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Participatory assessment of the health of Latino immigrant men in a community with a growing Latino population

Patricia I. Documėt[1], **Andrea Kamouyerou**[1], **Amalia Pesantes**[1], **Laura Macia**[1], **Hernan Maldonado**[4], **Andrea Fox**[2], **Leslie Bachurski**[3], **Dawn Morgenstern**[4], **Miguel Gonzalez**[4], **Roberto Boyzo**[4], and **Thomas Guadamuz**[1]

[1]Behavioral and Community Health Sciences University of Pittsburgh Pittsburgh, PA, U.S.A.

[2]Squirrel Hill Health Center and Department of Family Medicine University of Pittsburgh Pittsburgh, PA, U.S.A.

[3]Consumer Health Coalition Pittsburgh, PA, U.S.A.

[4]Latino Engagement Group for *Salud* Pittsburgh, PA, U.S.A.

Introduction

Currently, 20% of all Latinos live in “new growth communities” (NGCs)[1], areas with low (<5%), yet growing concentrations of Latinos. Because of insufficient linguistically and culturally appropriate services[1] Latinos' healthcare needs in emerging communities are assumed to be greater than in established Latino communities, yet published data on these populations are scarce.[1, 2] The objectives of this study were to explore health needs and healthcare barriers among Latino immigrant men in a new growth community and provide an insider account of the contextual factors impacting their health.

We conducted this assessment following a community-based participatory research orientation, an approach that engages the community as a partner in all stages of research.[3-5] The study emerged from the interest of the Latino Engagement Group for *Salud* (LEGS) to create a network of lay health advisors. LEGS is a partnership of health and social service providers, community members and university researchers with the goal of improving Latino immigrant men's health in a new growth community. LEGS designed the study and was the Advisory Board; the Project Team, a subset of the LEGS, implemented it.

Conceptual Framework

In this study we aimed to explore the situation of Latino immigrant men from their own perspective, rather than test any theory. We framed this study based on a variety of findings and theoretical views. Often, immigrants live in between countries and cultures.[6] In areas with traditional concentrations of Latinos, new transnational communities provide both a safety net and a culturally congruent experience.[7] We are interested in what happens with

Patricia I. Documėt (corresponding), 130 DeSoto Street, Room 223, Pittsburgh, PA 15261, Phone: 412-624-1601, Fax: 412-624-5510, pdocumet@pitt.edu.

immigrant men where there is no such concentration of Latinos and when family support is unavailable.

We realize that complex social and economic circumstances force men to migrate[8] to help their families, which are often left behind.[9-11] Latino immigrant men living in the U.S. face negative sentiments from a sizeable portion of the public, including instances of discrimination and racism.[6, 12] Latino immigrants are often portrayed as “illegal aliens,” who are in the U.S. to break the law or steal jobs, regardless of their actual immigration status.[6, 12] Additionally, the migration experience threatens men's perception of masculinity.[8, 13] The same man who is perceived by his family, his country and himself as a brave strong man who migrates to support his family finds himself in the U.S. at the bottom of the social ladder, earning low incomes, facing racism and being expected to behave in a submissive way.[8, 9] The situation of Latino immigrant men corresponds well with the tenets of Social Identity Theory, which states that people innately seek a positive identity based in part on the group to which they belong.[14, 15] Belonging to a low-status group poses difficulties to attain a positive identity,[16] which has been related to negative mental and physical health outcomes.[17, 18]

Isolation and lack of social support increase the vulnerability caused by migration[8, 10, 11, 13, 19-22] In fact, loneliness is a predictor of depression symptoms [23] and of risk for suicidal behaviors among Latinos[24], contributing to the adoption of risky behaviors (e.g., sex with sex workers or excessive alcohol use). [10, 11, 20-22, 25, 26] Additionally, many Latino immigrant men lack health insurance, which limits access to healthcare and information.[27, 28] Further, immigrant men delay seeking healthcare and do not use prevention due to *machismo* or because they do not connect present actions with future health conditions.[29] Despite these limitations, Latino immigrant men have been reported as being receptive to learning more about their health.[29]

Most of the literature on Latino immigrant men's health in non-border areas has focused on narrow health topics, such as sex-related issues[9-11, 21, 22, 28, 30] or workers' health[8], and comes from areas with large concentrations of Latinos. [8-11, 21, 22, 28, 30] However, it may not be applicable to the situation in new growth communities. We believe that listening to the concerns of immigrant men has the potential to reveal unforeseen issues and ways of perceiving health and social contexts.

Methods

Overview

In this exploratory mixed methods study in Allegheny County (Latino population: 2%),[28] we conducted 4 focus groups, 66 structured surveys with Latino immigrant men, and 10 open-ended interviews with staff from local health and social service organizations working with Latinos. LEGS collectively chose focus groups to allow participants to express themselves without being constrained by set response options. Additionally, the interaction among participants builds trust and produces a more nuanced account of the contexts specific to Latino immigrant men as they relate to healthcare needs and barriers.[31] LEGS decided that surveys would be appropriate to obtain information, albeit limited, from men

who might be unable to attend focus groups. Because finding workable solutions to access problems requires understanding perspectives from service providers, interviews with them were included. The study was approved by the University of Pittsburgh Institutional Review Board.

A subset of the LEGS coalition comprised the Project Team. While some project team members were researchers, there were health and social service providers and four immigrant men from the community. The immigrant men decided to participate according to their time availability and were compensated. Researchers trained non-researchers in research integrity, confidentially and ethics as well as focus groups and survey administration using a combination of lectures, participatory exercises, and mock focus groups and surveys.

Participants

The project team recruited Latino immigrant men 18 years of age and older to participate in focus groups (10-12 were invited per group) and surveys by conduction face-to-face outreach and placing posters in places where Latinos congregate (e.g., churches, Latino stores) and by word-of-mouth. Team members made an effort to recruit from a variety of venues to achieve a broad representation in focus groups and interviews. Focus group and survey participants received $20 and $5 gift certificates for their time, respectively. We recruited health and social service providers who served Latinos from LEGS professional members' networks. Participating providers received no compensation. All participants gave informed consent.

Data Collection

LEGS decided that immigrant men should be in charge of collecting data from other Latino immigrants and service providers should collect data from other providers. Two men conducted four focus groups. Four men conducted 66 anonymous surveys at semi-private community locations (e.g., public libraries). Two service providers conducted 10 open-ended interviews with providers.

Measures

Consistent with the holistic view of health community members in LEGS expressed, the focus group guide included five topics: (1) salient health issues, (2) strategies for seeking care when needed; (3) barriers to healthcare access; (4) actions geared to preserve and improve Latino men's health; and (5) acceptability of a *promotores* network.

The survey included topics derived from focus group results. We used the UCLA Loneliness Scale[32] (short version; 4 items), a short version of the MOS-Social Support Scale[33] (4 items, alpha=0.83), the PHQ-9[34] (depression;9 items), and questions from the Behavioral Risk Factor Surveillance Survey related to healthcare access and alcohol use.[35]

The provider interview guide asked about the most frequent problems providers confronted when serving Latino immigrant men and about the feasibility of a *promotores* network.

Analysis

Qualitative data were audio-recorded, transcribed in the language they were conducted, and analyzed by identifying patterns and themes that emerged with the aid of a qualitative data analysis software (Atlas.ti 5.2).[36] Three bilingual Project Team members independently read the transcripts and developed initial codes and definitions. Two Project Team members coded all transcripts, compared results and solved disagreements through discussion. They recorded possible links between themes in analytic memos and discussed the data further to identify overarching themes and produce a summary of the results. Survey data were stratified by respondents' time in the U.S. (<5 and >=5 years) and compared with Chi-squares using SAS statistical software (version 9.2, Cary, NC).

We shared and discussed summary results with LEGS. Members provided their interpretation of the findings, especially in relation to the effect of immigration status on health.

Data sharing

Participation in the study was anonymous and this precluded sharing data with specific study participants. However, we made efforts to share the data with community members and providers through several methods: 1) Celebration of the “end-of-the-study” at a local venue, attended by 120 community members, where the Project Team shared results by a) presenting study results and answering questions; b) showing a poster explaining how to become part of the LEGS coalition and another one with the study results; and c) distributing a color leaflet with the LEGS logo and the study results. 2) Distribution of the leaflet at church services, an annual local information fair, and to our health and social service partners as well as to LEGS' community partners so they could distribute the leaflets to their networks.

Results

Participants

In total, 25 men 19-51 years old participated in the focus groups. The majority had not finished high school and only one attended college. Sixty-six men 19-61years old participated in the survey; most worked in restaurants or construction sites; the majority lived without their spouse or partner (Table I). We intentionally avoided asking for immigration status. Through anecdotal comments from participants and the information provided by grassroots community members from the LEGS coalition we know that a number of participating immigrant men were undocumented. However, we cannot compute a reliable estimate. Four interviews were conducted with healthcare providers, five with social service providers, and one with the owners of a store that also functions as an informal referral place for immigrants.

Qualitative data

The analysis of the focus groups and the interviews yielded 51 distinct codes (Table II). Many related to barriers to care, such as language and uninsured status; others related to

specific health problems. We organized the codes into three overarching themes, which are described below in detail. Table III provides illustrative quotes.

Social isolation—Participants in all focus groups, as well as three providers, mentioned that the reason most Latino men migrated was to help their families economically. Participating immigrant men said that many men could not return to their countries for several years. In the U.S. they felt isolated even while with other people. Participants in all focus groups said they lived in an anti-immigrant environment, deepened by living in dangerous neighborhoods or sharing an apartment with several other men. In three focus groups, participants said they had difficulty finding other Latinos, with whom they would prefer to socialize.

According to focus group participants, loneliness coupled with the hostile environment made men feel stressed and worried about their families. To cope with loneliness participants in all groups reported doing extra work *"para no pensar"* ("to avoid thinking") and drinking alcohol. Sometimes, when they found no adequate social outlets, they went out drinking, often resulting in other risky behaviors such as getting into fights. Sexual urges and how to satisfy them was an emerging topic in all focus groups. Some men said they had girlfriends; in all focus groups, participants spoke about unprotected sex, mostly with sex workers. Participants said that these strategies for managing loneliness sometimes exacerbated loneliness and stress. Finally, participants in all focus groups mentioned that they or somebody they knew experienced depression.

Staying healthy—Participants in three focus groups stated that they knew that eating healthy, resting and doing enjoyable activities with others were crucial to maintaining their health. Additionally, men seemed to be ashamed of drinking too much. The shame for doing what they perceived as inappropriate behavior was compounded by their stated inability to stop drinking even when they said it might hurt their families.

Participants in two focus groups said that in order to behave in a healthy way, they constantly reminded themselves of their family. However, they listed several difficulties to healthy behaviors: lack of time; lack of knowledge of places to exercise or socialize; and lack of a companion with whom to do these things.

Four providers spoke of Latino immigrant men not taking actions to protect their health; two specifically said that men were not into prevention and therefore did not use the healthcare system.

Accessing the healthcare system—In all focus groups and interviews, participants mentioned men's fear to approach the health system because of immigration, financial, and language concerns. Participants in all focus groups and seven interviewees expressed that men often did not know where to go or who to contact when they were sick. Interviewees said that men lacked information on their civil rights, and how to identify a real emergency. Participants in three focus groups and six interviews said that men delayed care because, as men, they could endure pain for longer, they had no time due to working long hours, and they were fearful.

All participating providers said local low-cost service options in Spanish were scarce. In eight interviews and three focus groups, participants mentioned specific problems when accessing the healthcare system. Five interviewees mentioned most men were uninsured and healthcare options were not flexible enough to accommodate immigrant men. In one focus group participants spoke directly about lack of insurance and in another about lack of flexible services. Participants in two interviews and one focus group said that undocumented men did not qualify for a variety of benefits. Two interviews and one focus group referred to lack of transportation.

In all focus groups, participants reported using social connections and/or personal relationships with providers to solve their healthcare access issues. In contrast, this use of social connections was mentioned only in one interview. Other strategies included: using over-the-counter medications (4 focus groups), medications brought from their countries (2 focus groups), or waiting to return to their countries for care (2 focus groups).

Promotores are lay health advisors, trained individuals from the community they serve.[37] In focus groups we asked, “What would you expect from a *promotores* network?” and in interviews we asked, “How can *promotores* help you as a provider?” Providers spoke of the advantages of having a *promotor* to help men navigate the system, especially providing interpretation. Focus groups participants said they expected *promotores* to develop trust and familiarity, decrease fear of the health system, interpret, and help them connect to health services and the broader community.

Quantitative Data

Overall, less than 10% of respondents had health insurance and 29% visited a doctor in the past year. Sixty-two percent of respondents had at least one binge drinking episode in the last 30 days (>=5 drinks on one occasion); 16% reported having 5 or more episodes of binge drinking. Participants who were in the U.S. <=5 years where significantly more likely to exhibit depression symptoms and less likely to have seen a dentist in the past year (Table IV).

Discussion

Our data confirm that the main reason men migrate to the U.S. is to help their families in their countries of origin.[9-11] Latino immigrant men told us that most of their health problems stem from social isolation and loneliness. These may in turn cause stress in an already adverse environment, where fears of deportation and being treated differently because of being Latino are a day to day experience. Men's isolation starts with separation from their families, as is reported in the literature[10, 11, 13, 20-22] and in this new growth community, its effects are amplified in part because Latinos are scattered throughout the County rather than residing in a central location.[38]

The multiple references to isolation, sadness and the word “depression,” as well as the surveys' PHQ-9 scores indicate this population may be at high risk for depression. As in other research[19], focus groups participants attributed “depression” to social causes: isolation and a hostile environment, with no hope of seeing their family in the short term.

Loneliness has been reported to be an important contributor to depression.[23, 24] We can hypothesize, based on our data and on Social Identity Theory that men may be experiencing difficulties keeping a positive identity, because they feel isolated and unwelcome, and because the group they belong to is often vilified. A new study exploring overt discrimination and sense of identity may test this hypothesis.

Survey and focus groups data showed that men used alcohol to mitigate the effects of loneliness with counterproductive results, confirming findings from current literature.[11], Drinking was a problem for many survey participants, regardless of time in the U.S. Sixty-two percent of study participants reported one or more binge drinking episode in the past 30 days, compared to 25% of all men (CI: 23-28) in Allegheny County, and to 35% reported for Latino immigrant men in the literature.[11] Although we do not know if alcohol use actually increased after immigration, this seems to be the participants' perception.

Extramarital sex was reported as common in the focus groups and sexually transmitted diseases were a concern, confirming findings from assessments that focused specifically on sexual behaviors.[9, 11, 22] However, in our data loneliness rather than sexual behavior was identified as the root cause of health problems. This difference in results may be due to our broad focus or to the characteristics of this new growth community. According to our results, interventions targeting sexual health would be important but insufficient. To more adequately prevent a broad range of health problems, comprehensive interventions aimed at creating a healthy social environment are necessary. These may include interpersonal interventions that increase men's connections to community resources, programs that empower men in emerging communities, or policy interventions aimed at decreasing the risks of deportation.

We did not ask specifically for information on men's masculinity and the evidence that emerged was not enough to make any claims about the impact of migration on it as suggested by others.[8, 28] However, the social context our participants described, as well as the loneliness and inability to feel fulfilled, suggest that this question necessitates further inquiry. We did observe that masculinity is related to healthcare seeking behavior. Prior research has conceptualized prevention as use of health services and said that *machismo* is one of the main causes of the lack of prevention orientation among Latinos[29]. In our data, men reported enduring pain and illness for a long time before seeking help.

Providers tended to view prevention as healthcare utilization, unlike immigrant men, who conceptualized health in a more holistic way. Men expressed that their social and personal situation precluded them from doing what they said benefitted their health. It appears that intervening at the lifestyle level could be an effective way to channel health promotion messages at a more “upstream” point, since research indicates that men can be receptive to health messages.[29] An investigation of preventive orientation among Latinos is necessary. However, a lifestyle intervention can only be successful in a context that is conducive the health behaviors.

Our findings confirm that in this new growth community health and social services are not organized in a way that can meet immigrant men's needs in a culturally-competent way.[38]

Our three sources of data confirm that fear of immigration authorities, cost, and language were the main obstacles to seeking care for Latino men.

Latino immigrant men's use of social relationships to obtain care matches findings from prior research both locally,[38, 39] and in other areas of the U.S.[40] This finding is also congruent with our findings that a *promotores*-based intervention would be helpful.

Our results have to be seen within the limitations of this exploratory study. The non-probability nature of the sample and its small size, as well as the overwhelming majority of Mexicans precludes generalizations. Even though we made a special effort to reach individuals through several venues, it is unlikely we were able to reach the most isolated. At the same time, our study has several strengths. First, we succeeded in reaching truly disadvantaged men who could not be reached in other ways, in a context where a list that would constitute a reasonable sampling frame is not available. Second, we asked participants to express what health problems men deemed important instead of focusing a-priori on a given health issue. Third, we could triangulate information provided by men in focus groups and surveys with information from health and social service providers.

New Contribution to the Literature

This study offers a glimpse into the health concerns of Latino immigrant men in a new growth community, which to our knowledge has not been published before. It brings together the point of view of both immigrant men and providers who work with them, highlighting differences. For example, providers mentioned specific barriers within the healthcare system, such as times of operation and issues of legal documentation, more often than men. Men offered more information on their specific context and situation, but little on the health system. In other words, men could speak of their personal experience and sometimes that of their networks. It is possible that providers were able to articulate broad issues more clearly because they interact with many immigrant men and/or because they had extensive knowledge of the way the U.S. health system operates. Regardless, the differing responses may reflect distinct orientations toward the health and wellness of this population, which is an important area of further exploration.

Our findings underscore the interconnection of laws and regulations, broad social sentiments, economic status, and isolation in increasing stress and decreasing opportunities for healthy living and accessing health care. Loneliness resulting from lack of community connections and cohesiveness emerged as one of the main antecedents of mental and physical health issues. Fear of immigration status disclosure was perceived as the main barrier to access care. Additionally, our research confirms that men use social networks for stability and to access health services, but that these networks are not well established in this new growth community.

The present study also raises several questions to be pursued in future research. Do the unique characteristics of new growth communities exacerbate the relationship between depression and time in the US? How does discrimination affect self-identity? Does negative self-identity increase the risk of depression? How does men's perception of masculinity change after immigration? Are men truly interested in health promotion and disease

prevention from a lifestyle perspective? If yes, how can we harness that interest to implement culturally appropriate interventions? And finally, how can public health professionals implement interventions to strengthen social networks among Latino immigrant men in new growth communities?

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Table I

Demographic Characteristics of Latino Immigrant Men Participating in Focus Groups and Surveys

	Focus Groups	Survey
Number of participants	25	66
Age (mean)	36	33
Years in the U.S. (mean)	6.4	6.4
Mexican	20 (80.0%)	43 (65.2%)
Central American	5 (20.0%)	20 (30.3%)
Had not finished high school	17 (70.8%)	31 (50.0%)
Lives without a spouse or partner	17 (68.0%)	57 (86.4%)
Restaurant work	N.A.	37 (56.1%)
Construction work	N.A.	10 (15.2%)

All percentages were calculated using only valid answers.

Number of records with missing values

-Focus groups: Age: 1; education: 1.

-Survey: Age: 1; Education: 4.

Table II
Qualitative Codes Grouped Into Three Overarching Themes

Overarching Theme 1: Social Isolation	Overarching Theme 2: Staying healthy	Overarching Theme 3: Accessing the healthcare system
Self-worth	Taking care of self	Undocumented
Undocumented	Eating	Mistrust
Mistrust	Resting	Confidence
Confidence	Exercise	Men and care
Do it for family	Lots of work	Chronic diseases
Lots of work	Alcohol	Where to go
Hostile environment	Loneliness	Social chains
Loneliness	New growth	Helpful relationships
Family worries	Do it for family	Promotores
Sexual urges		Compliance
Alcohol		Misunderstanding of U.S. systems
STDs		Misunderstanding of health issue
Solutions for loneliness		Personal relationship with providers
New growth		New growth
Language		Over the counter
Transportation		Cost of care
Depression & Stress		Language
Drugs		Transportation
Humor		Scarce service options
Job issues		Flexibility
		Go to México
		Work risks
		New growth
		STDs

Note: Some codes were placed in more than one overarching theme

Table III
Quotes Illustrating the Overarching Themes

Overarching Theme 1: Social Isolation
"Not having a partner to be with creates loneliness; [you] miss the family. Then comes the state of depression, so that you do not care to do anything, […] nothing makes you happy. I think everyone goes through this, you know? And many people […] have no friends, […] do not go out anywhere, do not relate [to others]. […] They are engaged in work, they work sixteen hours and then the time they have they devote to sleep, […] and that creates separation from society, right? […] These isolated people enter a world […] of loneliness and depression." FG 3
"It is the pros and cons; […] [alcohol] gets rid of the depression you have for not having a family, but it also, on the other hand, screws you. […] No, there is no good option […] but to drink." FG 1
"Well, there is sometimes loneliness […] that leads us to […] let's say, drink […] when you have a sick child and you want to be with [the family] … But unfortunately we cannot [go back] because we come for a time to gather some money for our children to study, more than anything." FG 2
"I think us, as men, should walk around with condoms in the bag for emergencies [jokes and laughter behind]. Have them [the condoms] because we do not know at what time the opportunity [for having sex] will present itself and, frankly, we are so starved [for sex] that letting go of an opportunity is not…not so tasty … [laughs]." FG 3
"A lot of these men are dealing with substance abuse issues, mental health issues, including depression, anxiety, and a lot of that stems from unstable social circumstances regarding separation from their families and fear while living out of their own home country." Interview J
Overarching Theme 2: Staying healthy
"We are not careful in the sense that we work too much. Sometimes we even have two jobs; an average of sixteen hours. For example, [we] do not have time to go to a hospital or eating on time. We are running all the time and we don't eat on time, we leave that for later […] neglected" FG 1
"I do drink beer from time to time but it must be done with a limit, […] I drink one or two or maybe three [beers] after work or with dinner. But one drinks one or two beers; one eats well, one does sports. We maintain a balance, right?" FG 4
"Sports are very good […] and let's practice it as many times as we can. I like jogging, I like to go to the field to play ball, I like to go swimming, […] but I do not have anybody to go with me to a pool and spend two hours swimming. That [swimming] fascinates me, but I don't have the right person to go with." FG 3
"The idea too that here, we're used to yearly physicals, vaccinations, this and that. Education, because the guys – that's not common in Mexico. People go to the doctor when they're sick and that's it. They don't do preventative care." Interview G
"Preventive care is just not something they're maybe used to, so they don't do it here. It's not 'til there's an emergency, and then it's much harder to find someone to treat them." Interview H
Overarching Theme 3: Accessing the healthcare system
"Many of us take precautions or have the fear when we come to a hospital or […] use a service, one is fearful just because we do not know how to speak English […] They may speak to security or an important person and they can report you to immigration. […] Also, [participant name] […] went to the hospital and they billed him for a lot of money. [He] already has the idea of where to go, as he says, to another state where it is cheaper or easier to find medications than here in Pittsburgh." FG1
"If it is a hernia or something and it is very expensive, […] I'd better go to Mexico." FG 1
"I was not yet convinced to go to a hospital, I almost died. Then, […] I went to the store with the guy; he gave me a ride as well. […] That was how I could go to the hospital." FG 3
"There's a lady who worked at [STORE]. She gets me this help. It's been two years since I met her there. All is well, and you go there […] and we arrived at the hospital." FG 3

“The whole flying under the radar thing that I mentioned before, where people may not have a permanent address or have moved around a lot, and so it's hard to reach clients and get information from them, [get] the documentation that you need to even help them try to plow through the system.” Interview B
“It is the bad orientation we have, the not knowing… no communication, not knowing about where to go and what rights we do have. We don't know what our rights are.” FG 1
“Part of the barriers they face here, […] is our own [Latino] cultural values and men are kind of expected to be kind of this strong, steadfast character, and kind of bite the bullet through everything that comes.” Interview F

Table IV

Selected Characteristics of Latino Immigrant Men Surveyed by Years in the U.S.

	<=5 years in the U.S. Number (%) N=38	>5 years in the U.S. Number (%) N=28
Access to care		
Has health insurance	3 (7.9%)	3 (10.7%)
Has a regular source of care	4 (10.5%)	3 (10.7%)
Had a visit to the doctor in the past year	10 (7.9%)	9 (32.1%)
Had a visit to the dentist in the past year	3 (7.9%)*	56 (17.7%)*
Alcohol consumption		
Drank alcohol in the past 30 days	23 (63.9%)	22 (81.5%)
Had >=2 binge drinking episodes in the past 30 days	11 (28.9%)	10 (35.7%)
Other measures		
Loneliness (High 13-20) UCLA scale, short form[32]	16 (42.1%)	11 (39.3%)
Social support (Low 4-12) Abbreviated MOS-SSS[33]	25 (65.8%)	17 (60.7%)
Depression symptoms (any) the PHQ-9[34]	13 (34.2%)*	4 (14.3%)*

All percentages were calculated using only valid answers. Denominators may vary because of missing data. Data were missing in 0-4 cases for all variables except in visit to the dentist (18 cases)

*Indicates a statistically significant difference, $p<0.05$.