOTA NOTE: Maximum of 4 who work only with white men

19. Do you regularly work with men in any of the following income brackets:  
[multiple response allowed]

Lower income families,

annual household incomes <\$20,000 ( )

Moderate income families,

annual household incomes between \$20,000 and \$40,000 ( )

Higher income families,

annual household incomes over \$40,000 ( )

QUOTA NOTE: TERMINATE IF ONLY WORK WITH HIGHER INCOME FAMILIES

20. What is your job title?

Nurse practitioner ( )

Physician's Assistant ( )

Other non-MD clinician ( )

Social worker ( )

Case worker ( )

Outreach worker ( )

Other appropriate social service position ( ) SPECIFY: \_\_\_\_\_

Other appropriate health care position ( ) SPECIFY: \_\_\_\_\_

Other ( ) ➡TERMINATE

21. What does your work involve? Specifically, in what capacity do you work with men between the ages of 25 and 45? [RECORD RESPONSE] [USE RESPONSE TO DETERMINE ARTICULATENESS, FAMILIARITY WITH TARGET POPULATION, FAMILIARITY WITH HEALTH ACCESS ISSUES. TERMINATE IF DO NOT HAVE DIRECT CONTACT WITH MEN REGARDING HEALTH-RELATED ISSUES.]

22. What do you see as the biggest health issues for men in this age group?  
[MULTIPLE RESPONSE ALLOWED]

Insurance coverage ( )

Cost of health care ( )

Information about health risks, diseases ( )

Availability of doctors ( )

SPECIFIC RISK FACTOR (SPECIFY): \_\_\_\_\_

SPECIFIC DISEASE (SPECIFY): \_\_\_\_\_

OTHER (SPECIFY): \_\_\_\_\_

Appropriate response ( )

Inappropriate response ( ) ➡TERMINATE

Don't know ( ) ➡TERMINATE

23. What do you see as the biggest barriers to health care for men in this age group? [MULTIPLE RESPONSE ALLOWED]

Insurance coverage ( )

Cost ( )

Information ( )

Transportation ( )

Availability of doctors ( )

Language ( )

OTHER (SPECIFY): \_\_\_\_\_

Appropriate response ( )

Inappropriate response ( ) ➡TERMINATE

Don't know ( ) ➡TERMINATE

IF ELIGIBLE, ARTICULATE, AND WITHIN QUOTAS, PROCEED.

24. As part of this study we are conducting group discussions with health and social service providers regarding important health issues facing men between the ages of 25 and 45. The group will be held in Braintree on April 24 at 5:30 PM, and will last about an hour and a half. For your time and effort, we'd like to offer you \$100.00, and a light meal will be served. Will you be able to take part in our discussion group?

9. To confirm, we are holding the group discussion on \_\_\_\_\_ at \_\_\_\_\_. The discussion will last about an hour and a half. We will send you directions to the facility in the mail (or fax if prefer). Can I please get information as to how to contact you:

**RECORD INFORMATION BELOW:**

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

ORGANIZATION (EMPLOYER): \_\_\_\_\_

PHONE (with area code) : \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY : \_\_\_\_\_

STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_

INTERVIEWER INITIALS: \_\_\_\_\_

**FOCUS GROUP SCREENER  
MEN'S HEALTH ISSUES:  
GROUP WITH LATINO MEN**

**RECRUITMENT GOALS:** 3 groups of 8 Latino men between the ages of 25-45. One group to be held in the Western Mass area (in Holyoke), one group to be held in the Lawrence area (in Lawrence), and one group to be held in the Central Mass area (in Worcester). (The quotas described assume you are recruiting 12 people for a group of 8. If you need more than 12 recruits to ensure 8 people show up, adjust all quotas appropriately.)

- Mix of low and moderate household incomes:
  - min of 4 under \$20,000
  - min of 4 \$20,000 to \$40,000
  - max of 2 in \$40,000+--none in this category is fine
- Try for a mix of insured and uninsured
- All participants must have good command of English language and be articulate

**[RESPONDENT INTRO]**

ASK TO SPEAK WITH THE MALE HEAD OF HOUSEHOLD

Hello, my name is \_\_\_\_\_. I'm calling from \_\_\_\_\_. This is not a sales call.

We're conducting a study on health issues relating to men. For the purposes of this study, we are interested in talking to men between the ages of 25 and 45. We are talking to men to get their perspective on important health issues affecting their health, and how to improve health services for men. I would like to ask you a few questions if I may please. First of all...

I would like to ask you a few questions for classification purposes only.

**25. Do you or an immediate family member work as a health care professional or a health education professional?**

Yes ( ) ➔ TERMINATE

No ( )

**26. Are you between the ages of 25 and 45?**

Yes ( )

No ( ) ➔ TERMINATE

**27. Which of the following would you say best describes your race and ethnicity?**

White, Caucasian ( ) ➔ TERMINATE

African American, Black ( ) ➔ TERMINATE

Asian, Pacific Islander ( ) ➔ TERMINATE

Native American ( ) ➔ TERMINATE

Latino, Hispanic ( )

Other ( ) ➔ TERMINATE

**28. Into which of the following ranges does your household annual income fall?  
(READ LIST AND RECORD BELOW.)**

- Under \$20,000      ( )
- \$20-40,000      ( )
- \$40,000 OR MORE      ( )
- Refused      ( ) ➡TERMINATE

QUOTA NOTE: Mix of low and moderate. Max of 2 with \$40,000 or higher.

**Now I'd like to ask you some health-related questions.**

**29. Do you have any form of health insurance coverage?**

- Yes      ( )
- No      ( )

QUOTA NOTE: Try to get mix of insured and uninsured.

**30. Is this insurance provided through an employer, the state or federal government, or do you pay for your own plan?**

- Self-pay      ( )
- Insurance through employer      ( )
- State (Medicaid, Mass Health)      ( )
- Federal (Medicare, Veterans)      ( )
- Other      ( )

QUOTA NOTE: Try to get mix of private (employer or self) and public (state or Federal).

IF ELIGIBLE, ARTICULATE, AND WITHIN QUOTAS, PROCEED.

**31. As part of this study we are conducting group discussions with men regarding important health issues facing them and how to improve health services for men. The group will be held in \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_ PM, and will last about an hour and a half. For your time and effort, we'd like to offer you \$50.00, and light refreshments will be served. Will you be able to take part in our discussion group?**

32. To confirm, we are holding the group discussion on \_\_\_\_\_ at \_\_\_\_\_. The discussion will last about an hour and a half. We will send you directions to the facility in the mail. Can I please get information as to how to contact you:

**RECORD INFORMATION BELOW:**

NAME: \_\_\_\_\_

PHONE (with area code) : \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY : \_\_\_\_\_

STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_

INTERVIEWER INITIALS: \_\_\_\_\_

**FOCUS GROUP SCREENER  
MEN'S HEALTH ISSUES:  
GROUP WITH SPOUSES/PARTNERS**

**RECRUITMENT GOALS:** 1 Group with 8 women (see note below) who are married to or in committed domestic partnerships with men (which means they live with their boyfriend/partner) between the ages of 25-45.

(The quotas described assume you are recruiting 12 people for a group of 8. If you need more than 12 recruits to ensure 8 people show up, adjust all quotas appropriately.)

- Mix of low and moderate household incomes:
  - min of 4 under \$20,000
  - min of 4 \$20,000 to \$40,000
  - max of 2 in \$40,000+--none in this category is fine
- Max of 8 white non-Hispanics
- Try for mix of insured and uninsured male partners
- All participants must have good command of English language and be articulate

**[RESPONDENT INTRO]**

ASK TO SPEAK WITH THE FEMALE HEAD OF HOUSEHOLD

Hello, my name is \_\_\_\_\_. I'm calling from \_\_\_\_\_. This is not a sales call.

We're conducting a study on health issues relating to men. For the purposes of this study, we are interested in talking to women who are married to or in committed domestic relationships with men between the ages of 25-45. We are talking to spouses and partners to get their perspective on important health issues affecting their husbands and partners and how to improve health services for men. I would like to ask you a few questions if I may please. First of all...

I would like to ask you a few questions for classification purposes only.

**33. Are you married or in a domestic partnership with a man between the ages of 25 and 45 (having lived with your partner for at least one year)?**

Yes ( )

No ( ) ➔TERMINATE

**34. Which of the following would you say best describes your husband's/partner's race and ethnicity?**

White, Caucasian ( )

African American, Black ( )

Asian, Pacific Islander ( )

Native American ( )

Latino, Hispanic ( )

Other ( )

QUOTA NOTE: Maximum of 8 white recruits

35. Into which of the following ranges does your household annual income fall?  
(READ LIST AND RECORD BELOW.)

- Under \$20,000 ( )
- \$20-40,000 ( )
- \$40,000 OR MORE ( )
- Refused ( ) ➡TERMINATE

QUOTA NOTE: Mix of low and moderate. Max of 2 with \$40,000 or higher.

Now I'd like to ask you some health-related questions.

36. Does your husband/partner have any form of health insurance coverage?

- Yes ( )
- No ( ) Skip to question 6

QUOTA NOTE: Try to get mix of insured and uninsured.

37. Is this insurance provided through an employer, the state or federal government, or does he pay for his own plan?

- Insurance through employer (includes retirees) ( )
- State (Medicaid, Mass Health) ( )
- Federal (Medicare, Veterans) ( )
- Self-pay ( )
- Other ( )

IF ELIGIBLE, ARTICULATE, AND WITHIN QUOTAS, PROCEED.

38. As part of this study we are conducting group discussions with women regarding important health issues facing their husbands and how to improve health services for men. The group will be held in Braintree on April 24 at 7:30 PM, and will last about an hour and a half. For your time and effort, we'd like to offer you \$65.00, and light refreshments will be served. Will you be able to take part in our discussion group?

39. To confirm, we are holding the group discussion on \_\_\_\_\_ at \_\_\_\_\_. The discussion will last about an hour and a half. We will send you directions to the facility in the mail. Can I please get information as to how to contact you:

**RECORD INFORMATION BELOW:**

NAME: \_\_\_\_\_

PHONE (with area code) : \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY : \_\_\_\_\_

STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_

INTERVIEWER INITIALS: \_\_\_\_\_

# APPENDIX D: MODERATOR GUIDES

## MEN'S HEALTH PROJECT Discussion Guide - MEN

### I. INTRODUCTION (approximately 10 minutes)

- Welcome respondents and explain the purpose of today's discussion groups- i.e., to talk about health. Specifically, their views on their own state of health, how do they think about their health, and what might they be doing or not doing to try to remain healthy and prevent illnesses in the future.
- Explain the ground rules
  - We are audio-taping this meeting. We are taping it for two reasons. First, so I can review the tape after the meeting to prepare a report – by having the tape I don't have to take a lot of notes and can concentrate on listening to what you have to say. Second, the tape will be used to reinforce some of the points you are making. If you have a suggestion, it can be more powerful to have you say it than to have me summarize it.
  - Also, there are a few ground rules that we use for meetings like this that help them to run more smoothly. The first is, we really want to hear from everyone. We are only holding a small number of these groups, so each of you is representing a lot of people. So even if you are the only person who holds a specific opinion, I really want to hear it because there are a lot of other people in the area that have that same opinion.
  - Second, it is really important that only one person speak at a time. There may be times when you are tempted to start a side conversation with the person next to you, but I'd appreciate it if you'd hold back. I want to hear whatever you have to say and the audio on the tape will be impossible to understand if more than one person is speaking.
- Have respondents interview the person sitting next to them as a way to get them comfortable in the room and to learn about where they are in life.  
OR
- Have respondents introduce themselves, giving their name, what they do for work, plans for the weekend, etc.

**II. GENERAL DISCUSSION ABOUT THEIR PRESENT HEALTH STATUS, INCLUDING SOME OF THEIR PERSONAL HABITS AND ATTITUDES TOWARD THEM (approximately 20 minutes)**

- To start: have respondents discuss their present health and some personal habits.
  - **How would you describe your health right now? Do you have any major health concerns?**
  - Do you think you might have a health problem that perhaps hasn't been addressed yet? *E.g., I have a cough that won't go away. I frequently get headaches. There is cancer/high blood pressure in my family.*
  - **Do you have any habits that you think might not be good for your health? (e.g., smoke, drink, poor diet, lack of exercise, over-exertion)**
  - **How do you see these things affecting your health?**
  - Do any of you exercise? What kinds of exercise do you do? How often do you exercise?
  - How old were you when you started smoking and/or drinking?
  - Why did you start?
  - How about your diet? Are you choosing foods that are good for you to eat?
  - Some of you smoke or drink or don't think about the foods you eat. Do you think that doing this is affecting your health?
  - If so, is it affecting your health right now? Or is it something that will affect you later on? How much later on?
  - **Have you ever tried to change some of these habits, like tried to stop smoking or drinking?**
  - If yes, were you successful? If not, how long were you able to quit?
  - How did you go about quitting? (*Went to doctor, used an OTC patch*).
  - **Why did you try to stop? What influenced you to try to stop or change your behavior?**
    - *Pressure from spouse, ad campaign, aware of the dangers, too expensive.*
  - Do you plan to quit smoking/drinking in the future? When?
  - If you knew that the doctor could help you stop, would you go? Why not?

### III. ATTITUDES ABOUT SEEING A DOCTOR/HAVING TESTS DONE/DISCOVERING ILLNESSES (approximately 30-45 minutes)

- Discuss the issues of seeing a doctor and how they think illnesses are uncovered.
  - **When you were growing up, how often did you go to the doctor? Who would take you? In what situations?**
  - And did your (mother, grandmother, father) take you for regular check-ups, for physicals?
  - Did you also go to the dentist on a regular basis, say, at least, once a year?
  - Did you ever have your eyes checked when you were a kid?
  - **When was the last time you went to a doctor? What did you go for?**
  - **Where do you go for health care?**
  - *If illness, ask ethnic groups:* Did you see a doctor or did you go to someone other than a doctor? *If "other," ask:* then who did you see? And is that who you normally see? Would you go to this person for more serious problems?
  - **How frequently do you go to the doctor?**
  - **Do you go for routine physicals? How frequently? When was the last time? What does a routine physical include?**
  - Do you see the dentist regularly?
  - Have you ever had your eyes checked?
  - *If different than when growing up, probe for reasons why.*
  - **How often do you think a man should have a check-up or physical exam by a doctor, separate from a specific problem?**
  - **Why – what should happen at a physical?**
  - **Why not – why don't men need to have a regular physical?**
  - **How about tests for specific problems?**
  - **How often should men have their blood pressure tested?**
  - **Their cholesterol?**
  - **Their colon or prostate?**
  - **At what age do you think men should have those tests regularly?**  
*Probe for each of the various health problems.*
  - **At what age do you think men have to worry about these kinds of health problems? What about heart problems? Or colon cancer? Or prostate problems?**
  - **When was the last time you had your blood pressure checked?**  
Why did you have your blood pressure checked? Where did you go?
  - **When was the last time you had your cholesterol checked?**  
Why? And where?
  - **Have you ever had an exam that checked your colon or your prostate? Why? Why not?**
  - Why do you think doctors want to do these tests?
  - Are there any male family members, for example, your grandfather, uncle, father, brother that have any of these health problems?
  - How did they find out that they had a problem?

- Are you concerned this problem may run in the family and that it might be a problem for you too? *If yes, what do you think you can do about not having the same problem? Preventative care?*
- **Has it ever been recommended to you that you have any of these tests done? By whom?**
- **Have you ever seen a commercial on television or an article in the newspaper or magazine that tells men that they should be aware of certain problems and that they should go to have a check-up? Which were they?**
- **Where would you be most likely to notice information explaining about men's health, about the things that men should be aware of or should be doing for their own health care?** (*While watching sporting events, certain magazines, the side of a bus, in the bus, billboards*).
- **For those of you that are married or have girlfriends, how much interest does your partner have in your health? Does she ever say that you should see a doctor or that you should have tests done? Does that make you go and do it?**

#### IV. AWARENESS OF ILLNESSES AND POTENTIAL ACTIONS TAKEN (approximately 15 minutes)

- **Some racial or ethnic groups are more likely to have specific health problems than others.**
  - **As (*insert ethnicity, e.g., Latino men*), are you aware of any particular health problem that (*Latinos*), in particular, suffer from? Yes. What can you tell me about this disease?**
  - **How did you learn about it?** *Internet/family/friends. Where could you go to learn about it?*
  - **If you found out that many diseases are showing up in young men that look and feel healthy, would that cause you to want to find out if you have this problem? Why? Why not?** (*No cure so who cares? No health insurance so why even find out.*)
  - **Where would you go for a health check-up?** *Walk-in clinic, hospital, personal doctor.*
  - **What would you ask the doctor to do? What would you say you were there for?**
  - **Would you find it helpful if you saw commercials on television that told you what to look for? What to do about it? If not TV, where?**
  - **Can you suggest ways that would make it easy for you to find out about some of these health issues?** *Do you feel like you would like to know more about some of these issues? How would you like to learn about these things?*

- **What kinds of things would encourage you to go to the doctor more regularly?** (*Different hours at the clinics, serve coffee and sandwiches, have a TV in the waiting room, Information about diseases? Information about health care services? etc.*)

## **V. WRAP-UP**

- Any questions you want to go back to.
- Thank respondents for their time and thoughts.

**MEN'S HEALTH PROJECT**  
**Discussion Guide**  
**SPOUSAL**

**I. INTRODUCTION**

- Have respondents interview the person sitting next to them as a way to get them comfortable in the room and to learn about where they are in life.
- Explain to the respondents the purpose of today's discussion groups-i.e., to talk about health. Specifically, the health of their husbands or the men they live with, their partners. What is their state of health, how do they think about their health, and what might they be doing or not doing to try to remain healthy and prevent illnesses in the future.

**II. GENERAL DISCUSSION ABOUT THE PRESENT STATE OF THEIR AND THEIR SPOUSES' HEALTH, INCLUDING PERSONAL HABITS.**

- To start: have respondents discuss their partner's present state of health and personal habits.
  - How does your husband/partner presently view his own state of health?
  - Does he think he has any health problems?
  - What kinds of habits does your husband have that he might consider bad for his health?
  - Does he think that these habits will have any effect on his health? If so, what effect?
  - Does he think that they will affect, specifically, any of his health problems? If so, what effect?
  - How does he view these habits? Good/bad/indifferent/controllable/non-controllable?
  - What are his views as to the long-term effects of these habits? Good/bad/indifferent?
  - Has he ever tried stopping these habits? Why? Why not? Was he successful? For how long?

- Ask spouses about husband/partner's health.
  - How do you presently view your husband/partner's state of health?
  - What health problems do you think he has or may have?
  - What kinds of things does your husband/partner do that you might consider bad for his health?
  - Do you think he has actually tried to stop these habits? Why? Why not?
  - What do you think motivated him to try to stop?
  - And how successful, in your opinion, has he been?
  - Are there things that you think your husband/partner might be worrying about when it comes to his health? What are they? Is he planning to do anything about it? What?
  - When was the last time your husband went for a check-up, a physical exam?
  - Did the check-up include things specifically for cardiovascular problems like high blood pressure or cholesterol levels? What about an exam for possible types of cancer like colon cancer?
  - Does your husband go for regular check-ups? How often and to whom?
  - And you, do you go for regular check-ups? Mammograms/gyno, blood/work.
- Ask similar questions concerning their husband's immediate family members.
  - What about members of your husbands' families such as: fathers, mothers, brothers, etc. Do any of them have any health problems? And what are they?
  - Do any of them have habits that may not be good for their health?
  - Does a discussion about these habits and their effect on health ever come up when the family members are together, and are they viewed as serious problems that should be stopped or habits that just can't be broken?
  - What, if any, is discussed about health problems? Hereditary with nothing to do about it or can be helped?
  - And your children, do you or your husband take them for regular check-ups?
  - As a child, do you think your husband was taken for regular check-ups?

**III. DISCUSSION ABOUT ANY PRESENT SERIOUS ILLNESSES INCLUDING HOW THEY WERE UNCOVERED AND PRESENT TREATMENT.**

- Once a general state of health (or ill-health) has been raised, discuss how these problems were first discovered and what steps are being taken by their husbands to control the problems. Raise previously mentioned health issues with which their husbands are dealing.
  - How did your husband first discover that he had this problem?
  - How soon after discovering that something might be wrong did he seek treatment?
  - Where did he go for treatment?
  - What are the specific treatment(s) that have been recommended to him?
  - And how good is he about doing what was recommended to him?
  - If not: what, if anything, do you do to try to encourage him to take better care of himself? Other family member support?

**IV. GENERAL DISCUSSION ABOUT PREVENTATIVE CARE.**

- Discuss what they might consider as preventative health care. Say: we all know that there are things that we can do to be able to lead healthier lives...
  - What are some of the things that can be done that can help us all to be healthy? What does your husband/partner think about these kinds of things?
  - Who would you say is more interested in finding out about health care, you or your husband?
  - Does your husband ever bring home any information about how to be healthier?
  - If your husband is not interested in health care, what do you do, if anything, to try to encourage him to take better care of himself? What kind of reactions do you get from him?
  - Where would you go to learn about what you should be doing to better your health? Do you think that you are getting really good information?
  - Where would your husband go to learn about how to be healthier? Probe: Internet. Do you think that he is getting really good information?
  - How easy is it for you to get the information whenever you need it?

- The DPH is putting together a campaign to try and encourage men to take better care of themselves. They want these men to understand that it is important to do certain things, for example, to get a check-up, a physical exam. It is important for them do things that are better for their health, like not smoke.
  - Do you know of any campaign in the past that your husband may have noticed and responded to?
  - What kinds of message or messages do you think your husband might take notice of?
  - Where would be the best place to put these messages so that your husband would take notice of them?
  - Would your husband respond to a campaign that asks the wives to say to their husbands that it is time for them to go for a check-up?

## **V. WRAP-UP**

- Questions from the back room. Thank respondents for their time and thoughts.

**MEN'S HEALTH PROJECT**  
**Discussion Guide**  
**HEALTH CARE PROVIDERS**

**I. INTRODUCTION**

- Have respondents interview the person sitting next to them as a way to get them comfortable in the room and to learn about where they are in life.
- Explain to the respondents the purpose of today's discussion group-i.e., to talk about self-help health care, specifically among different ethnic or minority men and/or those men at lower income levels.

**II. GENERAL DISCUSSION ABOUT WHO THESE PROFESSIONALS SERVE.**

- Do you regularly work with men within these populations? Do you work with a variety of different ethnic or racial groups?
- How much of your work with men within these populations is for preventative types of health care?
- How much of your work is after some type of health problem occurs?
- What types of health issues do you see that are of most concern for these men? Cancer, diabetes, cardiovascular.
- What do you stress most in your approach to these populations of men? Do you stress different things to different ethnic groups? Why is that? Preventative/following recommended treatment/return visits/personal health habits.
- Do you see the women in these various groups as interested in preventative care as the men or are they more interested?

**III. LEVEL OF CLIENT'S KNOWLEDGE ABOUT A HEALTHY LIFESTYLE AND THE EDUCATIONAL TOOLS AVAILABLE.**

- How knowledgeable do you find these men to be concerning what it takes to lead healthier lives? Do you find any differences between racial or ethnic groups?
- And how aware are these men about the detrimental effects of poor personal health habits, e.g., smoking? Do you find any differences between racial or ethnic groups?
- Do you find much resistance among these groups of men toward taking responsibility for their own health? Or do you find that they are open and have a willingness to be proactive? Probe for types of resistance.

- What about going for screenings, such as for types of cancers or cardiovascular?
- If a man has experienced a health problem in one area, do you find his interest in preventative care increases for other potential problems?
- From where do you think they get most of their health care information? TV/newspapers/friends/family, and what about the Internet?
- What methods do you now use for educating these men about the benefits of a healthier lifestyle?
- What are the strengths and weaknesses of each of these methods?
- Is there one method that you are now using that you find to be more effective? Why is that?
- Have you used any programs in the past that you found to be particularly successful but are not now using, i.e., worked at another agency or state?
- How important is the spouse in supporting better health habits?
- How important are other family members in supporting these men toward a healthier lifestyle?
- What do you think their attitudes are concerning their children leading healthier lives? Do they discourage smoking, encourage eating lower fat diets?

#### **IV. RECOMMENDATIONS**

- What method or methods would you suggest as effective ways of reaching and educating these men on the benefits of preventative care? Post-problem care?
- Can you offer any suggestions about what kinds of tools might be helpful, e.g., wallet cards, handouts, advertisements, etc.?

#### **V. WRAP-UP**

- Questions from the back room. Thank respondents for their time and thoughts.

**APPENDIX E:**

**SUMMARY OF FINDINGS REGARDING  
CAMBODIAN MEN'S ATTITUDES  
TOWARD HEALTH ISSUES**

## METHODOLOGY

As part of the statewide study of men between the ages of 25 and 45 regarding men's health issues, Market Street Research conducted one focus group with Cambodian men in Lowell, Massachusetts. Munty Pot and Samuth Koam of the Lowell Community Health Center recruited participants using flyers, radio advertisements, and personal outreach to men. The group was held on May 13 at the Cambodian Mutual Assistance Association and eight men attended. The Translation Center at the University of Massachusetts provided a translation of the discussion. This Appendix presents a summary of findings from this group.

### MEN'S PERCEPTIONS OF THEIR HEALTH STATUS

Men who participated in this group had some concerns about their health. A few described their health as generally good, but several cited specific health problems for which they were being treated. A few were being treated for high cholesterol, and individuals were being treated for high blood pressure, diabetes, and gout. One man complained of generalized pain.

Overall, the men demonstrated an interest in their own health, and were aware of the adverse effects of behaviors such as drinking, smoking, poor diet, and lack of exercise. Most of the men said that they had identified certain unhealthy behaviors and had changed them, including exercising, quitting smoking, and switching to a low-fat diet. Often, these changes occurred after men were diagnosed with a specific health problem related to an unhealthy behavior. One man said, *"Before, I used to eat without any consideration to what kind of food it is. Such as pork that contained three layers of fat. Now that I know that I have high cholesterol, I have to cut down some of these foods that contained a high content of fat. Especially foods like red meat, and I also cut down on food that I used to eat lots. On the other hand, I have to increase my exercise activity. I have to exercise three times a week."* Cambodian men held similar attitudes as other men who participated in other focus groups in terms of changing behaviors; specifically, these men felt the motivation for change had to come from within, and was an issue of willpower, and they were not oriented toward seeking external support services. During the focus group, men had the following exchange:

**"Although I sometimes feel like I need to smoke badly, but when I made up my mind and kind of forget about it—that is how I quit."**

*"Talking about smoking, that brother is absolutely right. It is up to you to call it quits. It is up to your mind."*

As with other groups, men's attitudes about taking care of their health changed with age. Cambodian men echoed the feeling expressed by men of other cultural backgrounds in that young men have feelings of invulnerability. As one man said, *"The new generation, talking about smoking, they smoke like there is no tomorrow. . . . But we, the older generation, begin to realize from experience that smoking can damage our health in lots of ways, so we know. For the young generation, they are full of energy, they don't care. Any place you go, you see these boys and girls just smoke."*

## AWARENESS OF HEALTH RISKS AND HEALTH CARE GUIDELINES

These men expressed a general level of familiarity with health risks, such as high blood pressure, high cholesterol levels, smoking, poor diet, and lack of exercise. A few mentioned specific issues such as prostate cancer, although the men were not very knowledgeable about these issues. One man said, *“Lots of Cambodian men don’t understand much about prostate.”* Another man in the group asked what this meant, to which a participant replied, *“I think it is cancer of [the] balls.”* Another suggested that the condition was similar to hemorrhoids.

Certain health issues, such as vision and dental care were generally not considered major concerns. *“People in Cambodia, they [have] good eyes all their life,”* one man said. Clearly, men are not oriented toward regular vision exams: *“I am waiting for the day I could not see, then I will go,”* one man said. In addition, some men felt the deterioration of vision is a natural part of the aging process, which relates to a cultural attitude among Cambodians who may see these problems as part of their “destiny,” and are therefore not as concerned about seeking treatment. A few men who felt they had normal vision had nonetheless been prescribed corrective eyewear by a physician, indicating that men’s perception of their own health may sometimes be falsely optimistic. In addition, men were generally unconcerned about preventative dental care, and often went to the dentist only to have a tooth pulled.

Men identified two major issues that they faced as Cambodian men: (1) hepatitis; and (2) HIV/AIDS. Hepatitis was of particular concern, and one man identified a possible reason for its prevalence among Cambodians: *“During Khmer Rouge, everyone is Khmer Rouge, right? You live under control, you have to do what they do,”* he said. *“I was living with Khmer Rouge along Thai’s border, and the water along the border is so bad. . . . So, when I arrived in the U.S., I had hepatitis.”* Although a few mentioned HIV/AIDS in passing as a concern, they did not discuss anything specific related to HIV/AIDS.

In terms of recommended ages for routine testing, many agreed that men should go for physical exams once a year. One said men should have their blood pressure checked monthly. Others said men should begin being concerned for their health around the ages of 20 to 30, and should be checked for colorectal and prostate problems beginning at age 45.

## MEN'S USE OF HEALTH CARE SERVICES

In general, these men do not seek regular, preventative care. Many men do not have a primary care physician, and do not have regular vision exams or dental visits. As with other groups, some men only seek treatment in the event of an emergency.

Some, however, do have personal doctors, and some seek regular care. As with other groups, this is often dependent on a man's health insurance coverage. Men with health insurance tend to go to the doctor more often; for example, one man has a dental cleaning every six months. Others go less often than they should despite coverage. *"I [had] full coverage, so I went to [the] dentist every two years,"* one man said. *"Now, I have not gone lately."*

## ATTITUDINAL BARRIERS TO ACCESSING HEALTH CARE

Clearly, there are some important cultural issues that make it difficult for Cambodian men to access health care. Regular preventative care does not seem to have been a part of their experience growing up; as one man said, *"When I was young, I [wouldn't go] to see a doctor unless I was sick."* Others said doctors were rare or non-existent in parts of Cambodia, especially for those growing up outside of the cities. Cambodian men are often oriented toward **seeking treatment within the family, or using traditional healing practices**. For example, one man said that in Cambodia, he uses the practice of coining to relieve colds, although in the U.S., he uses Tylenol. During the focus groups, men had the following exchange:

*"From what I know, in the countryside, when children get sick, they go to see traditional Cambodian doctors [who] prescribe herbal medicine. Most family, the father is the doctor when children in the family get sick. My father learned the trait from his father."*

*"When I had the measles, my father cooked worms mixed with coconut juice, and I had to drink it. This kind of treatment [is] usually for light sickness, not very serious. If it is a very serious case, the patient can be sent to the regional hospital."*

*"For some sicknesses, such as chronic stomach pain, traditional medicine is very effective. And I am not just talking nonsense. During Pol Pot, I had this acute stomach pain. My father went to get the man who knows how to burn on the stomach to get rid of the pain. A few of them were holding me down while they were doing the burning. You know, since then, I never had any of that pain again."*

These men have other unique cultural factors that influence their health behaviors. For example, some men began smoking in order to keep mosquitoes away when they worked in the fields. Others began smoking because food was scarce, and they felt the tobacco would give them energy.

Another barrier to accessing care is that men **do not know where to go** to receive care. This is often a problem for men who are new to the U.S. One man said, *"Nowadays, my health is not good. I have pain in the stomach, my legs, and my arms. I*

*have just come to live here about a year [ago], so I don't really know where the health clinic or some sort [of thing is]."*

Several men said it is difficult to seek care due to their responsibilities to earn a living. Some complain that **doctors' hours are inconvenient**, because they are open from nine to five, when they are working. One man said, *"In this country, we are so busy [trying] to make a living. During the workday, you [are] so busy, and when the weekend comes, it is time to go shopping for food. . . . If worse came to worse, I will find some tree roots to boil it, and treat the sickness."* Another man said, *"Most clinics or hospitals opened from 8:30 or 9:00 to 5:00, and most Cambodians work in the first shift. We cannot take time off during this period to see a doctor, unless we have to take vacation for one day, or call [in] sick."* A few believe there are clinics with Saturday hours, but some who have used these clinics say that doctors are not there on Saturdays.

Men also feel discouraged from seeking medical care due to **long waits to see providers**. One man said, *"Even primary doctors, if they open on Saturday, you have to have an appointment. Because on Saturday, there are lots of people, so when there are lots of people, if you don't make your appointment a few months ahead, it can be very difficult."*

Cambodian men identified another cultural issue that contributes to their under-utilization of health care services. Cambodian men feel that men of their cultural background are often stubborn about putting off health care, and **view health problems as their destiny, and therefore as unalterable**. Men had the following exchange in the group:

*"Some people think that they never know what is doctor, so why should I go?"*

*"I think that's what's called stubborn."*

*"If you talk the way Cambodians believe, it is his destiny."*

*"That's why I think out of 100, there are probably five who go to check-ups regularly."*

Finally, there are clearly **language barriers** among this population. Doctors often use language that is unfamiliar to these men; for example, throughout the focus group, one man kept asking other participants if they knew anything about gout, a condition with which he had recently been diagnosed. He said, *"When I visited the doctor's office for a blood test, physical the other day, they told me I have high cholesterol, and one more thing in the English language I don't know how to read. It spells G-O-U-T, meaning 'pain in the leg.'" Later, this man spoke about a friend who went to the doctor, was told he had two months to live, and passed away within two weeks. "Next time I went for a blood check, and they sent the result to my house, I opened it immediately," he said. "I keep on thinking about my friend's case. It was not good news, either. They said I have high cholesterol and gout. Does anyone know what the word gout means?"* The language barrier and the lack of thorough explanations of their health problems from their doctors adds to men's feelings of fear about their health care, which often acts as a barrier to seeking treatment.

## SUGGESTIONS FOR INCREASING USE OF HEALTH SERVICES

Men who participated in the groups feel that Cambodian men need **more information** about where to go to seek treatment. This is especially important for men without health insurance, who need to find access to affordable health care. One man said, *“I think we should have an organization for helping those who have just moved to the area and don’t have health insurance. It is very difficult for those who do not have health insurance and would like to go see a physician.”*

In addition, men are **not well-informed about health issues**, and are often confused about medical issues. For example, during the group, one man said, *“From what I have learned about the narcotic, most medicines [are] made from one common component called heroin.”* Confusion about the nature of specific ailments, such as prostate cancer and gout, and a lack of understanding of Western treatments, which often differ dramatically from the traditional treatments with which they were raised, can complicate men’s experience seeking medical treatment.

The MDPH should work with providers to make it easier for them to **spend time with these patients**, in order to give Cambodian men a more thorough understanding of the medical conditions they have, and how to take care of themselves. The men who participated in the focus group who had been diagnosed with a variety of conditions, such as diabetes, high blood pressure, and high cholesterol, were interested in taking better care of themselves, and had changed unhealthy behaviors as a result of their understanding of their medical problems. This information must be provided to men in a way that is understandable to them. Language barriers and illiteracy are two factors that affect men’s understanding of these issues.

## SOURCES OF INFORMATION REGARDING HEALTH ISSUES

Men who participated in the focus group mentioned several ways of getting information about health issues, including television advertisements and information at clinics, such as pamphlets and bulletin boards.

There are some clear language barriers, however. Television advertisements in English are usually difficult to understand; for example, a man said with regard to these advertisements, *“All I understood was the word ‘health.’”* However, some saw a benefit in television advertising because it was accessible to those who could not read: *“Most people in our community are illiterate,”* one man said. *“There are very few people [who] could read and understand. I could see TV [as a] good [method]. One, because for those who could not read, but they can listen and watch.”* Others saw benefit to written materials, because they could be saved for future reference.

## SUGGESTIONS FOR EDUCATIONAL CAMPAIGNS

Cambodian men are very interested in the topic of their health, and a few expressed a desire to help in the process of educating men about health concerns. A few suggested that organizations such as the Cambodian Association could publish a magazine about health issues. A few said that they like public health campaigns in the U.S., such as the antismoking campaigns. These campaigns illustrate a difference from what they were used to in Cambodia, where they were more often exposed to smoking advertisements in the media, rather than public health campaigns about its risks.

As with other groups, these men are very oriented toward their families, and messages about their responsibility to their families to stay healthy are likely to be effective. As one man said, *“It is very important that we [stay] healthy, because most of us are head of the family. In the family, we are the head of the household, so when you get sick, the well-being of the family is also in trouble.”* Several men described doctor visits that they or a friend had experienced, in which a doctor made use of this familial obligation to encourage a man to seek treatment or change an unhealthy behavior. One man related, *“My father, he had been smoking since he was a young boy. . . . Until one day when his health was deteriorating very badly, he was admitted to the emergency room. The doctor told him that, ‘I give you a choice between your family or cigarettes, which one would you choose? You don’t stop smoking, you will die, and if you stop, you may live a little longer.’ Since then he decided to quit smoking cigarettes.”*

In summary, Cambodian men are much like white, black, and Hispanic men in terms of some of the attitudinal barriers they have in accessing health care. However, there are also enormous cultural differences, such as being oriented toward traditional healing practices, and significant language barriers that keep them from accessing or benefiting more fully from medical treatment. Culturally appropriate educational campaigns must be developed to provide information on specific illnesses and treatments affecting men, where to seek care, and the importance of regular preventative care.

**APPENDIX F:**

**SUMMARY OF FINDINGS REGARDING  
CAPE VERDEAN MEN'S ATTITUDES  
TOWARD HEALTH ISSUES**

## METHODOLOGY

As part of the statewide study of men between the ages of 25 and 45 regarding men's health issues, Market Street Research conducted one focus group with Cape Verdean men in Brockton, Massachusetts. The Cape Verdean Association of Brockton assisted in recruiting, organizing, hosting, and moderating the group. The Association also provided a translation of the discussion. This organization played a critical role in conducting culture- and language-appropriate outreach, managing logistics in order to be effective in this community, and providing a community center at which men would feel comfortable attending the focus group. Cape Verdean Association staff recruited participants using flyers and personal outreach to men coming into the agency and community members. The group was held on May 20 and 8 men attended. Most of the men were in their late 20s or early 30s. This Appendix presents a summary of findings from this group.

### MEN'S PERCEPTIONS OF THEIR HEALTH STATUS

As in many of the other groups, most of the participants see themselves as healthy in general. Some acknowledge unhealthy habits or health risks, such as high cholesterol; however, none had serious health concerns. Many of the men demonstrated a relatively high level of awareness about and interest in their own health. Several were physically active and had a keen awareness of the effects of certain behaviors, such as drinking and smoking, on their abilities and health in general. The group, however, also included men who mentioned some of these behaviors, but were not terribly concerned about them.

In terms of habits that affect their health, men talked about smoking, drinking, diet, and lack of exercise. A few of the men felt that getting more exercise was an important challenge for them in terms of taking better care of their health. For example, one man described, *"Exercise, too, is a big thing. I maintain activity, and if you don't, after a week or two you can feel the difference. And as you do get older, your body does get sluggish. And you do need that exercise to keep your body fit; and without exercise, you do tend to catch colds easier and so forth. And your attitude and mind-wise [there are] changes too, if you don't have regular exercise."*

Many men indicated they generally feel in touch with and in control of their health and health-related behaviors, suggesting that they are leading fairly health lives. While most men were familiar with the risks of smoking, drinking, and lack of exercise, several indicated that changes in these areas were not an immediate priority for them. For example, one participant explained, *"I tried to quit [smoking], but it isn't easy because I feel very bored if I don't smoke for a long time. I have to work harder in order to quit. I do not exercise enough. I do not have time to do it. I know that exercise is very important. So, first I have to quit smoking to be able to exercise regularly."* Men who had changed behavior indicated that with age, they felt the effects more and that motivated them to change.

## **AWARENESS OF HEALTH RISKS AND HEALTH CARE GUIDELINES**

Compared to many of the other focus groups, these men appeared to have a somewhat greater level of familiarity with health risks. In fact, many men independently brought up testicular cancer, their experience with prostate exams, high cholesterol and arteriosclerosis.

While some men had experience with related tests or exams, and others were familiar with many of these terms, there was very limited knowledge of any specific health risks they faced as Cape Verdean men. In terms of recommended ages for routine testing, most men were not aware of guidelines or professional recommendations, but many felt it was important for men in their 20s to be going for annual exams and getting tested for many of the conditions they were discussing, particularly high blood pressure, high cholesterol, and prostate cancer.

## **MEN'S USE OF HEALTH CARE SERVICES**

There was a clear division between men in terms of their current use of health services. As was common in other groups, several men indicated that they would see a doctor only in an emergency, and felt this was the norm for their peers. For example, one participant said, *"The majority of us don't go until there's a life threatening issue, or there's a crisis, then we make a choice."*

Others, however, reported that they get regular physicals or check-ups. In fact, as soon as these men were asked about their current health status, they responded by talking about their use of health services, reflecting a strong association for these men between health care and their own health. Many of these men described their current health status by describing the outcome of their most recent exam. For example, one man said, *"The last time I went to the doctor was last week, and everything is fine with me. . . . I hope I'm fine because I saw my doctor last week, and he said that everything was fine."* Among those that had been for a recent physical, two or three indicated that they had had a prostate exam.

## **ATTITUDINAL BARRIERS TO ACCESSING HEALTH CARE**

Men who regularly see a doctor agreed that their **current attitudes and use of health care services is in sharp contrast to what they grew up with in Cape Verde**, which partly explains these disparate behaviors. Most men recalled that when they were children, they would only see a doctor for injuries and severe illnesses. Many recalled getting shots fairly regularly, but seemed to distinguish this from going to the doctor, as inoculations were typically given by a nurse. Another man recalled that they frequently used various *"remedies"* for illnesses, broken bones, and other common ailments, and would often not see a doctor at all.

One man suggested that Cape Verdean men, being from an ethnic minority—facing **language and cultural barriers** and being relatively new to this country—often lack important health-related information. One man explained that in other populations, information is passed down from one generation to the next, but that for younger Cape Verdean men, many of their parents do not utilize health services and lack information that they might use to educate their children. Many men agreed that lack of information was a critical barrier to men accessing routine care.

Some also noted that when Cape Verdean men come to the United States, getting health care and health information is **not a priority**. Several men noted that when men first come to the U.S., their priority is getting a job and making money to support their families. This was one of their major reasons for coming here. Other men noted that even those who have lived here a long time focus most of their time and energy on work and family responsibilities and do not think they have time to see a physician or focus on their own health.

As in many other focus groups with men, several men indicated that a **general dislike of doctors**, ranging from discomfort to extreme lack of trust, was a major barrier to seeking care. One man told a story about a friend who died the day after a regular check-up, suggesting that physician incompetence during a test resulted in this friend's death. He went on to explain that due to hearing numerous stories like this, *"I just try to avoid doctors as much as I can."*

Other men related their own negative experiences with physicians, particularly in the emergency room. Some talked about the lack of personal attention and attentiveness. For example, one explained, *"To be honest with you, I didn't like the way he treated me, because he didn't, really. He took a look at it [the eye]. He just looked at it for a second, and suddenly he wrote a piece of paper and gave me medication. And I was out of there, and I knew that's not what I had."* Another complained of poor interpersonal skills that make already uncomfortable situations, such as prostate exams, even worse. For example, one man described a recent physical, in which his physician asked him to drop his shorts, and with little explanation or communication, proceeded to do a prostate exam. Other participants responded:

--**"I think that's why males don't go for like prostate checks because they feel so violated."**

--**"It's embarrassing."**

--**"They don't feel comfortable about the whole thing."**

Other men felt that **fear** also plays an important role in men avoiding doctors, noting that young men in particular do not want to hear that something serious could be wrong. One man reiterated a common theme heard in other groups—that egotism stops men from being able to acknowledge a potential health problem or weakness. For example, one man said, *"For men too, it's an ego thing. Men want to be healthy. They don't want to say they are sick. So basically they just don't go, and they leave it at that. Not until something severe comes along, and they have to cut a leg, then they'll go."*

## SUGGESTIONS FOR INCREASING USE OF HEALTH SERVICES

Most men in the group agreed that Cape Verdean men need to be better educated regarding health issues. One man explained, *“I just think that men are not very educated when it comes to this issue of health. I think they got to be more educated, I mean. For example, I’m one of those that’s not very educated when it comes to health issues. I don’t go to doctors, I don’t read much about health, I won’t ask people. I mean, the only time I hear about health issues is when someone gets sick, but basically that’s it. You don’t hear it too much.”*

Men think most of their peers and older men are fairly ignorant regarding specific health risks, in terms of the age at which they might affect men, the importance of routine testing, and the opportunities for prevention. Some suggested simple messages that clearly present the population at risk, the disease, the preventative care and testing options, and what the negative outcomes of late detection would be. Several men suggested that effective education with this population could overcome many of the cultural barriers to accessing care.

## SOURCES OF INFORMATION REGARDING HEALTH ISSUES

Coinciding with participant descriptions of the lack of information, **none of the participants could recall seeing or hearing any recent advertisements or other informational campaigns regarding men’s health issues.** One man clearly recalled an effective campaign in another state targeting the African-American population in Delaware: *“An ad for prostate, but I used to live in Delaware. . . . It’s a known fact amongst black males, there’s a high rate of prostate cancer. And when I was down there, they had banners and they had billboards that would say, ‘if you are over 25 and you’re a black male, you should have prostate cancer [screening] after age 25,’ but I’ve never seen one in Massachusetts.”*

## SUGGESTIONS FOR EDUCATIONAL CAMPAIGNS

Men suggested that the best way to educate this population is through community activities in which men engage in regularly; for example, at the barber shop, through work, and through the church. One man explained that the church could be a very effective organization for reaching Cape Verdean men and their families: *“Being a Cape Verdean, especially, they are very religious, and I think church plays a very important part, ‘cause everybody attends church on Sundays. Get the church involved, and get information to the people, [and] so forth. I think that would be very helpful. And also, all the older men go to church, and the women go to church, and I think if the women got the literature, they could pass it on to their husbands, sons, and so forth, so I think that would play a big part.”* Several men agreed with this suggestion.

A few men also suggested conducting outreach to children, giving them information regarding their parents’ health risks and available care. Some noted that in

this culture, parents are accustomed to having their children assist with translating information, accessing services, and getting information.

As in other groups, those men with children feel that campaigns could be effective if they focus on men's responsibility for their family—in other words, that staying healthy is an important contribution to their family. A related theme these men raised, and which was also raised in other groups, is their strong desire to stay healthy to see their children grow up.

In summary, this focus group discussion indicated that Cape Verdean men face many of the same attitudinal barriers that White, Black, and Hispanic men face in accessing health care. In addition, Cape Verdean men face language and cultural barriers, due to their diverse backgrounds and their experiences and expectations regarding health care. Any educational campaign may need to have diverse approaches to target both newer and more experienced immigrants.

**APPENDIX G:**

**SUMMARY OF FINDINGS REGARDING  
CHINESE MEN'S ATTITUDES  
TOWARD HEALTH ISSUES**

## METHODOLOGY

As part of the statewide study of men between the ages of 25 and 45 regarding men's health issues, Market Street Research conducted one focus group with Chinese men in Boston, Massachusetts. The Asian-American Civic Association in Boston assisted in recruiting, organizing, and hosting the group, which was moderated by Angel Yuen. The Asian-American Civic Association staff recruited participants using flyers and personal outreach to men coming into the agency and community members. The group was held on June 19, and 10 men attended. The Translation Center at the University of Massachusetts provided a translation of the discussion. This Appendix presents a summary of findings from this group.

### MEN'S PERCEPTIONS OF THEIR HEALTH STATUS

Overall, these men differed from other groups of men in that they are less concerned about their health and less oriented toward seeking preventative care. All the men who participated in the group described their health as good, despite the fact that each of them mentioned living with some kind of pain, such as headaches, backaches, or arthritis, which they generally attribute to working hard, or having other health problems, such as bronchitis.

In terms of habits that affect their health, these men seemed less aware of unhealthy behaviors than other men, and were less likely to feel they had any unhealthy behaviors. Interestingly, Chinese men had some difficulty discussing their behaviors. They often spoke in general terms about "what some people might do" that would affect health, rather than what they themselves do. For example, one man tried to help another in the group to respond to questions about smoking, even though he did not smoke himself.

A few men mentioned unhealthy behaviors they engaged in personally, including smoking, drinking, a lack of exercise, and poor dietary habits. However, none were very concerned about these issues. The individuals who smoke had heard of its adverse health effects, but a few did not believe this information. For example, one man said, *"That's what doctors say. That's what doctors and newspapers say. [In terms of whether it affects your health], not really, I don't think so. At least, nothing's happened [to me] yet. I don't know about the future."*

A few cited unhealthy dietary habits, such as eating too late, but most did not feel this posed a serious concern for their health. As one man said, *"Well, about food, if you can eat it, you can't really say it's bad for your health, right?"* It should be noted, however, that this lack of concern for dietary health may be due to the fact that these men actually have healthier dietary habits than most other groups of men. Many of the men who participated in the focus groups are in the restaurant business, and said that they usually ate whatever was on the menu at the restaurant, and so had a diet that usually consisted of healthy foods, such as fish and vegetables. When not at the restaurant, they still maintained healthy diets, such as a diet rich in fresh fruit. They do not seem to have the same high-fat diet that comes from fast food, fried foods, and take-out that forms the basic diet of many of the other groups of men. In addition, men had difficulty assessing the extent to which drinking is a health concern in general, and focused on factors such as determining the sugar content of alcohol.

## **AWARENESS OF HEALTH RISKS AND HEALTH CARE GUIDELINES**

Compared with other groups of men, Chinese men expressed much less familiarity with health risks. No one independently brought up issues of testicular cancer, prostate exams, colorectal exams, or cholesterol screenings. A few mentioned blood pressure screenings, but they tended to speak only very generally about the tests performed when they do see their doctors. For example, one man said his last doctor visit included *“blood tests, body weight, et cetera,”* and another man said, *“Blood tests, calorie tests.”* In terms of these men’s knowledge of recommended ages for routine testing, one believed men should begin regular blood pressure and cholesterol testing around age 30, and others felt 35 to 40 were appropriate ages. They felt colon and prostate tests were for *“older men.”*

These men felt that Chinese men were more likely to suffer from certain illnesses. A few felt they were at higher risk for lung diseases, due to exposure to fumes at the restaurants they work at. A few felt they were at higher risk for liver disease. One man said, *“From newspapers, I read that Asians have high rates of liver disease.”*

## **MEN’S USE OF HEALTH CARE SERVICES**

The men who participated in this group are not oriented toward regular, preventative care, and clearly identify this as a cultural issue. These men say that they did not have well-child doctor visits when they were growing up, and that they do not consider visiting a doctor unless they are sick. As one man said, *“If you’re sick, then you go to the doctor. Chinese people, in general, don’t usually go for check-ups. In those days, children didn’t have the need to go for check-ups. You’d only go if you were sick.”* Another man agreed, *“Of course you’d only go if you were sick. Who’d go when they weren’t?”* These men said that tests, such as eye exams and blood pressure testing, were performed annually through their school when they were growing up, if their school was located in the city.

However, despite the fact that these men are not oriented toward regular preventative care appointments, many of them have private doctors, and most of them had seen their doctor within the past year. Several of the men who had seen a doctor had made the appointment because they did not feel well. A few indicated that they do make appointments for an annual physical. One mentioned using blood pressure machines at shopping centers. A few said that they used to visit doctors more often, but had not been in a while for various reasons, such as a lack of time, or *“laziness.”*

In terms of other exams, one man indicated that he used to visit the dentist every six months, and about one-half of the men had visited a doctor for an eye exam. One man indicated that he had also seen a doctor for acupuncture. Their views on how often men should visit the doctor for a check-up varied between twice a year and once every one or two years. One man said, *“The best would be twice a year, but I’m too lazy. And there’s no time.”* Another agreed, *“Sometimes I feel there’s nothing wrong, so there’s no need to go to the doctor.”* Another man said, *“Your body would tell you if there’s anything wrong. You would feel it. So, you don’t have to go.”*

## **ATTITUDINAL BARRIERS TO ACCESSING HEALTH CARE**

These men did not identify any specific barriers to accessing health care outside of their attitude that doctor visits are necessary only when they feel there might be something wrong, which often prevents them from seeking preventative care. For example, no one in the group had had colon or prostate tests; as one man explained, *“No problems! That’s why [I haven’t been checked]. If there are no problems, why do you have to go check?”* In addition, these men are not oriented toward requesting tests, and feel that their doctor will perform any tests that are necessary. *“I think they’d only tell you to [have a colon or prostate exam] if there’s a need for it,”* one man said. *“If there’s no need for it, the doctor wouldn’t ask.”* These men said no one had ever mentioned to them that they should have these tests done.

## **SOURCES OF INFORMATION REGARDING HEALTH ISSUES**

These men said they would like to see information about men’s health issues presented in Chinese newspapers and posters on the subway. One man felt that information would most likely be presented in English, and that it would be easier to read the information if it were in Chinese.

## **SUGGESTIONS FOR INCREASING USE OF HEALTH SERVICES**

These men clearly need to undergo a significant shift in attitudes in order to orient them toward seeking regular preventative medical care. Currently, although these men have heard about the need to have regular check-ups, they tend to go to the doctor only when they have a health complaint; they do not request specific tests; and they often feel that certain tests are not appropriate for them, either because they are not old enough yet, or because they do not feel that there is anything wrong with them.

The MDPH should develop an educational campaign targeted toward Chinese men to address the issue of preventative care specifically, focusing on the broader issue of the need for regular check-ups, as well as the more specific issue of getting tested for men’s health issues, such as colon and prostate disease. Information in Chinese will make it easier for men to understand the issues. In addition, testimonials of other Chinese men, who have a similar cultural experience with respect to medical care, may make it easier for these men to relate to the idea that they should have regular exams, even when they feel fine. For example, the MDPH might consider a campaign that presents stories of Chinese men who felt they were in good physical health, but uncovered a medical problem due to preventative screening, which allowed for early and successful treatment.

**APPENDIX H:**

**SUMMARY OF FINDINGS REGARDING  
VIETNAMESE MEN'S ATTITUDES  
TOWARD HEALTH ISSUES**

## METHODOLOGY

As part of the statewide study of men between the ages of 25 and 45 regarding men's health issues, Market Street Research conducted one focus group with Vietnamese men in Dorchester, Massachusetts. The Vietnamese-American Civic Association assisted in recruiting, organizing, hosting, and moderating the group. This organization played a critical role in conducting culture- and language-appropriate outreach, managing logistics in order to be effective in this community, and providing a community center at which men would feel comfortable attending the focus group. Association staff recruited participants using personal outreach, telephone calls, and letters to targeted households. The group was held on June 7, and eight men attended. This Appendix presents a summary of findings from this group.

### MEN'S PERCEPTIONS OF THEIR HEALTH STATUS

When discussing their current health status, several men in the group had specific concerns, regarding their own or other family members' health, with men mentioning problems like back pain, headaches, and arthritis. Most others indicated that they generally feel young and fit. Similar to men in the other groups, there was a common sentiment that as long as they feel well and are functioning in their work and family roles, they are healthy. For example, one man described, *"In 20 years, I haven't been for a blood pressure test. For me, if I have high blood pressure, I cannot work at a high level because I would easily get dizzy. At my work place, I have to work at a high level. I feel normal, and that is why I think that I don't have high blood pressure."*

In contrast to some of the other focus groups, only a few of the Vietnamese participants brought up health-related habits, such as diet, smoking, or exercise on their own. A few suggested that since coming to this country they have been very busy, primarily with work responsibilities, and therefore are less physically active than they used to be or than they should be. In addition, one man indicated that the diet is different from what many were used to in Vietnam, noting that the increase in their meat intake probably affects their health.

### AWARENESS OF HEALTH RISKS AND HEALTH CARE GUIDELINES

Many of the participants feel that men should get a regular check-up fairly often—every six months or year; however, only a few actually do so, and most feel that it is not an important priority. Many seemed to trust their physicians to tell them when to come in for any necessary exams or tests. In general, most men felt that at their age, they only needed to see a doctor for specific problems. They felt it was older men—those in their 50s, 60s, or 70s—who might need more routine care.

Men seemed to be much more aware of (or possibly more comfortable discussing) blood pressure and cholesterol issues than prostate or colon cancer screening. Men had some familiarity with the health issues surrounding blood pressure

and cholesterol, although none had knowledge of specific guidelines for screening. Most men had little or no familiarity regarding prostate or colon cancer screening. In contrast to most other groups, where men suggested these screenings should begin in when men reach their 30s or 40s, those Vietnamese men that were familiar with prostate cancer suggested that men should begin to get screened in their 50s or 60s, when men become less active.

In terms of specific illnesses affecting Vietnamese and Vietnamese-Americans, some men suggested that stress and mental illness are significant problems this population faces. These men noted that Vietnamese men face excessive stress related to moving to this country, as they acclimate to a new culture, language, weather, and work life, and face social isolation.

## **MEN'S USE OF HEALTH CARE SERVICES**

Many men indicated that they had recently visited a physician, most frequently for specific problems. Many of these men do not seem to feel comfortable with the health care services or systems they have experienced. For example, one man complained of severe back pain and explained that for each visit with a different physician, it took a month to get an appointment: *"I am confused about the long time to get treated, while my illness moves rather fast. One medical doctor made an appointment in one month. I saw another doctor; he again made an appointment for another month. Three doctors made appointments—it took three months."*

Others are confused by insurance requirements and other issues affecting access to health care. Many also noted that the cost of health insurance or not having insurance coverage at all are barriers to accessing care.

Men recounted that while growing up in Vietnam, they would go to a doctor when they were sick, but not for routine health care. Some noted that there is more of a focus on health care in the U.S. than they were accustomed to growing up in Vietnam. While some noted that they bring their children in for routine visits, few of the men had become more regular health care users since coming to this country.

## **ATTITUDINAL BARRIERS TO ACCESSING HEALTH CARE**

As with other groups, men who have used health care services have a number of concerns about the way services are delivered, and feel that negative experiences affect their likelihood of returning for future visits. These problems are heightened in this population due to the language and cultural barriers that make it all that more difficult to have a positive experience with the health care system.

Several men reported specific **negative encounters they had experienced with health care services**, including long waits to get an appointment, long waits on the day of an appointment, and problems with paperwork and referrals. In addition, some complained about poor interactions with physicians, complaining that physicians are not attentive to patients' symptoms and do not accurately diagnose problems, and also

feeling that doctors' recommendations are often motivated by finances. For example, one participant described, *"When I moved to [the] U.S., I went to the medical doctor and told him about my sleeplessness and headaches. He said that it was due to the weather change. I think that it is not only caused by the weather change. I really don't know how to get effective treatment."*

Several men indicated a lack of understanding of health insurance coverage, health care systems, and, in general, how to access appropriate care. For example, one man explained how he has access to health care, *"I received a card—Men's Health Neighborhood sent me another card, and someone sent me another card. So now I have three. The health care programs here are very weird. When you go to the hospital, they always cancel your appointment and take your money. I didn't need or ask for the cards, but they just sent them to me."* Similarly, other men indicated frustration with learning about how to access health care and described various problems they experienced.

## **SUGGESTIONS FOR INCREASING USE OF HEALTH SERVICES**

Men clearly indicated that they face both financial barriers and barriers relating to a lack of information. Many of the Vietnamese men do not understand the types of services they can access and how to access them.

To assist this population in increasing their use of health services, DPH will want to consider initiatives that:

- clearly define the health care and screening guidelines for different age groups; and
- assist this population in understanding their insurance options and how to access health care.

## **SOURCES OF INFORMATION REGARDING HEALTH ISSUES**

Several men agreed that they have no sources of health information, and that information is badly needed in the community. Some noted that those with good English skills are more likely than others to hear and learn things on television. None seemed interested in watching programs specifically on health issues, nor could any recall television advertising about health issues, except perhaps tobacco. Some recalled reading information in Vietnamese-language newspapers or advertising in the subway or on billboards.

As in many of the other groups, men indicated that their community desperately needs more health education and information. One man said, *"The Vietnamese community here needs more information about health. We need some place for the communication and exchange of ideas about health."* While many men agreed with this sentiment, few felt they themselves needed information about major health issues

affecting men. Rather, they were interested in information regarding specific problems they were having or about questions regarding access to health care.

## **SUGGESTIONS FOR EDUCATIONAL CAMPAIGNS**

Men expressed some interest in learning more about health issues from television, radio, or newspapers. They emphasized that any advertising or informational campaigns must be in Vietnamese. In addition, there is some agreement that wives and family members could help to educate men or to encourage them to see a physician.

Also, men indicated that they trust their doctors to inform them about needed tests, and that few would be proactive in asking their doctor for recommendations or specific tests. Therefore, DPH may want to consider creative initiatives to assist health care professionals in providing education to Vietnamese patients of both genders. This would have to happen at any type of health care encounter, including urgent care and emergency room visits, because those may be the only encounters younger men have with health care providers.