

ORIGINAL RESEARCH

Social determinants of self-evaluated good health status of rural men in Jamaica

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ABSTRACT

Introduction: A comprehensive literature review revealed a gap in health research regarding the determinants of good health for rural men in Jamaica. This study seeks to fill this void by examining cross-sectional survey data to model the social determinants of the self-reported good health status of rural men in Jamaica.

Method: A sample of 5041 males (≥ 15 years) was extracted from a national cross-sectional survey of 25 018 respondents. A stratified random probability sampling technique was used to draw the sample. Data were stored, retrieved and analyzed using SPSS for Windows 16.0 (SPSS; Chicago, IL, USA). Descriptive statistics were used to provide pertinent socio-demographic characteristics of the sample, and logistic regression was used to establish a predictive model for good self-reported health status in rural Jamaican males.

Results: Seventeen percent of rural men claimed that they had poor health, 4.9% had health insurance, 61.6% visited a healthcare practitioner, 96.0% purchased prescribed medications and 45.3% completed the course of prescribed medications. The social determinants of good health status of rural men in Jamaica are cost of medical care (OR = 0.916, 95% CI = 0.841-0.997); retirement income (OR = 0.0382, 95% CI = 0.0206-0.0707); marital status: separated, divorced or widowed with reference to those never married (OR = 0.270, 95% CI = 0.178-0.410), and married with reference to never married men (OR = 0.465, 95% CI = 0.356-0.609); health insurance coverage (OR = 0.041, 95% CI = 0.027-0.063); number of children in household (OR = 1.200, 95% CI = 1.069-1.347); and number of durable goods owned (OR = 1.107, 95% CI = 1.050-1.166).



Conclusion: Children continue to be not only futuristic assets to parents, but they also currently improve the health status of rural men.

Key words: good health, health status, Jamaica, public health, rural men, social determinants of health.

Introduction

In Jamaica, culturally and traditionally, health has been viewed as being on the other side of the sickness pendulum. This is also the case in many Western societies where health is seen as the 'absence of diseases'^{1,4}, an approach both negative and narrow in scope. According to some scholars, such a concept of health emphasizes the absence of some disease-causing pathogens rather than the presence of health¹⁻³. Such a perspective is in keeping with the traditional biomedical model that views exposure to specific pathogens as the cause of diseases in organisms. This began during the period 130–200 CE in ancient Rome^{2,5}, and despite the efforts of WHO as early as 1946⁴ and Engel⁶⁻¹⁰ to expand this image of health, it is still widespread in contemporary Jamaica.

Owing to this image of health, healthcare utilization for men can be interpreted as weakness rather than an opportunity for preventative care. With this cultural bias the term 'sicky sicky' (sickly) is used to describe men who frequently visit healthcare facilities or claim that they are suffering from dysfunction. Men believe they must protect their machoism (masculinity) and will only visit healthcare facilities infrequently in an attempt to display strength; keeping sickness at a distance assists their social survivability. Task specialization is important for Caribbean males and they will not publicly execute certain functions¹¹⁻¹⁴, because gender defines social roles and functions. Masculinity for the Caribbean man is synonymous with power, strength and 'toughness', and he must not show any 'softness' or fragility because these are associated with female behaviour. Therefore Jamaican males generally do not like reading or literature, the English language, home management, child care, nursing or cosmetology, and they cannot appear to be 'sicky sicky' or seek medical care.

Over the last two decades (1988-2007), statistics from the Planning Institute of Jamaica and the Statistical Institute of Jamaica (in Jamaica Survey of Living Conditions - JSLC)¹⁵ have showed that the percentage of Jamaican men reporting illness or ailments to be 16.3% (in 1990), and that 37.9% of these sought medical care. Women, however, reported more dysfunctions and sought more health care, except in 1991, 1995 and 1997 (Table 1). The latest health data available from Jamaica was collected in 2007; this showed that 13.1% of men reported illness and 62.8% of these sought health care. In comparison, 17.8% of women reported ailments and 68.1% visited healthcare facilities for medical care, and spent less time suffering from those illnesses (9.3 days vs 10.6 days for men). This health-gender differential accounts for the disparity in life expectancy between the sexes with women outliving men by 6 years⁵. Globally, this difference in life expectancy is 8 years more for women than men^{16,17}, emphasizing the role that culture plays in denying men comparatively better health.

Although it is not possible to establish that in Jamaica urbanization has resulted in more illness being experienced by rural residents, the Jamaica Survey of Living Conditions (JSLC) revealed that in the period 1988–2007 there were more instances of self-reported illness/injury by rural Jamaicans than urban dwellers. In 2007, 17.3% of rural Jamaicans reported illness compared with 13.9% of those in 'other towns' and 14.1% of those in urban areas. Of those who reported illnesses, 59.9% indicated a chronic recurring ailment. The chronic ailments suffered by rural residents were asthma (8.2%), diabetes (10.8%), hypertension (22.6%) and arthritis (9.3%). The incidence of arthritis and diabetes were higher and lower, respectively, than for those in other geopolitical zones.



Table 1: Percentage of those seeking medical care, self-reported illness, and gender composition of those who report illness and seek medical care in Jamaica, 1988–2007

Year	Seeking medical care	Health insurance coverage	Seeking medical care		Reporting illness		Mean days illness	
			Men	Women	Men	Women	Men	Women
1988	NI	NI	NI	NI	NI	NI	NI	NI
1989	54.6	8.2	44.7	52.8	15	18.5	10.6	11.1
1990	38.6	9	37.9	39.2	16.3	20.3	10.2	10.2
1991	47.7	8.6	48.5	47.4	12.1	15	10	10.3
1992	50.9	9	49	52.5	9.9	11.3	10.7	10.9
1993	51.8	10.1	48	54.7	10.4	13.5	10.7	10.1
1994	51.4	8.8	49	53.4	11.6	14.3	10.3	10.4
1995	58.9	9.7	59	58.9	8.3	11.3	10.6	10.7
1996	54.9	9.8	50.5	58.5	9.7	11.8	10	11
1997	59.6	12.6	60	59.3	8.5	10.9	11	10
1998	60.8	12.1	57.8	62.8	7.4	10.1	11	11
1999	68.4	12.1	64.2	71.1	8.1	12.2	11	11
2000	60.7	14	57.4	63.2	12.4	16.8	9	9
2001	63.5	13.9	56.3	68.2	10.8	15.9	9	10
2002	64.1	13.5	62.1	65.3	10.4	14.6	10	10
2003	NI	NI	NI	NI	NI	NI	NI	NI
2004	65.1	19.2	64.2	65.7	8.9	13.6	11	10
2005	NI	NI	NI	NI	NI	NI	NI	NI
2006	70	18.4	71.7	68.8	10.3	14.1	9.7	10
2007	66	21.2	62.8	68.1	13.1	17.8	10.6	9.3

NI, No information available.

Source: Jamaica Survey of Living Conditions, various issues.

Statistics from the Statistical Institute of Jamaica¹⁸ indicated that the 5 leading causes of mortality in Jamaican men were cerebro-vascular diseases, diabetes mellitus, ischaemic heart disease, malignant neoplasm of the prostate and hypertensive disease. The rate of cancer in Jamaican men has been said to be greater than that of men in the USA¹⁹. If the Jamaican culture means that men are less likely to visit healthcare facilities and more likely to live in rural zones, what determines good health for rural men? A comprehensive review of Caribbean health literature, in particular Jamaican, revealed few relevant studies.

This study examines the social determinants of good health status for rural Jamaican men to assist in health planning. Because Jamaican men make less use of healthcare facilities than women, understanding those with good health may provide an insight into the lives of those with poor health.

Methods

Participants and questionnaire

The current research extracted a sample of 5041 respondents (20.2% of the survey) from a Jamaican national cross-sectional survey of 25 018 respondents²⁰, based on those who lived in rural parishes and were male over the age of 15 years. The original survey used a stratified random probability sampling technique to draw the 25 018 respondents; the non-response rate was 29.7% with 20.5% not responding to particular questions; 9.0% did not participate in the survey and another 0.2% were rejected due to data cleaning. The Jamaica Survey of Living Conditions (JSLC) was commissioned by the Planning Institute of Jamaica (PIOJ) and the Statistical Institute of Jamaica (STATIN) to collect data from Jamaicans on their standard



of living in order to assess government policies. These two organizations are responsible for planning, data collection and policy guidelines for Jamaica. The JSLC is an administered questionnaire where respondents are asked to recall detailed information about particular activities. The questionnaire covers demographic variables, health, immunization of children 0–59 months, education, daily expenses, non-food consumption expenditure, housing conditions, inventory of durable goods and social assistance. Interviewers are trained to collect the data, which is prepared by household members. The survey is conducted annually between April and July.

Model

The multivariate model used in the present study is a modification of those of Grossman²¹, Smith & Kington²² and Bourne^{5,23}, which captures the multi-dimensional concept of health and health status. The current study added some new factors, such as crowding and consumption per person in the household. Another fundamental difference between this and the former models is that the present study is area-specific and focused primarily on rural residence, which includes the majority of the poor in Jamaica. For effective health education and private care to take place, this cohort's health status must be understood.

Measure

Some critical variables used in this study and their definitions and measurements are provided in Table 2.

Statistical analysis

Statistical analyses were performed using SPSS 16.0 for Windows (SPSS; Chicago, IL, USA; www.spss.com). Descriptive statistics included frequency, mean and standard deviation. Logistic regression was used to explore the relationship between the predictor variables and health status. The final model was based on those variables that were jointly statistically significant ($p < 0.05$).

The Hosmer and Lemeshow test²⁶ was used for goodness of fit of the model, and an odds ratio was used to interpret each significant variable²⁷.

Results

Demographic characteristic of sample

Of the sampled respondents 39% were young adults (15–30 years), 41.8% adults (31–59 years) and 19.2% elderly (≥ 60 years). In all, 83% reported good health. Only 61.6% ($n = 371$) of those who indicated poor health had visited a health practitioner in the last 4 weeks. Of those with self-reported health conditions, 96% claimed they had purchased medication, with only 45.3% mentioning that they completed taking the prescribed medication. Of those who responded to the health insurance question, 4.9% ($n = 241$) had private coverage (Table 3).

Multivariate regression

Of the 12 identified variables tested in this study, 6 were found to be statistically significant ($p < 0.05$) for the final model (Table 4). These 6 social determinants are: retirement income, marital status, health insurance, number of children in the household, asset ownership (durable goods), and sex of respondents. The model provided a good fit to the data, based on the Hosmer and Lemeshow test.

Discussion

Jamaica is among those Caribbean societies and developing countries in which men understand health in terms of sickness. They associate sickness with weakness and are less likely to attend healthcare facilities for preventative care because they believe this to be an indicator of weakness. This situation is prevalent in many developing nations. Often these men only become active participants in addressing their health conditions when these have become chronic, incapacitating or life-threatening, affecting their



employability, livelihood or sexuality. For instance, men in the Caribbean, and in Jamaica particularly, are less likely to undergo digital prostate examinations; likewise, sexual dysfunctions are not spoken about. This later is not limited to Caribbean men. With Viagra the leading medicine worldwide, sexual dysfunction is not only seen as a weakness in men, but it also suggests how manhood is defined in many societies.

When Jamaican men have an illness their first remedy is self-care or self-medication, compared with women, who seek health care at an early stage in an illness and also for preventive care. It has been found that men are only willing to report life-threatening diseases such as heart disease, and that of those who suffer from erectile dysfunction only 10.5% seek help²⁸. Reasons for barriers to health-seeking behaviour may be embedded in personal beliefs, perceived loss of control, or be related to levels of optimism²⁹, ethnic background and tolerance to risk-taking. This is not limited to Jamaican men; a Malaysian study showed similar health-seeking behaviour, and also reported similarities in Pakistani men²⁸.

Low et al. stated that 'erectile dysfunction (ED) is a common sexual disorder affecting men. Although new treatments for ED have emerged for many years, this does not directly translate into men actively seeking treatment for their ED problem'²⁸. Aspects of this issue include the emphasis placed on biomedical treatment, men's perceptions of issues classified as health related, and even how health information is collected and measured. Low et al. stated 'some men did not see ED as a medical problem, while others accepted it as a normal consequence of ageing'²⁸.

Rural Jamaican men's health

What constitutes good health for rural men in Jamaica? In this study, self-reported health status was used to examine the health of rural men. Is this a good measure? Self-rated health is a complex variable that captures multiple dimensions of the relationship between physical health and other personal and social characteristics. It is consistent in its

capacity to predict mortality^{25,30}. It has also been strongly associated with successful aging³¹. Ringen³² in a paper entitled 'Wellbeing, Measurement, and Preferences' argued that non-welfarist approaches to measuring wellbeing are possible despite subjectivity. The direct approach to establishing wellbeing, according to Ringen, is not better than gathering data by the indirect method (using social indicators). Questions are raised about whether *utility* is a function of goods and preferences or products and taste. Wellbeing is based on choices, which are a function of individual assets and options. Choices are sometimes 'irrational', which makes for a departure from empiricism³². Hence, self-reported health status (or subjective wellbeing) is a useful way to evaluate people's health.

Self-reported good health in rural Jamaican men is determined by medical expenditure, retirement income, marital status, health insurance, the number of children in the household and ownership of durable goods (excluding property and land). Of the 6 social determinants of rural men's good self-reported health, only 2 positively influence good health: the number of children in the household and ownership of durable goods. The current study revealed that young children (<14 years) not only positively determine the good health of rural men, but that for each additional child in the household, good self-reported health is likely to increase 1.2 times. Good health will also increase 1.1 times if more durable goods are owned by the rural man. Other studies have agreed that wellbeing is increased according to material resources³²⁻³⁵, and that children positively determine good health (or wellbeing).

The impact of number of children: Culturally in Jamaica, children have been seen as futuristic goods for parents (ie income in old age). This cultural reality accounts for the number of children in particular households. In the 1960s, the mean number of people per household was in excess of 6; in the 1970s this had declined to 4, and currently (2007) the figure is approximately 3 per household.



Table 2: Operational definitions of particular variables^{24,25}

Variable	Operational definition	Coding
Self-evaluated health status (or health status)	People's evaluation of their health conditions	1 (good health) = not reporting an ailment or dysfunction or illness in the last 4 weeks, (survey period) 0 (poor health) = no self-reported ailment, injury or illness. While self-reported ill-health is not an ideal indicator actual health conditions as people may underreport their health condition, it is still an accurate proxy of ill health and mortality[24, 25].
Social support (or network)	Social networks with which the individual has or is involved	1 = membership of and/or visits to civic organizations or having friends that visit ones' home or with whom one is able to network 0 = otherwise
Age group	Age classified into 3 categories: young adults, other adults or elderly	Young adults (15–30 years) Other adults (31–59 years) Elderly (>60 years)
Crowding	Number of people who live in a room	Total number of people in household divided by total number of rooms, excluding kitchen, bathroom and verandah
Social class	Income quintiles used to measure social class, ranging from quintile 1 (poorest 20%) to 5 (wealthiest 20%)	Low = poor quintiles (ie poorest 20% and poor) Middle = middle quintile Upper = affluent quintiles (ie quintile 4 and wealthiest 20%)
Durable goods	Items owned by household members excluding property (or land)	Summation of durable goods
Health care-seeking behaviour (health seeking- behaviour)	Visits to pharmacies, medical practitioners, healers, nurses	1 = Visits to healthcare professionals and/or healers 0 = otherwise
Income	Measured by consumption	In dollars

Although the national average is 3.3 people per household (2007), rural households had 3.4¹⁵. Part of the rationale for more people per household in rural Jamaica is the number of children. Historically, rural people were farmers who owned land. The survivability of the family was based on the farm and the labor available to work it. Poor men who could not afford to hire more workers increased their workforce by using their own children, who would also support their parents in old age. The number of children, and males in particular, were a source of pride for men. The more the farm was worked, the greater the opportunity to acquire possessions. Currently children still provide psychological benefits for rural males, and fatherhood is associated with reduced risky behavior. This accounts for the positive influence of an increased number of children in the household on the wellbeing of rural men in Jamaica.

The impact of poverty: In 1997, the prevalence of poverty in the nation was 19.9%, with rural poverty 2.95 times greater than urban poverty (9.3%), and 1.85 times greater than in 'other towns' (14.8%). By 2007 the nation's poverty had fallen by 50.3% (to 9.9%); however, although rural poverty had fallen by 44.2% (to 15.3%) it was 3.83 times greater than in 'other towns', and 2.47 times greater than urban poverty. It is well established that poverty correlates with ill-health³⁶, but this is not the case for rural Jamaican men for there is no significant statistical association between social class and good health status. It should be noted that rural poverty does not suggest an inability to consume, because the cultural family in rural zones extends beyond heredity to community. Within this social 'family', those who are poor, senior citizens, orphans, ill and children will be assisted by those who have more.



Table 3: Demographic characteristics of sampled population, rural residence in Jamaica

Demographic variable	<i>n</i> (%)
Age group	
Young adults	1968 (39)
Other adults	2015 (41.8)
Elderly	968 (19.2)
Retirement income	
No	4922 (98)
Yes	103 (2)
Health status	
Poor	838 (17)
Good	4087 (83)
Health insurance coverage	
No	4658 (95.1)
Yes	241 (4.9)
Per capita income quintile	
Poorest	1012 (20.1)
Poor	1034 (20.5)
Middle	1071 (21.2)
Wealthy	1006 (20)
Wealthiest	918 (18.2)
Social support	
No	2370 (54.2)
Yes	2371 (45.8)
Educational level	
Primary and below	1032 (23.3)
Secondary	3287 (74.2)
Tertiary	108 (2.4)
Marital status	
Married	1228 (25.5)
Never married	3401(66.6)
Divorced, separated or widowed	241 (4.9)
Physical environment	
No	3970 (79.8)
Yes	1003 (20.2)
Visited health practitioner	
Yes	371 (61.6)
No	231 (38.4)
Purchase prescribed medication	
Yes	339 (96)
No	14 (4)
Completed the medication	
Yes	167 (45.3)
No	202 (54.7)



Table 4: Logistic regression: explanatory variables of rural health of Jamaican men

Variables	Coefficient	Std. Error	Odds Ratio	95% CI	P
Retirement income	-0.963	0.314	0.382	0.206-0.707	0.002
Middle quintile	0.172	0.172	1.188	0.8481.664	0.316
Two wealthy quintiles	-0.138	0.173	0.871	0.621-1.222	0.425
Two poor quintiles†		1.000			
Household head	-0.020	0.595	0.980	0.305-3.145	0.973
Logged medical expenditure	-0.088	0.043	0.916	0.841-0.997	0.042
Separated or divorced or widowed	-1.309	0.213	0.270	0.178-0.410	< 0.0001
Married	-0.765	0.137	0.465	0.356-0.609	< 0.0001
Never married†		1.000			
Health insurance	-3.187	0.213	0.041	0.027-0.063	< 0.0001
Self-reported physical environment	0.023	0.131	1.023	0.792-1.323	0.861
Secondary	0.040	0.140	1.041	0.791-1.370	0.775
Tertiary	0.317	0.438	1.373	0.581-3.240	0.470
Primary or below†		1.000			
Social support	-0.213	0.119	0.808	0.640-1.021	0.074
Crowding	-0.003	0.084	0.997	0.846-1.175	0.970
Property ownership	-0.247	0.134	0.781	0.601-1.015	0.065
Number of female in household	-0.023	0.070	0.978	0.853-1.121	0.745
Number of child in household	0.182	0.059	1.200	1.069-1.347	0.002
Ownership of durables	0.101	0.027	1.107	1.050-1.166	< 0.0001
Average consumption	0.000	0.000	1.000	1.000-1.000	0.174

Hosmer and Lemeshow goodness of fit $\chi^2 = 5.321$ (8), $p = 0.72$.

Nagelkerke $r^2 = 0.282$

†Reference group.

Apart from the labor supply aspect to large rural families, and the pride that children provide, poverty is another motivation for large households. Poverty encourages increased fertility and more children in rural areas, for the future contribution they will make to the economic improvement of the household. A strong association has been found between family size and wellbeing in adult years³⁷, with each additional child in a family increasing future economic wellbeing. In Jamaica, children less than 15 years are unable to work, so their positive influence on rural men's good health is of a psychosocial nature. However poverty alleviation may be seen in terms of investment in a child/children, as equivalent to investing in stocks, bonds, shares.

Other determinants of rural men's good self-reported health

Health insurance coverage: Health insurance is a product people use for future health conditions. In the present study,

a rural man was 0.96 times (or 96%) less likely to purchase health insurance. Health insurance coverage cannot be used to measure healthcare-seeking behaviour as it is a precaution, rather than a preventative measure. Rural men buy private health insurance in Jamaica for the high likelihood of ill-health; therefore, health insurance coverage is not a good indicator of preventative health - and rural men's good health is not improved by the purchase of this product. Similarly, those rural men who spent more on medical care were 0.08 times (or 8%) less likely to have good health. Expenditure on medical care is to restore good health and is therefore not a preventative approach to health care for rural men, contrary to previous studies^{5,23}.

Marriage: The literature search suggested that married men have greater wellbeing than those non-married. Smith and Waitzman added that men's gains from marriage were greater than women's³⁸. It has been said that 'many observers have theorized that married individuals have access to more informal social support than do non-married



individuals³⁹, and this explains the higher quality of life of married couples than 'non-married' individuals. Some studies have shown that married people have a lower mortality risk³⁹, and this explains why they take fewer life-threatening risks^{38,40}.

With a sample of 1049 Austrians aged 14 years and over, Prause et al. found that married individuals reported better subjective health-related quality of life index (8.3) than divorced persons (7.6), or singles (7.7)⁴¹. Smock et al. found a direct relationship between married women and economic wellbeing⁴². Their longitudinal data from the 1987-1988 National Survey of Families and Households (NSHH1) and a follow-up survey (NSFH2) revealed that married women had higher economic wellbeing than those who were divorced, with those who remarried matching their married counterparts and exceeding the wellbeing of single women. For divorced women, as for their married counterparts, educational attainment and work experience were positively associated with wellbeing.

Despite the plethora of studies showing a correlation between marriage and health, Lillard and Panis disagreed⁴³. They found that healthier men were less likely to be married, and that the healthier married men married later in life and postponed remarriage. The study found that unhealthy men entered marriage at an early age, suggesting that these men do so for health reasons⁴³. The results of the present study are consistent with this, finding that rural Jamaican men who had never married were more likely to report good health, compared with married or divorced men.

Retirement income: Another important finding that emerged from this research is the negative correlation of those who rural men who received retirement income with good self-reported health status. This is counter to studies that found increased income to mean greater wellbeing^{36,44,45}. For example, Keister stated (in an article entitled 'Sharing the wealth: the effect of sibling on adult's wealth ownership') that there is 'little doubt that material resources can improve quality of life and wellbeing...'³⁶. It has also been found that material resources have the capacity to

improve one's choices, comfort level, state of happiness and leisure, which militates against static wellbeing^{46,47}.

By way of explanation, retirement income is received primarily by those men older than 65 years, a cohort less likely to be in good self-reported health. The current findings were that rural men who received retirement income were 0.382 less likely to report good health in comparison with those who had not received this benefit, and this was the least predictor of good health status of the study.

Conceptual change

It may be that it is necessary to re-cultivate health practitioners and health researchers regarding their views and their image of the health and wellness of rural men. Rather than focusing on disease, a positive approach was suggested by a group of Caribbean scholars who stated 'wellness involves the different measures that we use to maintain good health and is geared towards preventing illness and diseases'⁴⁸. Health *is* broader than diseases⁴, and this confirms the use of social determinants in health discussions⁴⁹⁻⁵⁵. However, Davidson et al.'s conceptual framework for good health in Jamaica⁴⁸ lacks specifics for rural residents or rural men⁴⁸. Empirical studies have shown that self-reported illness, self-evaluated health status, happiness, and life satisfaction can all be used to measure health^{21-25,30,49,56}, and self-reported illness or health status have been found to be good predictors of objective health (such as mortality or life expectancy)^{24,25,30}.

The Jamaica Survey of Living Conditions collects data from Jamaicans on their living conditions, and among the questions is the item: 'In the last 4 weeks have you had an ailment or illness not caused by injury?'. The current study used the self-evaluated health conditions to measure health status, seeking to model the social determinants of health among rural men.

Since 2000 the WHO and others have discussed the use of social determinants of health in anticipating policy directions^{53,54,57}. Like others before it^{4,48,57}, the present study



has shown the role of social determinants in determining good health. However, this study has distinguished factors specific to sex and geographic location, and this is significant in predicting the health (or wellbeing) of a populace or a sub-population^{1-3,5,21-23,49-55} – in this case rural Jamaican males.

Using self-reported health conditions to measure the self-evaluated health status of rural Jamaicans, Bourne & McGrowder⁵⁶ found 12 socio-psychological variables that determined good self-reported health (cost of medical care; education; retirement income; health insurance coverage; house tenure; gender; crowding; psychological affective conditions, positive and negative; age; living arrangements; and typology in the number of people who resided in the household – age and sex). Although the current study used the same definition of self-evaluated health, the social determinants of good health for rural men were not necessarily the same. Identifying these for this specific sub-population provides a framework for understanding⁵⁸⁻⁶⁰ and addressing inequalities that exist in the health of males in Jamaica. This also offers a useful approach for future work.

Conclusion

In summary, good self-reported health status in rural men is a function of health insurance coverage, marital status, the number of children in the household, retirement income and ownership of durable goods (excluding property and land). This study provided insights into social factors that determine the good health status of rural men, and within this reality healthcare practitioners can now devise appropriate programs to address the health concerns of this cohort.

One way to improve the level of health in a population is to address the health concerns of the poor – in Jamaica this means rural residents. Men continue to seek less care than women, and when this is added to rurality, poor rural men seek even less health care. Addressing the health gaps that

exist in the Jamaica population, particularly among rural men, is an urgent concern.

The present study highlights that social determinants of self-evaluated (or reported) health status may differ among countries, and even within nations and between sexes. Public health practitioners must understand this when seeking to make a difference.

The way forward

Men, in particular rural men, have been understudied in Jamaica. This study has provided an understanding of some issues surrounding health from their perspective. These findings may be used to inform future studies. Policy-makers may also be able to use the information to inform health promotion, interventions and education campaigns specifically for rural men. The results of this study suggest that health status is experienced similarly among the rural men studied, regardless of social determinants. Current health policies may, therefore, not meet the needs of this particular group of men in Jamaica.

The results of this study also challenge the notion that education means people make better health choices, thereby gaining improved health status. This may explain the higher mortality in males as policies fail to reach the target population. Another issue highlighted by this study is the relationship between health and marital status, with married men reporting lower health status than single men, suggesting that rural married men should be included in health promotion campaigns. Further research is needed into the relationship between health and marital status in rural Jamaican men to understand the impact of their value systems, health challenges, health decisions and lifestyle on health inequality.

This study on the social determinants of health does not provide all the answers but it has identified some health inequalities among rural men in Jamaica. More answers are needed to effectively aid policy formulations. Policy implementation in Jamaica needs epidemiological



monitoring and analyses over time in order to understand how to guide future research-based policy implementation.

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