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Mexican Immigrant Male Knowledge and Support Toward Breast and Cervical Cancer Screening

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Abstract

Background—We conducted a focus group study to assess the influence of partner communication on breast and cervical cancer screening and the perceived existing and potential support from male partners in participating in cancer screening. Secondarily, Mexican male and female views on health care and cancer were explored.

Methods—Seven focus groups (two female-only, three male-only, and two couples) were conducted in Spanish.

Results—Findings suggest that knowledge about cervical cancer was significantly less than knowledge about breast cancer among both men and women. Barriers to cancer screening included language barriers, lack of health insurance, and lack of awareness of the need for screening. Male partners expressed willingness to support their female partners in cancer screening activities.

Conclusion—Cervical cancer education is desperately needed, including education on the availability of free and low cost screening services. Education efforts should include the male community members, especially as the males perceive themselves as responsible for the financial burden of care.

Keywords

Cervical cancer; Breast cancer; Screening; Mexican-American; Male involvement; Access to care

Introduction

In 2004, the United States population included more than 40 million Latinos, comprising 14% of the total population [1]. An estimated 66% of documented United States Latinos are

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of Mexican origin [2]. In New York City, the Mexican community is now the fifth largest immigrant group, numbering 122,600 [3].

Data on cancer incidence, mortality, and health disparities among immigrants in the U.S. remain limited [4–7]. Immigrant minorities continue to experience disproportionately higher cancer incidence and mortality rates for many cancers [8, 9]. For example, the diagnosis of invasive cervical cancer due to lack of screening and follow-up explains the elevated age-adjusted mortality rate from cervical cancer among minority immigrant women [10].

Cervical cancer incidence among Latinas (15.8/100,000) is more than twice as high as for White women (7.1/ 100,000), and the mortality rate is 40% higher than among Whites [11]. The age-adjusted mortality for this treatable disease is 3.26/100,000 for Latinos, considerably higher than that for the general population of 2.5/100,000 [12].

Latina immigrants have significantly less cervical cancer knowledge than non-Latinas, and are less likely to have a Pap smear [11]. Lower screening rates among Latinas may be due to reluctance to be examined by a male, lack of convenient appointments, poor communication with staff [13–16]. A qualitative study of 11 Mexican immigrant and Mexican-American women who did not follow-up with referrals for Pap screening [17] revealed that institutional impediments played a significant role in adherence to follow-up. Reluctance to be examined by a male practitioner, lack of flexibility in scheduling appointments, poor staff communication, and seriousness of the condition were better predictors of non-adherence than were participants’ expectations, knowledge, lack of social support, and insurance access. Only 65% and less Mexican-American women over ages 65 reported ever receiving a Pap smear in a population-based study, although they were more likely to report getting a mammogram [18]. Different predictor variables influenced participation in mammogram and Pap smear screening. Women who lacked health insurance and had fewer doctor visits were less likely to receive a mammogram. Women with low education, low acculturation, and lower cognitive scores were less likely to ever have a Pap smear. Utilization rates for both mammograms and Pap smears declined with increasing age [18].

Breast cancer is, after lung cancer, the second leading cause of cancer death in women, but the leading cause of death among Latinas. Later stage at diagnosis is partially responsible [19]. Early stage disease is diagnosed approximately 30% less frequently in Latinas than among non-Latinas. Latinas are seven times less likely to recognize early signs of cancer, and are less likely than non-Latina Whites or African-Americans to have mammograms [14,15]. Among Latinos, *fatalismo* (fatalism), a “general outlook on life founded on the belief that life events are inevitable” and cannot be altered by ones’ actions [20], may influence screening utilization. A study investigating the predictors of mammography utilization among urban Latinas in Massachusetts revealed that higher fatalismo was strongly associated with a lower probability of screening [21]. Ramirez et al. [22] found that Mexican-Americans and Puerto Ricans had more negative or fatalistic attitudes towards breast and cervical cancer screening than do other Latino communities.

The influence of a Latina’s social network on her decision to seek cancer screening has been previously explored. Suarez et al. [23] investigated the importance of social networks among various Latino groups, including Mexican-Americans, in influencing a woman to be screened for cervical cancer. Using the Social Network Index [24], it was found that, although “highly socially integrated” Latinas were more likely to have been recently screened for cancer, the effect of social integration was stronger for Pap smear utilization than for mammography utilization among Mexican women. Cancer prevention programs such as *Por la Vida* attempt to work within social networks and to involve the larger Latino community in promoting cancer screening among Latinas [25].

Although gender roles have been found to influence condom use in the prevention of HIV/AIDS [26–28], and breastfeeding behaviors of Latinas [29, 30] the effect of gender roles in the prevention of cancer has received little research attention. In general, Latino women were found to make their own health maintenance a low priority, lower than that of their children, spouse, or family as a whole [31]. Having a male partner who was supportive to cancer screening was a significant predictor of women's participation in cervical cancer screening in northern Peru [32]. Focus groups conducted with Mexican men in Colorado identified their supportive and non-supportive attitudes and behaviors toward their spouses' breast and cervical cancer screening [33]. As the age of the male partner and number of years married increased, so did their interest and concern for their spouses' health and well-being, including their partners' participation in cancer screening. While this earlier study by Flores and Mata [33] suggested that Mexican male partners are interested in their partner's health care, what remains unknown is their knowledge base, and what they do to either discourage or encourage screening.

To address the gap in the literature on male partners' attitudes and their partners' breast and cervical cancer screening behaviors, we conducted a series of focus groups to determine the influence of partner communication on breast and cervical cancer screening and the perceived existing and potential support from male partners in participating in cancer screening. Secondarily, Mexican male and female views on health care and cancer were explored.

Methods

Upon institutional review board approval from New York University, participants for the focus groups were recruited through Project Reach Youth, Inc. (PRY), and Asociacion Tepeyac de NuevaYork (Tepeyac). Staff invited prospective participants to sign up for the study if they were at least 18-years-old, were of Mexican descent, were a New York City resident, and lived with a significant other or spouse of the opposite gender.

We conducted seven focus groups (two female-only, three male-only, and two couples), with 5–10 participants each. Bilingual trained focus group facilitators were matched to the gender of the focus group participants. The focus group questions spanned the following areas: healthcare utilization patterns, beliefs regarding the cause of general, breast and cervical cancer, effect of their provider's gender on use of breast/cervical cancer screening services, nature of social support and health decision-making within the couple, and their interest in receiving cancer education.

All focus group sessions were audiotaped, transcribed, translated into English, and then analyzed through inductive analysis [34]. Coding was done from the original Spanish text or from the English translation. Two coders reviewed the transcripts independently from each other to classify the data into major themes and to identify subcodes. The categories and relationships of the subcodes were compared and a coding scheme developed. The act of coding allowed the researchers to scrutinize the salient issues raised in the focus groups and provided an opportunity to peruse the narrative for particular subtopics. The transcripts were then read again and statements related to a specific theme were coded according to frequency, length, accuracy (of knowledge statements), emotional intensity of discussion, and amount of disagreement among participants. Observations were written up and discussed between the two raters for accuracy and completeness.

Results

Except for one Brazilian woman who was married to a Mexican partner, all participants were born in Mexico. Female participants were between the ages of 18–45. Male participants were between the ages of 25 and 62. Responses for the male-only, female-only, and couples-only group were similar for each area of inquiry, unless otherwise indicated. The main focus group questions and responses are summarized in Table 1.

Healthcare Utilization Patterns

Focus group participants reported mixed experiences with health services, highlighting primarily language barriers and the lack of health insurance. Some participants reported that family members, even children, accompanied them to medical visits to act as the interpreter and explain medical procedures. Poor linguistic access was perceived to lead to poor quality of care. Participants commented that health care facility staff often get impatient if the participants cannot explain their health problems in English or if they have heavy accents.

> We try to say the words in English, …, but we can’t pronounce them well and the physicians and nurses become impatient.

Lack of proficiency in English led to longer waiting periods, partially because of the time required for personnel to locate interpreters. Some participants complained of not understanding the medication instructions or doctors’ not always explaining the medical procedures they were performing. Language discordance also discouraged participants from using preventive services. Participants who did not experience language barriers usually encountered bilingual hospital staff or English-speaking health care providers that were more patient.

The issue of discrimination within health care settings was brought up in two of the male-only groups. Participants believed that the poor service and quality of health care, including longer waiting times, were caused by discrimination because they were Latino.

> I think that we … are put at the end [of the waiting line], and when an American arrives, Hispanics are forced to wait until the end.

However, other participants in these groups commented that discrimination exists everywhere, including in Mexico.

The issue of trust in United States health care facilities was introduced in one of the couples-only groups, where a participant stated his preference to obtain his health care in Mexico because he did not trust the health care system in the States.

Health insurance was an important variable in obtaining preventive health care. The majority of participants said that without health insurance, they only sought medical attention when they were sick. Overall, several participants said that it did not make sense to pay a lot of money for screening activities just to find out that nothing was wrong, although they would take their children for preventive care. Some participants said that they had regular checkups when they were insured, but discontinued the practice when their health insurance was discontinued. Other participants reported that they would utilize preventive and early detection services once they became insured.

Cost considerations also influenced participants’ decision-making around where to go for health care. While the majority of the participants reported going to public hospitals, several participants reported seeking the care of private doctors, primarily because they would not have a long wait and losing a full day’s pay as a result. Participants reported that some doctors in private practices offered discounts for uninsured patients and sometimes provided them with free medication. One participant indicated that some doctors in private practices charged Mexican patients more. Participants also said that they took their children, who may be insured by public health insurance, to doctors in private practices.

Overall, the men reported that they were less likely to seek preventive care than their female partners and children. Some men said that they would get regular exams when they were treated for other illnesses, such as chronic back pain. The majority of the male participants did not believe there was a need to go to the doctor if they felt healthy and symptom-free. Male participants in the maleonly groups voiced such beliefs more strongly than those participating in the couples-only group.

> (Male) I never go. We are irresponsible. When we are sick, we want to go. But the next day we wake up feeling better and don't go.

General Cancer Beliefs

Cancer was strongly associated with death, being terminal, and dangers among all focus groups. The majority of participants in three of the focus groups believed that some cancers, such as cervical cancer, were untreatable. However, in the remaining four groups, participants emphasized that cancer could be treated, if it was detected early. There were no significant demographic differences among these groups. Participants also noted that cancer cannot be prevented because the causes are often unknown or hereditary.

> I think that they have done research [to determine what causes cancer], but they don't know yet…. You can never know. Who knows if it's the environment, or what you eat? It can be hereditary many times.

In addition to environmental, dietary, and hereditary factors, participants named lifestyle factors, such as smoking and drinking, as causes of cancer. In the maleonly groups, participants mentioned work-related exposure to carcinogens from dust in the construction industry as a cause of cancer. Nevertheless, the men believed that women were at a higher risk than men of developing cancer.

Beliefs Regarding Breast Cancer

When asked specifically about causes of breast cancer, the participants named lifestyle and genetic factors. Furthermore, they thought that breast cancer could be caused by physical trauma to the breast, hitting or punching the breast. Participants in several groups also indicated that breast cancer is caused by the lack of, or insufficient, breastfeeding, which would result in "spoiled" milk remaining in the woman's ducts, and turning into cysts, which would become malignant tumors over time.

Focus group participants reported that one's breast cancer risk could be reduced through participation in breast cancer screening activities and breast self-exams ("observing the breast"). Women who had received a mammogram indicated that it was very painful. The majority of focus group participants indicated that women should start to have regular mammograms at age 40 and that mammograms should be performed on an annual or bi-annual basis. One male participant voiced his opinion that women should start having mammograms when they become sexually active. Two participants said that it was the doctor's responsibility to determine when a woman was at an increased risk for breast cancer and hence when she should receive a mammogram.

Participants in the male-only focus groups stated that, in general, Latinos wait until they have severe symptoms before getting screened for cancer. It is often then too late to cure the disease. On the other hand, participants in three other focus groups seemed to believe that women did not wait too long before getting a mammogram. They also indicated that some women received mammograms and/or Pap smears in Mexico before arriving in the U.S.

The main barriers to obtaining cancer screening included lack of money, lack of transportation, lack of time, and embarrassment. One participant in the male-only group stated that the husband's jealousy might prevent his partner from getting a mammogram. In one of the male-only focus groups, participants did not feel that women experienced any barriers to cancer screening.

Beliefs Regarding Cervical Cancer

There was an overall lack of knowledge about cervical cancer. The participants were less likely to volunteer their opinions when discussing cervical cancer compared with breast cancer; the facilitator had to employ more probing questions. In two of the groups, facilitators had to clarify where the cervix was located in a woman's body.

> (Male 1): Cervical cancer, is that something in the mouth? In the throat?
>
> (Male 2): How ignorant are we men.

Female participants appeared to be more fearful of developing cervical cancer than breast cancer. Women and men named the risk factors for cervical cancer as frequent intercourse, intercourse with a person with sexually transmitted diseases, or a general lack of hygiene. Some stated that virgins did not need to get tested for cervical cancer. Participants also speculated that vaginal ruptures or cesarean sections during pregnancy and childbirth might be risk factors.

Most of the women and men did not know the screening guidelines for cervical cancer. One participant indicated that she received a Pap smear only at the time of her pregnancy. Of the females who did get Pap tests, few of their male partners were aware of this. One participant said that his wife had commented to him that the procedure was painful. In one focus group, participants thought that a woman needed to make a special appointment to receive a Pap smear additionally to the regular medical visit, similar to what is required to schedule a mammogram. Of those who were familiar with the Pap test, all had received one at least once in their lives. Many participants cited embarrassment and discomfort as barriers to getting screened for cervical cancer.

> (Facilitator): What is the main barrier for you to get a Pap smear?
>
> (Female 1): How I am forced to open my legs. It is very uncomfortable.
>
> (Female 2): It's embarrassing.

The embarrassment factor was heightened with male providers. One woman said that it felt "awkward" to be seen by male providers in the U.S., because she had only seen female providers in Mexico. However, none of the male participants stated that they did not want their female partner to see a male gynecologist. Some women reported that male doctors could be "unfriendly" and "not gentle" in conducting Pap smears, which made the experience more uncomfortable and discouraged them from seeking future care. In response to these comments, some men in the couples-only focus groups argued that female doctors could also be rude and that, ultimately, the woman had to select a provider based on comfort, rather than on gender.

Social Support and Decision-Making Within the Couple

Women reported talking to friends, sisters, or partners about health issues, whereas men indicated that they sought health advice exclusively from their spouses/partners. Women often went to medical appointments alone, or on some occasions, with a female relative or friend. Men stated that inflexible work schedules impeded them to accompany their spouses/partners to doctor's appointments. In some cases, the male partners would stay at home to care for the children while their partners were at medical appointments. Both male and female participants did not consider this to be an indicator of poor social support.

None of the male participants reported problems in communicating with their partners about health care issues, from scheduling appointments to selecting a provider or medical facility. However, some male focus group participants did state that the women felt embarrassment when talking to their partners about sexual health, cervical cancer, and Pap smears. Partners reported that they encouraged one another to seek preventive care and to adhere to prescribed medication plans. The desire to stay healthy to be able to provide for the family and the children was named as a powerful motivator.

Men said that women are more likely to get medical and preventive health care for themselves and their children and that they are, therefore, more knowledgeable about the health care system than men.

> They (the women) already know more, since they go more often with the kids to the hospital. They know more or less where to go, what to do and what to say.

Women indicated that they made their health care decisions either by themselves or with their partners. However, the women were often the ones to encourage their partners to get regular check-ups. In some cases, men seemed to dominate the decision-making process because they were “more experienced” with a specific disease or more likely to remain calm. Women offered the following suggestions of how their male partners could be more helpful: being more patient and understanding; assisting them in finding a medical provider or specialist; or reminding them to make or keep future appointments. Men believed that their primary role was to provide the financial means for health care visits.

> (Facilitator): What do you think you could do as men in your relationship to help women have better health?
>
> (Male 1): Apart from good nutrition, getting health insurance.
>
> (Facilitator): Health insurance?
>
> (Male 1): Yes, and to get it as soon as possible. Many of us don't have it. We have what our work offers, but usually it doesn't cover the family.
>
> (Male 2): Even when you have health insurance and go, they still make us wait. I think that in that case it is better, having a private doctor see her when she's sick, even if we have to pay.

Interest in Cancer Education

Both male and female participants stated a desire to attend cancer health education workshops open to both men and women, even if workshops focused on a specific gender (i.e. women's cancer health issues, such as cervical cancer), if they were offered at a convenient time. Men indicated that they could provide better support to their partners, if they knew more about the female cancers.

> They [the women] want us to be more knowledgeable about this disease so that we can say “no, this is severe, you have to get it looked at.”

Interest was not universal, however. Some men stated that women should attend the cancer educational sessions and then tell their spouses about what happened when they returned home.

> I'd go play soccer instead.

Discussion

The focus groups highlighted the influence of language access, health insurance access, and appropriate knowledge on cancer screening behaviors of Mexican immigrant women. Language discordance and/or being of Latino origin were named as causes for lower quality of care and poorer access to care, including longer waiting times. Focus group participants commented that they did not feel adequately briefed about procedures during the medical interaction if they did not speak English. While these factors may not directly impede women from seeking screening services, they may have caused them to delay them and/or to seek timely follow-up care.

The association between health insurance/coverage for screening and preventive health behaviors was striking. Participants reported that they delayed preventive health visits until they could enroll in health insurance or that they had stopped getting physical exams when their insurance coverage expired. The financial impact of preventive health visits on the family's budget was named as the primary factor in the couple's decision as to whether or not to seek early detection services. Male participants' interest in encouraging their spouses' participation in cancer screening activities increased considerably when they heard that mammograms are available at no- or low-cost. Outreach should highlight the free- and low-cost screenings that are geographically accessible.

These structural barriers are interwoven with immigrant's cultural norms and knowledge gaps on cancer etiology and screening. There was a more pressing need for education on cervical cancer, with which participants were significantly less familiar than breast cancer. In general, males' knowledge about female cancers was low, especially for cervical cancer and Pap smear screening. As a result, the fear of developing cervical cancer appeared to be more intense than for breast cancer. Women who had not previously received a Pap smear, and men, tended to apply the screening guidelines for breast cancer to cervical cancer. However, lack of knowledge is not the sole deterrent to screening. Due to the potential for embarrassment, being seen by a male provider seemed to be more of a deterrent for cervical cancer screening than for breast cancer screening.

While women in general commented that they talked openly with their partners about health problems and the decision about whether or not to seek medical attention, some of the women stated that they had difficulties talking to their partners about reproductive health issues. It is, therefore, necessary to develop cervical cancer materials that facilitate the communication between Latino couples in a culturally sensitive manner.

A main motivator for cancer screening was to prevent prolonged sickness of the mother, which would in turn affect the care of the children. Cancer outreach should emphasize that it is worthwhile to participate in cancer screening, to ensure that the mother is not "taken away from her family."

While men were supportive of their partners making health care visits, they were often not able to accompany them, due to conflicts with their employment and would only accompany them in the case of medical emergencies. Some men expressed an interest in joining their partners in cancer education sessions, but their attendance at those, too, would be limited by work-related constraints. Coupleoriented cancer education would be acceptable to the community, but would be used by a limited number of couples. However, the males often feel responsible for enabling financial access to health care, hence, this issue should be targeted in education.

The National Cancer Institute recently released a seminal report on the continued incidence of cervical cancer deaths, completely preventable, in underserved communities, including the Mexican-American community [35]. The Report highlights the importance of enhancing overall health care access for women with a disproportionate share of the cervical cancer burden. This would include innovative outreach strategies to all sectors of the community and the formation of key partnerships.

These focus groups findings highlight the need to increase the knowledge of cervical cancer etiology, screening, and coverage in the Mexican immigrant community. While some of the observations may not apply to other Latino groups or to acculturated Mexican-Americans, the principle of increasing male involvement in breast cancer detection and educational programs targeting men has also been suggested in other multi-cultural communities [36]. Men encourage and support women to seek preventive health services but usually women attend the clinics alone. Increasing men’s knowledge about gynecologic cancers could help foster male involvement in actively supporting their partners’ participation in cancer screening. Male partner education and support programs should be developed and then tested for their effectiveness in increasing cervical cancer knowledge among both the male and his partner, screening behavior changes, and, ultimately, downstaging of cervical cancer in the Mexican immigrant community.

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Table 1

Themes and participant comments on breast and cervical cancer screening

Main themes	Questions	Participant comments
Health care utilization pattern: men are less likely to seek preventive health care than women	How would you characterize your health care experiences?	Language barriers; no English at all and when trying to speak English, staff are impatient with heavy accent; resulting in longer waiting times and difficulties in understanding doctor's instructions and orders
	What type of health insurance do you have?	Lack of health insurance, resulting in delayed health care seeking and no participation in screening unless insured
	What factors help you decide whether and when you should seek a doctor for care?	Cost of getting health care vary by provider type: save time waiting by going to private provider; public providers have sliding fee scale
General cancer beliefs: men believe that women are at a higher risk of contracting cancer	What comes to your mind when you hear the word cancer?	Cancer is terminal, may be treatable if detected early; resulting in disagreement among participants over whether cancer can be prevented
Beliefs regarding breast cancer: participants have several misconceptions about cancer etiology	What do you believe causes breast cancer?	Lifestyle (physical trauma to the breast, breastfeeding and "spoiled" milk) and genetic factors are thought to be causes
	Do you believe that mammograms can detect breast cancer?	Breast cancer screening can reduce risks; many were already familiar with use of mammograms before coming to the U.S.
	What do you consider are the major barriers to receiving a mammogram or to conduct a selfbreast examination?	Lack of money, lack of transportation, lack of time, and embarrassment, result in delays in screening until it is too late
Beliefs regarding cervical cancer: participants lack knowledge about cervical cancer	What do you believe causes cervical cancer?	Risk factors are thought to be frequent intercourse; intercourse with a person with sexually transmitted diseases; general lack of hygiene; vaginal ruptures during delivery; resulting in higher fear of cervical cancer than of breast cancer and uncertainty about cervical cancer screening guidelines
	What do you consider are the major barriers to getting a Pap smear?	Having to see male provider is a potential barrier to getting a Pap smear. However, trustworthiness and competence of provider are more important than provider's gender
Social support and decision-making within the couple: women are more knowledgeable in navigating health care system than women	From whom do you seek advice about health matters?	Women receive health advice from variety of sources; men get health advice mainly from partners. Women are more likely to go to a provider than men (pre-natal care and children's medical need)
	Does your male partner help you to get cancer screening and if so, how?	Inflexible work schedules prevent male partners from accompanying their female partners to doctor appointments; sometimes support is given by caring for children while wife goes to doctor
	Do you talk with your partner about women's health and screening?	Good couple communication on scheduling appointment and selecting provider but poor communication about sexual health and cancer screening
	Do you talk with your partner about men's health and screening?	Women encourage male partners to get regular check-ups and take care of their health; but in case of illness, men may dominate decision-making process
	How could men make it easier to take care of your health and to get cancer screening?	Women wish that men were more patient and understanding, would assist them in finding a doctor and remind them of appointments
Interest in cancer educatio	Would men be interested in education about breast and cervical cancer?	Interest in cancer education if it is at a convenient time but some men have other priorities; prefer to receive information from women at home