A QUALITATIVE STUDY TO BETTER UNDERSTAND ASIAN AMERICAN WOMEN’S CANCER SCREENING DECISIONS

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DEDICATION

This thesis is dedicated to my parents: Maximino Raon Sadile & Yvette Trinidad Sadile. Not only did you give me the breath of life, but also the inspiration and ambition to be successful in whatever endeavor I choose to conquer in life. Words cannot express the gratitude and admiration I have for all the hard work that you do, and the care, dedication, support and words of wisdom that you provide. My sisters and I are very blessed and fortunate to have such amazing and loving parents. Thank you for everything and always know that I love you.
ABSTRACT OF THE THESIS

A Qualitative Study to Better Understand Asian American Women’s Cancer Screening Decisions
by
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Cancer is the leading cause of death in the Asian American (AA) population; yet cancer screening rates in the AA population are lower compared to other major racial groups. To have a better understanding of AA women’s health decisions, especially in choosing to screen for cancer, a qualitative exploratory study was conducted. Participants were asked to complete a brief health survey and a one-time in-depth interview regarding their perceptions of health, cancer, and cancer screening. A total of 26 AA women completed the study. Results of constant comparison analysis showed that (a) accurate knowledge about a health behavior is important to make an informed decision about cancer screening, (b) social contacts may be instrumental in raising awareness about health and cancer issues, and (c) having healthcare coverage provided the access to screen for cancer and paved the way for participants to have a relationship with their healthcare provider and receive reminders to screen for cancer. Through exploration of AA women’s health and cancer screening perceptions, findings from this study will add to the scant research available on the AA population and may be used to better tailor cancer screening interventions for AA women.
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CHAPTER 1

INTRODUCTION

Asian Americans (AAs) are the only racial group for whom cancer is the leading cause of death (McCracken et al., 2007). The burden of cancer, which includes high incidence rates, high mortality rates, and poorer survival rates, is particularly noticeable in preventable cancers, such as breast, cervical, and colorectal cancer (McCracken et al., 2007). Screening tests, such as the pap test, mammogram, and colonoscopy have been shown to be effective in detecting certain types of cancer at an early stage (National Cancer Institute, 2010); yet cancer screening rates are very low in the AA population (Kagawa-Singer & Pourat, 2000). To better understand AA women’s decision to screen for cancer, a qualitative exploratory study was conducted with 26 AA women 40 years of age and older.

Participants completed a health survey and a 30-45 minute semi-structured in-depth interview. Results of constant comparison analysis showed that (a) accurate knowledge about a health behavior is important to make an informed decision, (b) social contacts may be instrumental in raising awareness about health and cancer issues, and (c) having healthcare coverage provided the access to screen for cancer as well as persistent reminders from healthcare providers. Findings from this study will not only add to the scant research available on the AA population, but through better understanding of AA women, may better tailor cancer screening interventions.

PURPOSE OF THE STUDY

While cancer is the leading cause of death in the AA population, screening rates for breast, cervical, and colorectal cancer do not meet cancer screening national objectives (Pourat, Kagawa-Singer, Breen, & Sripipatana, 2010). Guidelines include: increase the proportion of women who receive a pap test, increase the proportion of adults who receive a colorectal cancer screening examination, and increase the proportion of women aged 40 years and older who have received a mammogram within the preceding two years (California Department of Public Health, 2009). Among racial and ethnic groups in the United States, in
2008, only 79% of AA women reported ever receiving a pap test, compared to 95% of non-Hispanic White women and women of two or more races (National Center for Health Statistics, 2011). Along with Pacific Islander (PI) women, AA women have been reported as least likely to receive a mammogram or pap test (Pourat et al., 2010).

Little progress has been made to better understand factors associated with decisions in the AA population (Kagawa-Singer, Dadia, Yu, & Surbone, 2010). This study explored health and cancer screening decisions of AA women to add to the limited body of research and contribute to future promotion of cancer prevention and screening programs tailored to AA women. Although quantitative data demonstrate the differences in cancer incidence, mortality, and screening behaviors of all major racial groups and even AA subgroups, a qualitative research approach using in-depth interviews allows for further examination of possible factors related to the decision to screen for cancer. The aim of this study is to obtain a deeper understanding of AA women’s decisions to screen for cancer.

**DEFINITIONS**

For this research study, it is necessary to define some of the associated terms, listed here:

- **Asian American:** Racial group having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (Office of Minority Health, 2011).
- **Breast self examination:** Self-inspection of one’s own breasts (Mayo Clinic staff, 2011).
- **Cancer:** A general name for a group of diseases in which abnormal cells divide without control (National Cancer Institute, n.d.).
- **Clinical breast examination:** An inspection of one’s breasts by a health professional (American Cancer Society, 2010).
- **Colonoscopy:** An examination of the inside of the colon using a colonoscope (National Cancer Institute, n.d.).
- **Fecal occult blood test (FOBT):** A test that checks for blood in the stool (National Cancer Institute, n.d.).
- **Human Papillomavirus test.** A test, also called the HPV DNA test, in which cells are scraped from the cervix to look for DNA of human papillomaviruses (HPV) (National Cancer Institute, n.d.).
**Mammogram:** An examination of the breast using an x-ray (National Cancer Institute, n.d.).

**Pap test:** Also known as the pap smear, an examination in which cells are scraped from the cervix to detect cancer or any changes that may lead to cancer (National Cancer Institute, n.d.).

**Sigmoidoscopy:** An examination of the lower colon using a sigmoidoscope (National Cancer Institute, n.d.).

**PREVIEW OF THE LITERATURE REVIEW**

Although disparities in cancer incidence, mortality, and screening utilization are existent in the AA population, they have received little attention in cancer control research studies or intervention programs (Kagawa-Singer & Pourat, 2000). Data collected on the AA population are often aggregated, making obscure any distinct cultural, demographic, socioeconomic, historical, and linguistic differences within the AA subgroups (Chen, 2005) and hide vulnerable populations (Kagawa-Singer et al., 2010). AA incidence and mortality rates for certain cancers are lower compared than non-Hispanic Whites, until the data on the population is disaggregated (Kagawa-Singer & Pourat, 2000), revealing that AA subgroups suffer from cancer disproportionately compared to other major racial groups (Kandula, Wen, Jacobs, & Lauderdale, 2006).

The AA population is a diverse group that embodies various countries of origin, languages, religions, and cultural practices (Ghosh, 2003), any of which may influence “access to health information, health maintenance opportunities, health care, and health outcomes” (Sadler et al., 2003, para. 1). Although cancer screening tests are an effective tool to reduce mortality from cancer, screening rates in the AA population are lower compared to other major racial groups (Kagawa-Singer & Pourat, 2000). Research shows that several factors may play a role in AA women’s cancer screening behaviors. These include: lack of knowledge and awareness about cancer prevention, language barriers, cultural differences, and access to care.

**PREVIEW OF THE METHODOLOGY**

To better understand AA women’s perceptions and understanding of cancer screening, a qualitative exploratory study was conducted, in which participants were asked to complete a brief health survey and a 30-45 minute in-depth interview. A qualitative study
was chosen because of its strength and ability to capture rich descriptions of experiences from the participant’s perspective.

A total of 26 AA women participated in the study. All surveys were collected and analyzed using descriptive statistics on SPSS for PC. Interviews were transcribed, and through constant comparison analysis, themes were developed.

**THEORY**

This study was based on Albert Bandura’s (2004) social cognitive theory (SCT), with particular attention to outcome expectations, self-efficacy, and observational learning. The SCT posits that people “do not operate as isolates” (Bandura, 2004, p. 144); rather, that human behavior is the product of “interplay of personal, behavioral, and environmental influences” (Glanz, Rimer, & Viswanth, 2008, p. 170). SCT is a well-supported conceptual framework and is comprehensive in helping understand “the factors that influence human behavior and the processes through which learning occurs, offering insight into a wide variety of health-related issues” (Glanz et al., 2008, p. 175).

Core determinants include knowledge of health risks and benefits of different health practices; perceived self-efficacy that one can exercise control over one’s health habits; the health goals people set for themselves, and the concrete plans and strategies for realizing them; and the perceived facilitators and social and structural impediments to the changes they seek (Bandura, 2004).

Interview questions related to outcome expectations examined perceptions of the consequences of engaging in cancer prevention behaviors, including the positives and negatives of cancer screening, events that led to the participant’s initial screening test, and whether or not she would repeat the screening examination and why. Self-efficacy refers to a person’s beliefs about her own ability to perform a behavior. To gauge the confidence a participant had in performing a health behavior, questions were asked about personal engagement in cancer prevention activities and the influence of other women in the participant’s decision to screen for cancer. The final construct used in the interview guide, observational learning, involves exposure to interpersonal or media displays of the behavior and the consequences associated with engaging in the behavior (Glanz et al., 2008). Interview questions related to observational learning pertain to the participant’s source(s) of
health information and her knowledge of whether other women she knows with similar ethnic backgrounds screen for cancer.

**SIGNIFICANCE OF THE STUDY**

This research may assist in laying the groundwork for follow-up qualitative studies regarding health and cancer screening in AA women. Additionally, through better understanding of AA women’s perception of health, cancer, and cancer screening, interventions may be better tailored and improve the practice of health promotion and cancer prevention strategies.

**LIMITATIONS**

It is important to note the limitations to this study. First, results may not be generalizable to the broader female AA population given that participants were generally well acculturated and could speak and understand English. In addition, this study was based on a convenience sample of twenty-six AA women, with the majority of Filipino descent. Potential bias may emerge since three interviews were conducted over the phone, whereas the remaining twenty-three were face-to-face interviews. To combat these limitations, future studies should include assessment of more AA women of different ethnicities and acculturation levels to strengthen comparisons between groups. It would also be helpful to interview women who do not regularly engage in cancer screenings to further explore any barriers or perceptions they may possess.

However, despite these limitations, the strength in this study lay in the insights brought forth by each interview. Qualitative research is not grounded in numbers, but rather is designed to gain a better understanding of a phenomenon “in terms of the meanings people bring to them” (Greenhalgh & Taylor, 1997, p. 740). As such, this study captured contextual factors that may be missed in traditional, quantitative methods of data collection. This is apparent when comparing participants’ health survey results to their interview responses. Participants were asked their most preferred method for receiving health information, and almost 60% reported they read brochures/pamphlets, followed by 50% who reported using a website. However, interviews illustrated that participants were more likely to receive information from their social contacts, such as family, friends, and co-workers via word-of-mouth. Participants also shared that they spoke to their family, friends, and healthcare
provider during times of health concern. Data triangulation showed that the answers reported in the interviews enhanced, and sometimes altered, the responses from the written health survey.

**SUMMARY**

This study aimed to answer the question: what factors are associated with Asian American women’s health decisions, especially in choosing to screen for cancer? The Office of Minority Health (2005) suggests that health care professionals and services that recognize and appreciate “the health beliefs, practices, and cultural and linguistic needs of diverse patients can help bring about positive health outcomes” (para. 2), making it crucial to better understand AA women’s perceptions on health and cancer screening.
CHAPTER 2

LITERATURE REVIEW

Although screening tests, such as the pap test, mammogram, and colonoscopy, have been shown to be effective in detecting certain types of cancer at an early stage (National Cancer Institute, 2010), screening rates are low and the burden of preventable cancers (such as breast, cervical, and colorectal cancer) remain high in the Asian American (AA) population (Kagawa-Singer & Pourat, 2000). While the research on this population is limited, some studies appear. To better understand AA women’s cancer screening decisions, a review of those studies follows.

ASIAN AMERICANS

AAs are defined as people who have origins in the Far East, Southeast Asia, or the Indian Subcontinent (Office of Minority Health, 2011). Comprising about five % of the U.S. population in 2010 (Humes, Jones, & Ramirez, 2011), the 2010 U.S. Census reported the AA population as having experienced the fastest rate of growth compared to all other major racial groups between 2000-2010. The AA population has roots in at least twenty-nine countries and speaks over a hundred languages and dialects. Because AAs represent multiple countries, cultures, and languages, they are not at all a homogenous group (Ghosh, 2003). Thus, the ways in which these populations approach health care varies considerably.

CANCER DISPARITIES IN ASIAN AMERICAN WOMEN

Although AAs have low cancer incidence and mortality rates compared to other major racial groups, disaggregated data show that great variance and disparities exist among Asian subgroups (Kwong, Chen, Snipes, Bal, & Wright, 2005). In fact, cancer is the leading cause of death in AAs 25-44 years old and 45-64 years old (Chen, 2005). McCracken et al.’s (2007) study, which compared Asian subgroups in California, revealed that Filipino women had a breast cancer mortality rate of 17.5 per 100,000 compared to Korean women at 7.7 per 100,000, Vietnamese women at 9.0 per 100,000, Chinese women at 13.2 per 100,000, Japanese women at 17.1 per 100,000, and non-Hispanic White women at 27.4 per 100,000.
The incidence rate of cervical cancer in Vietnamese women was 14.0 per 100,000 compared to total Asian Pacific Islander (API) women at 8.8 per 100,000 and non-Hispanic White women at 7.3 per 100,000. Finally, McCracken et al. also found that Japanese women died from colorectal cancer at a rate of 15.1 per 100,000, compared to total API women at 11.6 per 100,000 and non-Hispanic White women at 15.7 per 100,000.

Southeast Asian women present later-stage cervical cancer diagnoses and have the highest mortality rate of all ethnic groups (Kagawa-Singer & Pourat, 2000). Cancer screening tests may detect cancer at an early stage when treatment is more effective, making tailored interventions to increase cancer screening in AA women all the more important (Henley, King, German, Richardson, & Plescia, 2010). The five-year survival rate for women with late-stage breast cancer diagnosis is 23%, compared to localized breast cancer diagnosis at 98%. The five-year survival rate for women with late-stage cervical cancer diagnosis is 17%, compared to localized cervical cancer diagnosis at 92%. The five-year survival rate for late-stage colorectal cancer diagnosis is at 11%, compared to localized colorectal cancer at 91% (Henley et al., 2010).

**Cancer Screening in Asian American Women**

According to the National Cancer Institute (2010), screening tests may help detect certain types of cancer at an early stage or before a person has symptoms. Early detection plays an important role in reducing cancer-related mortality since cancer treatment may be more effective the earlier abnormal tissues are found (National Cancer Institute, 2010). Common screening tests include: the breast self-examination, clinical breast exam (CBE), and mammography for the early detection of breast cancer; the Pap test and human papillomavirus (HPV) test for the early detection of cervical cancer; and the high-sensitivity fecal occult blood test (FOBT), sigmoidoscopy, and colonoscopy (either used alone or in combination with each other) for the early detection of colorectal cancer.

According to the American Cancer Society (2010), all women are recommended to screen for cervical cancer annually about three years after they begin having vaginal intercourse or no later than age 21. In addition, CBEs are recommended every three years for women in their 20s and 30s and every year starting at age 40. Annual mammograms are recommended starting at age 40. Starting at age 50, men and women are encouraged to
engage in a variety of tests that screen for colorectal cancer and polyps. Although cancer screening has shown to be an effective tool to reduce mortality from cancer, screening rates among the AA population are the lowest compared to all racial groups (Kagawa-Singer & Pourat, 2000).

Of all racial groups, AA and PIs have the lowest cancer screening rates (Kagawa-Singer & Pourat, 2000). Compared to White women at 5%, AA and PI at 21% have never had a pap test. AA and PI women at 30% have never had a mammogram compared to White women at 21% (Kagawa-Singer & Pourat, 2000). AA and PI women in the United States had the lowest percentage of women age 18 years and older who reported having a pap smear within the last three years at 75.6% compared to Black women at 87.2%, White women at 84.5%, and Hispanic women at 81.6% (Kaiser Family Foundation, 2006).

In 2008, the Centers for Disease Control and Prevention (CDC) reported that 66.1% of AA women aged 40 years and older have had a mammogram in the last two years, compared to White women at 67.9% and Black women at 68.0% (National Center for Health Statistics, 2010). Whites, African Americans, and Latinas, at 78.1%, 78.5%, and 69.9%, respectively, have had a mammogram in the past two years, meeting the national Healthy People 2010 objective to have 70% of U.S. women age 40 and older receive a mammogram at least every two years. AA women at 67.2%, however, have yet to meet that same objective (Gomez, Tan, Keegan, & Clarke, 2007). To further illustrate that cancer screening continues to be a national issue, Healthy People 2020 aims to: increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines, increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines, and increase the proportion of women who receive a breast cancer screening based on the most recent guidelines (Healthy People 2020, 2011).

Wong, Gildengorin, Nguyen, and Mock’s study (2005), which compared colorectal cancer screening in Asian subgroups and non-Hispanic Whites, demonstrated that, overall, colorectal cancer screening, which includes the FOBT, sigmoidoscopy, and/or colonoscopy, was lower among Asian subgroups at 58% for any type of colorectal cancer (CRC) screening, compared to 75% for any CRC screening in Non-Hispanic Whites.
THE NEED TO BETTER UNDERSTAND ASIAN AMERICAN WOMEN’S HEALTH BEHAVIORS

Lack of accuracy and attention to AAs may stem from William Peterson’s 1966 Model Minority Myth that argued that “Asian cultures, with their emphasis on family values and strong work ethics enabled Asian Americans to overcome prejudice and to avoid becoming a ‘problem minority’” (Islam, Trinh-Shevrin, & Rey, 2009, p. 4). Though this AA profile attempted to shed a positive light, the incomplete and misleading perception concealed the health problems and needs of the AA population (Islam et al., 2009). Lin Fu’s (1988) research on the inadequate research on the AA population brought forth greater awareness about AA health disparities, bringing to light the need for researchers to improve documentation and assessment practices on AA health. Early work on cancer illustrated that many AAs are “disproportionately affected by cancers of the liver, breast, cervix and stomach compared to other groups” (Islam et al., 2009, p. 7).

The Office of Minority Health (2005) suggests that culturally competent health care professionals and services is “one of the main ingredients in closing the disparities gap in health care.” Unfortunately, however, little progress has been made to better understand potential factors of health decisions in the AA population (Kagawa-Singer et al., 2010).

POTENTIAL FACTORS RELATED TO ASIAN AMERICAN WOMEN’S CANCER SCREENING BEHAVIORS

Prior cancer-prevention studies in the AA population have shown that lack of knowledge and awareness about cancer and cancer prevention and language barriers are recurrent themes that highlight possible reasons for cancer disparities. Denberg, Wong, & Beattie’s study (2005) of perceptions of cancer from racially and socially diverse women demonstrated that misconceptions about cancer and cancer prevention strategies are common across all groups, including AA women, and may compromise the quality of screening decisions. For example, when interviewing women about their perceptions on screening for cancer, there was belief in the misconception that screening was only necessary if one had symptoms or family history. It was also common for women to think that screening provided a level of protection from disease. Similarly, Nguyen, Leader, and Hung’s (2009) revealed that young AA women, compared to young White women, were the least informed about the HPV vaccine. This demonstrates that fundamental cancer screening knowledge (such as what
screening is and is not, benefits, and potential consequences) may not be effectively communicated to the AA population. Thus, the messages are not acted upon and may also allow the opportunity for misconceptions and myths to spread.

Cultural practices and beliefs towards a cancer diagnosis played a predictive role in whether or not an AA would participate in cancer screening. Herbal or alternative medicines are commonly used throughout the AA population, and belief in “luck” or “fate” has many women thinking that absence of a cancer diagnosis is simply “repayment of one’s good deeds” (Wang, Sheppard, Schwartz, Liang, & Mandelblatt, 2008, p. 1972). Different beliefs in the etiology of disease also exist in certain AA subgroups, such as Hmong, in which biomedical treatment may infuriate a spirit or because a disease is spirit-based, prevention or treatment may be ineffective (Lee & Vang, 2010). Traditional Asian views towards health also tend to be more holistic, linking mind, body, and soul, and focusing on moderation and balance. Some disorders are perceived as caused by an excessive intake of a certain type of food or over-exposure to particular kinds of weather (Kaiser Permanente National Diversity Council, 2003).

Sadler, Ryujin, Ko, and Nguyen’s (2001) study found that “virtually all women preferred to be interviewed in Korean” (p. 4), which illustrates the need to focus on multilingual communication given an increasingly multilingual society who may also have limited English proficiency (LEP). Providing opportunity to communicate in languages other than English may empower AAs to share their health needs and wants with their physician and other healthcare professionals, as well as to better understand the need to screen for cancer.

Finally, understanding AA family structure and the role that women play may also shed light on their health decision-making. Certain AA populations, such as Hmong, are patriarchal, meaning males in the household have strong influence on a family member’s decision to utilize health care services (Lee & Vang, 2010). Lee suggests that with modesty being a widespread concern, male heads of the household and women may feel uncomfortable and anxious over certain screening tests, evident in traditional Korean culture in which openly discussing topics of sexuality, the breasts, or cervix is considered taboo. In addition, even the translation of “breasts” in Korean is indirectly and modestly labeled as “milk room” or “front chest” (Lee, Tripp-Reimer, Miller, Sadler, & Lee, 2007, p. 717). In
collective populations such as AAs, women are willing to value the welfare of a group over their own, often resulting in non-adherence to physician recommendations (Lee & Vang, 2010).

**SUMMARY**

Given the diversity of the AA population, women’s approaches to health care may vary. Studies showed factors such as lack of knowledge and awareness about cancer prevention, language barriers, and cultural differences may influence AA women’s cancer screening behavior.

Studies also show that in comparison to other major racial groups, AA women have the lowest cancer screening utilization (Kagawa-Singer & Pourat, 2000). Although program planners and physicians may feel that considering culture is a reinforcement of stereotypes (Denberg et al., 2005), in actuality, improved understanding of the various perspectives and beliefs that patients hold can be used as an effective tool to better communicate health needs to the AA population and close the gap of health disparities.
CHAPTER 3

METHODOLOGY

To gain a better understanding of health, cancer, and cancer screening from the perspective of Asian American (AA) women, a qualitative exploratory study was conducted. Participants were asked to complete a brief health survey (see Appendix A) and participate in an in-depth interview (see Appendix B). A total of 26 women completed the study, all of whom were residents of San Diego County, identified as Asian American, may or may not have had a prior history of cancer, able to speak and understand English, and 40 years old or above. Survey data were analyzed with descriptive statistics using SPSS for PC, while interview data were transcribed and then coded for themes and patterns using NVivo 9 (QSR International, 2010) for PC.

RESEARCH DESIGN

This qualitative exploratory study used in-depth interviews to elicit insight into AA women’s cancer screening decisions. A brief health survey and interview questions generated data on the following: perceptions, beliefs and knowledge of health, cancer and cancer screening, utilization of services, health communication preferences, and the impact of social contacts. Upon review of prior qualitative cancer-related studies, interview questions also included who the participant approaches when she has a health concern; the role of family, friends, and religion in her health; and any health beliefs and/or personal perspectives. Because these are concepts that are not easily assessed in a quantitative study, in-depth interviews allowed women to speak freely and provided the researcher an opportunity to follow up and delve deeply into any ideas mentioned that were not clearly understood. The study protocol was reviewed and approved by San Diego State University’s Institutional Review Board.

THE RATIONALE FOR A QUALITATIVE STUDY

Qualitative research, “pragmatic, interpretive, and grounded in the lived experiences of people” (Marshall & Rossman, 2010, p. 2), is a broad approach to the study of social
phenomena. The strength of qualitative research lies behind “its ability to provide complex
textual descriptions of how people experience a given research issue” (pg. 1) and may
provide richer insight into identifying intangible factors, such as social norms, gender roles,
and religion (Mack, Woodsong, MacQueen, Guest, & Namey, 2005).

Modes of data collection for qualitative research include observation, life history,
narrative inquiry, and in-depth interviewing (Marshall & Rossman, 2010). As context and
culture may not be accurately captured through quantifiable methods, this exploratory study
used open-ended interview questions to elicit participant opinions. The interviews led to a
fairly comprehensive understanding of factors associated with Asian American women’s
health decisions.

In-depth interviews are regarded as an optimal mode of data collection of individuals’
personal histories, perspectives, and experiences (Mack et al., 2005) and are efficient in
yielding large quantities of data as well as allowing the researcher to understand the
meanings attached to day-to-day activities (Marshall & Rossman, 2010).

**Sampling and Interview Setting**

Community-based organizations and personal contacts were used to recruit potential
study participants. The brief health survey and interview took place at the participant’s
location of choice in San Diego County, such as the participant’s home or at a local
restaurant or coffee shop. When necessary, the interview was conducted over the phone. All
participants were San Diego County residents, female, identified as Asian American, who
may or may not have had a prior history of cancer, were able to speak and understand
English, and were 40 years old or above. Age is an important variable given that those 40 and
older are recommended to screen for certain cancers, including breast and colorectal cancer.
Interviews were conducted until theoretical saturation was reached, the point at which new
data collected no longer brings additional information to the research (Marshall & Rossman,
2010).

Recruitment came in the form of mass email distribution and verbal announcements
at two Filipino health and wellness organizations’ meetings and a Chinese women’s social
group meeting. A total number of contacts cannot be provided because of the broad nature of
the recruitment effort. Women who were interested in the study were asked to respond via
email or phone call to arrange a convenient meeting time for the interview. A total of thirty-three women expressed interest in participating in the study; however, only twenty-six were interviewed. At least five women explicitly refused to participate in the study, noting that their reason was that the topic addressed was cancer. After the researcher explained the nature of the study at the meetings, these non-participant women stated either that they did not have cancer or did not know anything about cancer and, therefore, had no interest in participating in the study. Time constraints or loss of contact caused the removal of the seven from the study.

**DATA COLLECTION INSTRUMENTS (HEALTH SURVEY AND INTERVIEW GUIDE)**

Participants completed a health survey (see Appendix A), consisting of demographics and preferences on health communication strategies. They then proceeded to complete a one-time in-depth interview (see Appendix B). The interview format was open-ended and structured around Bandura’s social cognitive theory, with particular attention to the concepts of outcome expectations, self-efficacy, and observational learning. Topics of discussion included the following: the participants’ general perceptions and knowledge of health, cancer and cancer screening tests; the knowledge of whether other women from the same ethnic background as the participant screen for cancer; cancer screening experiences; and the influence of social contacts and personal beliefs on the participant’s health. To gauge the participants’ perception of effective communication towards women with their similar background, a question was also asked as to how they would encourage other women of their background to screen for cancer.

**PROCEDURE**

All interviews were conducted by the researcher and audio-recorded, with permission from the participant, for accuracy and transcribing purposes. All questions from the interview guide were asked and unclear responses were further explored. Interviews were conducted from January 21st, 2011, to March 1st, 2011, and ranged in length from 30-45 minutes. The audio recordings were used to transcribe each interview.
ANALYSIS

Constant comparison analysis, the process of comparing events, experiences, and perceptions of each participant for similarities and differences (Corbin & Strauss, 2008), was used to generate meanings and develop codes. After the completion of each interview, the audio was played back and transcribed verbatim. Each transcript was read once before being manually analyzed with memos and preliminary codes and themes. Transcripts were organized by date of interview completed and analyzed further using qualitative analysis software NVivo 9 (QSR International, 2010) for PC.

Preliminary codes were entered in NVivo 9 (QSR International, 2010) and refined. Recurring concepts, as well as differing concepts, were noted, resulting in a total of three major categories: perceptions, social relationships, and relationship with healthcare provider. Corbin and Strauss’ (2008) work noted that “higher level concepts… represent relevant phenomena”, (p. 159). Lower-level concepts under each category were also developed and coded accordingly. In addition, descriptive statistics (frequencies and averages) were produced for the health survey data and calculated using SPSS for PC.

SUMMARY

A brief health survey and an in-depth interview were given to 26 participants in order to better understand AA women’s health decisions, especially in choosing to screen for cancer. A qualitative exploratory approach was used because of its ability to identify intangible concepts such as social norms, gender roles, and religious beliefs—concepts not easily captured in quantitative studies. Descriptive statistics were calculated from the brief health survey on SPSS for PC. Interview data were audio-recorded for accuracy and transcribing purposes. After each interview was transcribed, themes regarding perceptions of health, cancer, and cancer screening were generated.
CHAPTER 4

RESULTS

Given that cancer is the leading cause of death in the AA population and that cancer screening rates in the AA population are lower compared to other major racial groups, a brief health survey and in-depth interview were administered to gain a deeper understanding of AA women’s cancer screening decisions. A total of 26 AA women participated in the study. Findings show that (a) accurate knowledge is important to make an informed health decision, (b) social contacts may be instrumental in raising awareness about health and cancer issues, and (c) having healthcare coverage and a relationship with a healthcare provider is helpful in providing access to and utilization of cancer screening tests.

QUANTITATIVE FINDINGS

A total of 26 Asian American (AA) women completed the survey and interview. Table 1 presents the demographic characteristics of the study participants, showing that participants’ ages ranged from 40-75 years with the average age of 51.62 years. A total of 73% (n=19) were born outside of the United States. The mean of the number of years lived in the United States was 37.28 years. A total of 65% (n=17) of participants identified themselves as Filipino, 19% (n=5) as Chinese, and the remaining participants represented the following ethnicities: Cambodian (n=1), Korean (n=1), Laotian (n=1) and Vietnamese (n=1).

Table 2 shows the health information preferences of participants. Eighty-one percent (n=21) of participants indicated that their preferred way to receive health information is via their doctor/health care provider. Other preferred vehicles for health information include brochure/pamphlet (n=15), website (n=13), word-of-mouth (n=13), and newspaper and/or magazine (n=11). The least preferred ways of receiving health information were from posters and cell phone. Ninety-two percent (n=24) of the participants preferred receiving health information in the English language.
Table 1. Demographic Characteristics of Study Participants (n=26 Persons)

<table>
<thead>
<tr>
<th>Demographic Characteristics</th>
<th>Category</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Category</td>
<td>40-45 years</td>
<td>7</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>46-50 years</td>
<td>6</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td>51-55 years</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>56-60 years</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>61-65 years</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>66-70 years</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>71+ years</td>
<td>4</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Not Recorded</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Born in the United States?</td>
<td>No</td>
<td>19</td>
<td>73%</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>7</td>
<td>27%</td>
</tr>
<tr>
<td>Length of Years Lived in</td>
<td>0-10 years</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>the United States</td>
<td>11-20 years</td>
<td>4</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>21-30 years</td>
<td>7</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>31-40 years</td>
<td>4</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>41-50 years</td>
<td>6</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td>51-60 years</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>61-70 years</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>71+ years</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Not Recorded</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Filipino</td>
<td>17</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Chinese</td>
<td>5</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>Cambodian</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Korean</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Laotian</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Vietnamese</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

1Totals may not sum to 100% due to rounding.

Additional survey findings revealed that the doctor/health care provider was the most preferred source of health information (n=22), followed by the internet (n=14), books (n=8), and family and/or friends (n=7). None of the participants expressed interest in using the television and/or radio as a source of retrieving health information. Totals may not sum to the total sample because participants could choose more than one response.

Table 3 shows screening behavior of participants. All participants stated having had a cancer screening test done in the past. Eighty-five percent (n=22) of participants have had a mammogram, 77% (n=20) reported having had a pap test, and 35% (n=9) have had a colonoscopy. Seventy-seven percent (n=20) of participants reported having had at least one
Table 2. Health Information Preferences of Study Participants (n=26 Persons)

<table>
<thead>
<tr>
<th>Health Preferences</th>
<th>Category</th>
<th>n</th>
<th>Percent¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>In what language do you prefer getting health information?</td>
<td>English</td>
<td>24</td>
<td>92%</td>
</tr>
<tr>
<td></td>
<td>Pilipino²</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>In what way do you prefer getting health information?</td>
<td>Doctor</td>
<td>21</td>
<td>81%</td>
</tr>
<tr>
<td></td>
<td>Brochure/Pamphlet</td>
<td>15</td>
<td>58%</td>
</tr>
<tr>
<td></td>
<td>Website</td>
<td>13</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Word-of-mouth</td>
<td>12</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>Newspaper/Magazine</td>
<td>11</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>Email</td>
<td>5</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>Radio</td>
<td>5</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>Television</td>
<td>4</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Poster</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Text (Cell phone)</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>If you wanted to find out information about health, where would you go?</td>
<td>Doctor/Healthcare provider</td>
<td>22</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>Internet</td>
<td>14</td>
<td>54%</td>
</tr>
<tr>
<td></td>
<td>Books</td>
<td>8</td>
<td>31%</td>
</tr>
<tr>
<td></td>
<td>Family and/or friends</td>
<td>7</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>Newspaper and/or magazine</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Radio announcement</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Television (ads, news, show)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Other³</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>26</td>
<td>--</td>
</tr>
</tbody>
</table>

¹ Percentages may not add up to 100% because persons may choose as many responses as they desired.
² Pilipino also includes Tagalog.
³ Other includes: seminars (n=1)

screening test done within the last 12 months; however, 12% (n=3) reported their last screening test was performed more than three years ago.

**Qualitative Findings**

A total of three themes were identified as important in AA women’s cancer screening decisions: perceptions, social relationships, and the healthcare provider. Within each theme were various subthemes. For the theme on perceptions, subthemes were specific to a topic, which included: health, cancer, and cancer screening. For social relationships, subthemes included: knowing a family or friend affected by cancer, social contacts as an information source, the role(s) of family and friends, and encouraging other women to screen for cancer. Subthemes within the healthcare provider theme included: having healthcare coverage and
Table 3. Screening Engagement of Study Participants (n=26 Persons)

<table>
<thead>
<tr>
<th>Screening Behavior</th>
<th>Category</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a medical test that helped check for cancer?</td>
<td>Yes</td>
<td>26</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>If you have had a medical test that checked for cancer, which test did you get?</td>
<td>Mammogram</td>
<td>22</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>Pap test</td>
<td>20</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td>Breast self-examination</td>
<td>12</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>Clinical breast-exam</td>
<td>12</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>Colonoscopy</td>
<td>9</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Stool test</td>
<td>7</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>Other2</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>When was the last time you had at least one of these medical tests3?</td>
<td>Within last 12 months</td>
<td>20</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td>&gt;1 year but &lt;2 years ago</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>&gt;2 years but &lt;3 years ago</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>&gt;3 years ago</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>26</td>
<td>--</td>
</tr>
</tbody>
</table>

1 Percentages may not add up to 100% because persons may choose as many responses as they desired.
2 Other includes (n=1 each): follow-up to mammogram (diagnostic test), thyroid, ultrasound.
3 Test options include: colonoscopy, mammogram, pap test, or other test that checks for cancer.

access to screening tests, having persistent recommendation from the healthcare provider, and the role(s) of the healthcare provider.

**KNOWLEDGE AND PERCEPTIONS OF HEALTH, CANCER AND SCREENING**

To deepen the understanding of AA women’s health decisions, especially in choosing to screen for cancer, participants were asked about their opinions on and experiences in health, cancer, and cancer screening. In this theme, three subthemes were generated: perceptions on health, perceptions on cancer, and perceptions on cancer screening. The importance of this theme is that this information may be used as a basis to provide accurate information and dispel any misconceptions about health, cancer, or cancer screening in future tailored cancer screening interventions.

**Perceptions of Health**

In general, each participant understood that health involved one’s physical well-being. Moreover, half the participants also acknowledged that being healthy included emotional, mental, and social well-being, highlighting that health may be affected not only
by diet and physical activity, but also by relationships with others and other negative and positive stressors. This understanding is displayed in the following quote:

…free of pain and… have a positive anticipation for life, y’know, you’re not depressed or anything like that… that you look forward to everyday kind of things; your quality of life is good in that you have good relationships with people and you have something constructive to do and you feel healthy. (Filipino, 49 years old)

However, three participants stated that although they are aware of factors that may affect their health, including a healthy diet and active lifestyle, they also revealed that they are affected by a level of satisfaction related to a healthful behavior because “We know it’s [certain unhealthy food] is bad for me, but who cares? We just gonna live once” (Filipino, age not specified). In a similar case, a participant also stated:

…my husband said, “let’s go start eating healthy food” and all that. And I said, “even if I eat healthy food, I mean, you never know, you might die the next day. Might as well me eat all the foods that I want.” I’d rather enjoy life then me, like, later on, “why didn’t I do this? I’m gonna die, anyway… I know it’s not the philosophy that you’re supposed to do…” (Filipino, 50 years old)

For 69% of participants (n=18), religion/spirituality played a role in their health. Thirty-five percent of participants (n=9) found comfort in their religion/spirituality, in that it provided a sense of peace and stress reduction. Four participants found that their religion/spirituality directly guided their behavior. For instance, one 44 year old Laotian said:

My decision to stay healthy and be healthy has a lot to do with my religion… y’know, the no drinking, the no smoking, no drugs, healthy eating and stuff like that has a lot to do with my belief as well.

A 51 year old Filipino participant observed that, in comparison to where she grew up, her religious/spiritual behavior better incorporates physical well-being also. She stated:

Well, I’m part of a bible study… and so one of the things we’ve been talking about, for some reason or another, is to keep ourselves not only spiritually healthy but physically healthy. So there’s, like, an encouragement from each of us to really do physical exercise. … Growing up in the Philippines, no - spiritual is spiritual. We never talk about food, we never talk about doing exercise. It’s more like coming together for prayer, for worship, but it’s never, like, coming together to do something healthy physically.

Participants’ perception of health also involved the existence of common health beliefs in their specific racial group. The most commonly mentioned and existent belief in the responses of Chinese, Filipino and Vietnamese participants (n=6) was the use of traditional/alternative medicines and treatments, with one participant stating, “…they have
more faith in the herbal medicine and feel that they don’t really need to have screenings and they may believe that they can deal with some of the issue with acupuncture or whatever else” (Chinese, 58 years old). Compared to Filipino participants, the Chinese, Lao and Vietnamese participants all mentioned balance and a holistic approach to health as a common belief, as illustrated in the following: “I think that Chinese medicine looks at you as a whole person in ways that Western medicine doesn’t” (Chinese, 41 years old).

Other participants commented that prevention, such as regular physical exams and/or screening, was not a significant health concern, especially if they did not grow up in the United States. Reasons for this varied from prevention being outside of the cultural norm, the understanding that the only purpose of going to the doctor is because one is sick, lack of access, and monetary issues associated with doctor visits. These concepts are illustrated in the following quotes:

… traditionally in the Vietnamese culture, you don’t go for screenings. You go to see your providers when you’re sick. You don’t go to see them just for a physical exam. So that’s the thought they’re raised with. But since you’ve been here, we know that prevention is always better. (Vietnamese, 40 years of age)

I think older, my parents’ generation are the ones that we can’t convince them to go [engage in cancer screening]. I think our generation, I guess the people who grew up here, are more inclined to just take care of themselves. … I think because they grew up in the Philippines, they think going to the hospital, they come out and think they’re dying. Actually, it’s because you go into the hospital too late. (Filipino, 48 years of age)

Some people… it’s like a monetary thing. They don’t wanna go to the doctor because just to go to the doctor, it’s money. And medicines and everything. So I think most of the Filipinos doesn’t wanna think that way because they don’t wanna spend money. But here, we’re lucky. We have free medical and everything. (Filipino, age not specified)

The following were also cited as common health beliefs: females playing the caretaker role and, thus, “not encourage[d] to take care of themselves… encouraged to take care of other people” (Chinese, 58 years old) and general passivity and lack of interest when it comes to health.

**Knowledge and Perceptions of Cancer**

When participants were asked about their immediate thoughts on cancer, the eventual result of death was a common reaction. Most participants viewed cancer as a disease that is “bad,” fearful, stressful, and, ultimately, “terminal” and “an awful way to die.” “It’s like
when you hear ‘cancer,’ you think you’re gonna die the next day,” expressed one 50 year old Filipino participant. The idea that cancer removes one’s ability to function normally and places burden on others was also a common reaction, as displayed in the following quote: “You may have to stop working… even you need someone to look after you. That’s gonna take, of course, time and energy on their part. It’ll worry them, the people you love” (Filipino, 49 years old). However, there were few participants who were hopeful in the outlook of cancer. “Before I used to think that it’s uncurable, but now, you can prevent it, especially on the first stage. ‘Cause I have living proof – my sister. She had it on the first stage and now she is cancer free” (Filipino, 49 years old).

When asked about potential causes of cancer, participants, in general, expressed an understanding that having an unbalanced diet and a sedentary lifestyle may cause cancer, as well as exposure to pollutants in the environment. Family history and genetics were also identified as potential causes of cancer. Few participants (n=5), however, expressed concern about the inconsistency of hearing about persons who lead a healthy lifestyle yet were still diagnosed with cancer. A fifty-year-old Filipino participant expressed, “I hear a lot of stuff that sometimes you don’t do this, you don’t do that, you eat healthy food, you exercise, and then, all of a sudden, you have cancer. Where does that come from?” Though there was understanding that limiting risk behaviors, such as smoking or having a poor diet, may reduce the chances of getting cancer, inconsistencies such as the one mentioned above have led some participants to think that a cancer diagnosis is merely ruled by fate, or as one participant (Laotian, 44 years old) stated, “luck of the straw.”

**Knowledge and Perceptions of Cancer Screening**

Similar to participants’ general understanding of factors that affect health, there was also an awareness of cancer prevention strategies. When asked about the prevention of cancer, the most common answers were lifestyle choices, including diet, physical activity, and reducing environmental exposures. Interestingly, only 50% (n=13) directly mentioned screening as a way to prevent cancer. When asked about personal engagement in cancer prevention behaviors, lifestyle choices, again, were most commonly mentioned at 58%. Engaging in screening tests, such as the mammogram, colonoscopy, or pap test was only
mentioned by 35% of participants, even though each participant reported having had a screening test in the brief health survey.

When participants were asked about their knowledge of cancer screening tests, 69% (n=18) knew of types of screening tests, with the mammogram, colonoscopy, and pap test most commonly mentioned. Forty-six percent (n=12) said they knew that the purpose of screening tests was to detect any abnormalities in particular parts of the body, with one respondent stating,

They look to see what’s going on in terms of early tumor development or other problems… so they’re really just markers for problems that might be there. If it comes back funny, then you come back for the next level of the test. (Korean, 40 years old)

Three participants did not have much knowledge about screening tests aside from knowing that they were recommended by their physician. Five participants reported engaging in cancer screening tests regularly but did not have much knowledge about them, illustrated by the following quote: “I really don’t know what does it mean but I know it’s the mammogram, everything. Everything laboratory” (Filipino, age not specified).

Eighty-five percent (n=22) of respondents reported early detection as one of the positives of having a cancer screening test. The following quote, “If you have screening test, you would be able to detect, early treatment for that one and… you would probably have a higher chance of surviving” (Filipino, 61 years old), indicates that participants acknowledge that engaging in cancer screening tests has the potential to detect cancer and/or other abnormalities at an early stage. Several participants also mentioned that participating in screening tests provides peace of mind and accomplishment, as illustrated in the following, “And when you get that ‘everything’s fine,’ it feels really good” (Chinese, 62 years old) and “It’s a routine thing and it gives you peace of mind in knowing that you don’t have cancer at that time” (Chinese, 71 years old). This suggests that the absence of cancer may be just as important to know as a cancer diagnosis.

The negatives associated with engaging in cancer screening tests included: stress; physical discomfort or pain; cost/access; inconvenience; prior bad experiences; diminished sense of choice; and conflicting information regarding screening recommendations. Nine participants indicated that waiting for the test results and facing the potential of a positive result was a negative aspect to cancer screening due to the stress and worry incurred, with
one participant (Filipino, 50 years old) stating, “If I have cancer, I don’t really kind of wanna know ‘cause… I’m thinking that I’m not gonna die of cancer, I’m gonna die of stress thinking about it!” In addition, a 42-year-old Cambodian participant said she was prolonging cancer screening testing until she is “mentally ready.”

Inadequate access and costs related to screening were also commonly mentioned throughout the interviews, as illustrated in the following response, “If they don’t have any coverage… they may choose not to because they can’t afford it” (Vietnamese, 40 years old). Twenty-three percent of participants also mentioned the physical discomfort and pain associated with screening, especially mammograms, as a negative aspect of screening, with one 47-year-old Filipino participant saying, “The reason why I’m probably apprehensive to go get breast/mammogram is because I’ve heard how painful it is… like, I’m not running to go get that done, y’know?” Only two participants noted the conflicting health messages from media and health officials regarding the frequency and necessity of certain cancer screening tests as a negative, as expressed in the following quote:

Health officials are really contradicting themselves. One group is saying that we really need testing every year, there’s another that it’s really not necessary… and to be hearing that, do they even know what they’re doing? They’re messing up with my breast, y’know. (Filipino, 51 years of age)

In contrast to the aforementioned negatives associated with cancer screening, however, is noting that 19% of participants did not associate any negatives with cancer screening tests. Furthermore, despite the positive and negatives associations, all participants reported still engaging in screening because of the importance of early detection, illustrated in the following quote: “I think the momentary unpleasantness is certainly outweighed by knowing the results and getting that early detection if you do have early signs of cancer” (Chinese, 62 years old). Few participants did express that lack of insurance and/or reminders from their healthcare provider may prevent their future participation in cancer screening tests, illustrated by 75-year-old Filipino participant: “I don’t really go there if they will not notify me. Unless I feel something different. But, if not, I just wait for the notice.”

Thirty-five percent of participants (n=9) reported that recommendation from their physician and access to health insurance were their reasons for first engaging in cancer screening. Twenty-seven percent of participants stated that their knowledge of the benefits of early detection prompted their cancer screening experience; whereas another 27% were
influenced by an experience of a friend or family member who was affected by cancer. One participant who had a family member pass away from cancer at an early age stated, “Having the personal experience of my sister and other relatives or close friend is a good incentive or convincing. You don’t need much convincing after that” (Chinese, 58 years old). Four participants reported that their own personal health experience made them aware of their risk and impelled them to undergo cancer screening tests regularly.

When asked what participants have heard other women say about their screening experience, there was a pattern of many women complaining of the physical discomfort but because of the strong doctor recommendation and value of early detection, they continued to screen on a regular basis anyway. One participant stated, “They’re uncomfortable and they are just forced to do it ‘cause we need it… even me, if I had a choice, I will not do it” (Filipino, 49 years old). In support, another participant stated that due to the discomfort of the mammogram, their social contacts would prefer not to go. Some participants reported they knew of their female social contacts who did not engage in cancer screening, reasons for which included: fear of “the unknown,” fear of receiving a positive result, and perceived low risk.

Cancer screening behaviors may also be predicted by the level of acculturation in AA women. Defined as “cultural changes resulting from [migration, colonization or other forms of intercultural] encounters” (Berry, 1997, p. 293), acculturation seems to affect participants’ decision to seek healthcare and adhere to health recommendations. One participant stated, “I think older, my parents’ generation, are the ones that we can’t convince them to go [engage in cancer screening]. I think our generation, I guess, the people who grew up here, are more inclined to just take care of themselves” (Filipino, 48 years old). Similarly, a 57-year-old Filipino participant stated, “They’re [her parents] set in their ways… it’s because they grew up that way” regarding health-related behaviors, such as diet. Based on the responses, it seems that newcomers to the United States may not necessarily be aware of cancer screening tests and their benefits and will not engage in cancer screening or face much apprehension regarding the topic.
THE ROLE OF SOCIAL RELATIONSHIPS ON AA WOMEN’S DECISION TO SCREEN FOR CANCER

Interview results showed that family and friends play various roles including: giving advice, providing encouragement to engage in healthful behaviors, and providing emotional support. Sixty-five percent of participants (n=17) had a personal connection to cancer by knowing someone (family member and/or friend and/or co-worker) who had been diagnosed with cancer or had personally been diagnosed themselves. Knowing social contacts affected by cancer made participants more likely to engage in cancer screening tests. When asked about effective ways to encourage AA women to screen for cancer, the use of social contacts to spread information and encouragement was commonly mentioned.

The Role of Family

For almost all participants (n=24), family played a significant role in participants’ perception and maintenance of health. The most common roles that family play included: giving health advice or information; giving support and encouragement to engage in healthy behaviors; and serving as an outlet to release stress, concern, or worry. Approximately thirty-five percent of participants mentioned knowing a family member affected by cancer. Ten participants stated that they referred to family members with experience with a specific health issue, asking them general questions such as: “Have you ever had this before?” and “Are you experiencing this?” Interestingly, five participants expressed concern over burdening family members with their personal health issues, with one participant (Filipino, age not specified) stating, “I don’t want them to feel the suffer.” When asked about placing a burden on family members during times of poor health, one participant stated, “They have to care for me, they have to spend money on me, they have to put their life on hold for me” (Cambodian, 42 years old). The caretaker role and tendency to value the welfare over a group of her own is also illustrated in the following quotes:

A part of it just might be the traditional passivity of women in the Chinese culture, um, and certainly there’s exceptions, but… the foreign born, people who were born abroad, like my mom, we had to encourage her… She understood, y’know, all of us nagging her to do things, but I think had she been left to her own device, she wouldn’t have done it. And I think partly it’s because of embarrassment. And culturally it’s not something you talk a lot about it. Which probably is not that different from other traditional, um, cultures, where maybe
women aren’t necessarily, y’know, encouraged to take care of themselves. They’re encouraged to take care of other people. (Chinese, 62 years old)

Women, a lot of women, put themselves on the back-burner when it comes to their health and to doing anything for themselves ‘cause we’re just so busy, multi-tasking, taking care and, y’know, this great woman at work and at home and everything else that we put our own health on the back-burner. (Filipino, 47 years old)

### The Role of Friends

Describing them as “cheerleaders” or “encouragers” and “good to bounce ideas off of,” Fifty percent of participants indicated that their friends play a major role in providing support and encouragement to engage in healthy behaviors as well as during times of need. Thirty-one percent (n=8) mentioned giving and receiving health advice from friends, while six participants stated that they used their friends as a basis for comparison in health behaviors and experiences, as seen in the following quote: “I trust them because they all have a good idea – we’re all the same age so they all would say, ‘y’know, go to this doctor or this’” (Filipino, 48 years old). In contrast, six participants also mentioned that their friends played a minimal role in their health as health was not a common topic discussed, with one 59-year-old participant stating, “I think it’s [health and cancer screenings] the least topics that’s talked about unless somebody’s actually going through it.” In contrast to family relationships, participants seemed more cautious of sharing and receiving health information from friends due to their level of trust and closeness. One 75-year-old Filipino participant expressed: “wrong friends too,” those who may be negative or show too much pity.

### KNOWING FAMILY AND FRIENDS AFFECTED BY CANCER

Discussions with social contacts, which ranged from reactions of knowing somebody with cancer to asking about specific cancer symptoms and/or treatments, seemed to be an effective way of raising awareness about cancer and screening. As one participant (Filipino, 44 years old) reported, “Before I just used to hear it [about cancer] on the news and now it’s coming closer to home, hearing it from people I really know and some relatives.” This comment not only shows the increased frequency of hearing about cancer in the community, but also the changed awareness about cancer -- from an unrelated health issue to a disease of actual concern. In contrast, participants who were not frequently confronted with issues of cancer showed less concern about cancer and in engaging in cancer prevention activities, as
illustrated in the following quote, “I haven’t been paying attention to cancer. I pay more attention to reducing weight because of diabetes.” When this idea of not paying attention to cancer was further explored with the 42-year-old Cambodian participant, she responded, “I guess I’m not being exposed to people with cancer on a daily basis. But I do work with people who suffer from diabetes.” In similar sentiments, other participants indicated that they may be more aggressive in cancer prevention activities if they were more directly affected by it: “It’s [cancer-related brochures] sent to me. I don’t seek it out because I’m not affected by it yet - maybe if I’m affected, then I will seek that” (Filipino, 75 years old).

Several participants mentioned knowing a family member, friend, and/or co-worker who has or had been diagnosed with cancer, the experience of which seemed to shape much of their perception of cancer and screening tests. Specifically, some participants were more motivated to engage in cancer screening tests, as exhibited in the following quote, “My sister-in-law is a survivor of breast cancer. My friend is a survivor of breast cancer, so they would help me remember, just the fact that they’re around” (Filipino, 47 years old). In addition, having personal experience of knowing somebody with cancer and understanding its hardships brought forth a raised awareness for some participants, evidenced by the following quote, “Because of my husband… we have one Filipino die here [participant’s workplace] of cancer and there’s a lot of people here who got breast cancer and it’s really an eye-opening for us [participant and her co-workers].” (Filipino, age not specified)

**Encouraging Other Women to Screen for Cancer**

Participants were asked their opinion on how to effectively encourage other AA women to screen for cancer. Sixty-five percent (n=17) reported providing basic information on cancer and prevention, including the topics of early detection with cancer screening tests and the potential of early treatment, with one 61-year-old Filipino participant stating, “… they’re not really educated about things that’s going around, the causes of cancer, treatments, prevention.”

Some participants also mentioned sharing their personal experience as a method of encouraging other AA women to screen for cancer: “Tell them my experience and how the screening goes. I mean, that’s all, you cannot force them. All you can do is talk about it and talk about your experience” (Filipino, 50 years old). In addition, six participants mentioned
the “plus factor” in discussing other women’s success stories in treating cancer early through early detection, as one participant stated:

I would tell the truth. My sister got it and then it was diagnosed on the first stage and was able to recover because they found it early… the early diagnosis of cancer helps so much, especially for breast and colon cancers. (Filipino, 49 years old)

Discussing other women’s experiences also seemed to play a role in raising awareness about the reality and risk of cancer. One 49-year-old Filipino participant mentioned that knowing other people in her social group with cancer became an “eye opener” for her and another participant stated, “Social contacts, I think, help establish a possibility in their mind that the information might apply to them.” Other suggestions for topics to discuss with other women included: making known the burden and suffering of cancer to the individual as well as to family members and friends, discussing concerns or questions with their healthcare provider, and addressing perceptions and barriers to cancer screening such as fear or cost.

Furthermore, participants were asked what setting would be most effective in communicating various cancer screening messages. Utilizing social contacts (friends and family) for encouragement or simply discussing were most commonly mentioned. Six participants reported that communicating via word of mouth would be effective as it “adds a little ring of credibility to it” and, additionally, 15% of participants suggested that discussing cancer screening tests in social gatherings and/or small groups would be effective and efficient. In support, one participant stated:

I think, um, word of mouth is very strong in the Korean community, as far as health issues go. So, y’know if one person were to advocate for, y’know, breast clinical exam annually and, um, that starts to spread then people tend to listen. And follow through. (Korean, 40 years of age)

Making the setting personal was also an important factor in communicating with other Asian women, as one participant stated, “You gotta learn how to approach them… if you just kinda, like, standing at the corner and trying to approach them, I don’t think it would work. They would just brush you off” (Vietnamese, 40 years old). A 44-year-old Laotian participant stated that health promotion campaigns should be “something you bring into the community so that it’s there and it’s easily accessible.” Four participants mentioned face-to-face communication would be helpful. One 45-year-old Chinese participant stated, “If
someone was encouraging me, I would like to see them in person and it’s more personal that way, instead of, I don’t know, TV – it’s not the same.” Similarly, participants suggested using statistics they could relate to (i.e. cancer rates in Filipino women) because it would convey a stronger and more realistic message. Other factors mentioned in encouraging other Asian women to screen include: offering free screenings or directing women to free resources; setting an example; and providing follow-up to remind women about screening.

The Importance of Healthcare Coverage and the Role of the Healthcare Provider

Although it was not explicitly asked about, each participant mentioned their relationship with her healthcare provider and having healthcare coverage, suggesting that both factors play a facilitative role in health decisions and cancer prevention activities. Since having healthcare coverage provides the access to have a cancer screening test and persistent recommendation to screen for cancer from participants’ physicians often prompted the actual engagement in screening, both are important factors to consider for cancer prevention strategies. Healthcare providers may also be used as effective communicators of the importance of cancer screening as interview results showed that some participants viewed physicians as authoritative figures whose advice needed to be followed.

Healthcare Coverage and Access to Cancer Screening

Although the participants’ relationship with their healthcare provider seemed to be more commonly mentioned throughout the interviews, thirty-eight percent of participants (n=10) directly stated that having healthcare coverage played a role in whether or not they would engage in cancer screening, with several participants similarly stating, “As long as the insurance will pay for it, I will go” (Korean, 40 years old). Another participant observed that the cost and access to cancer screening played a role in whether or not some of her social contacts would screen, saying that “If you do it [engage in cancer screening tests] in the military, everything is free. But if you… don’t have military, it’s more, like, there’s the copay and not everything be paid” (Filipino, 50 years old).
Persistent Recommendation from the Healthcare Provider

Sixty-five percent of participants (n=7) reported that the reminders and recommendations from their healthcare provider prompted them to engage in cancer screening. Furthermore, a 46-year-old Filipino participant stated that the doctor’s recommendation was the main reason she began engaging in cancer screening. She said, “because I feel physically that nothing is bothering me,” suggesting that unless she felt symptoms or was at risk for cancer, she would not personally engage in cancer screening tests as recommended.

The Role of the Healthcare Provider

Healthcare providers also seemed to play a role when participants felt concern about their health, although the degree of information they give or when they report to the doctor varied. Some of the reasons participants talked to their doctor/healthcare provider when they had health concerns include: “Because he’s actually been trained in the field” (Filipino, 47 years old), “…over the years, I have been close enough that I have never hesitated in phoning them and leaving a message” (Chinese, 71 years old) and “’cause there’s confidentiality and professionalism, they would know how to go about things if there was something wrong. I have confidence in them” (Filipino, 44 years old). In contrast, however, one participant reported that because of the nature of her healthcare coverage, she does not have a regular healthcare provider, making her more likely to talk to her friends in the healthcare field. In addition, participants seemed to rely on their healthcare provider to receive health information, with fifty-four percent (n=14) reporting receiving cancer-related information from their healthcare provider or from brochures, pamphlets, and/or the website of their healthcare provider.

There also seemed to be a pattern of participants viewing their healthcare provider as an authority figure with thirty-one percent (n=8) stating following screening recommendations because “He [healthcare provider] tells me what to do and I do it” (Chinese, 62 years old). There seemed to be a perception in which recommendations from the healthcare provider were “mandatory,” with another participant saying “but it’s the doctor’s recommendations. I have to abide by the doctor’s recommendation” (Filipino, 75 years old). “Because he is the professional” as well as having trust and confidence in their healthcare
provider’s knowledge and recommendations made some participants more likely to adhere to cancer screening recommendations.

Healthcare providers who were also well-informed about participants’ personal and family history are also catalysts for particular women screening earlier than recommended, as seen with the following participant, “…actually I have a pretty good doctor too ‘cause she knows my history, so, I think, when you have a mammogram, it’s usually forty, I actually started mine when I was 30-35” (Chinese, 45 years old). In addition, some participants who mentioned receiving screening reminders from their healthcare providers also mentioned that the absence of such reminders may delay their seeking screenings at the recommended time or may cause them to forget about them altogether.

**Summary**

A brief health survey and in-depth interview with 26 AA women generated three themes regarding AA women’s cancer screening decisions: knowledge and perceptions of health, cancer, and cancer screening; relationship(s) with social contacts; and relationship(s) with the healthcare provider. Understanding the level of knowledge and beliefs held by AA women regarding health, cancer, and cancer screening is important for the tailoring of health interventions. Findings also showed that social contacts, such as family or friends, may be helpful in raising awareness about cancer and cancer screening. Many participants mentioned talking to family and friends when personal health concerns arose, illustrating that social contacts may be effective channels for dispersing information and encouraging healthful behaviors. Finally, although it was not explicitly mentioned during the interviews, all participants mentioned their healthcare provider as playing an important role in their health, through both providing access to cancer screening tests and regular reminders to screen for cancer.
CHAPTER 5

CONCLUSION

Although cancer is the leading cause of death in Asian Americans (AAs), cancer screening rates in the AA population are lower compared to other major racial groups (Kagawa-Singer & Pourat, 2000). While it is important to have culturally competent health services and agencies that appreciate the various health beliefs and cultural and linguistic needs of diverse patients to close the gap of health disparities (Office of Minority Health, 2005), little progress has been made to better understand the AA population. To obtain a deeper understanding of AA women’s health decisions, especially in choosing to screen for cancer, a qualitative exploratory study was conducted. Twenty-six AA women completed a brief health survey and an in-depth interview regarding their perceptions of health, cancer, and cancer screening. Findings showed that it is important to understand AA women’s knowledge and perceptions of health issues, such as cancer and cancer screening, to provide a basis for communicating the need to screen for cancer; that social contacts may be effectively used to raise awareness about cancer and cancer screening, and, finally, having healthcare coverage is important in providing access to cancer screening and may also pave the way for AA women to have a productive relationship with their healthcare provider. This chapter discusses how the findings from the study are related to Bandura’s (2004) Social Cognitive Theory (SCT) constructs and the implications of this study for future public health efforts.

SOCIAL COGNITIVE THEORY AND AA WOMEN’S HEALTH DECISIONS

According to Rimal and Lapinski (2009), health communication has relevance in every aspect of health and well-being, as it is a way of exchanging information, which may affect disease prevention, health promotion, and quality of life. In addition, however, is that communication also serves a ritualistic component, in which “target audiences are conceptualized as members of social networks who interact with one another, engage in social ceremony and derive meaning from the enactment of habitual behaviors” (Rimal &
Findings from this research not only support the importance of information dissemination but also highlight the importance of social interaction in the health communication process. Information received and their meanings depend upon several factors, both at the individual level (prior experience, efficacy beliefs, and knowledge) and macro-social level (interpersonal relationships, cultural patterns, and social norms) (Rimal & Lapinski, 2009).

Given that the SCT is a comprehensive and well-supported framework for the understanding of factors that influence human behavior, Bandura’s (2004) SCT helped shape the brief health survey and interview guide administered to study participants. With particular attention to SCT’s constructs of outcome expectations, self-efficacy, and observational learning, insight was gained on AA women’s health decisions, especially in choosing to screen for cancer. Their insights may be worth considering when developing health promotion interventions specifically tailored towards AA women.

Considering that participants generally viewed cancer negatively, tests that screened for cancer were perceived as a mechanism not only to identify cancer or abnormal cells but also as a first step to cancer survival (via early detection and treatment). As a result, perceived benefits of cancer screening tests were deemed valuable to participants’ health and outweighed the experiences and/or perceptions of pain or stress adequately enough such that participants continued to engage in cancer screening. Coupled with the fact that many participants mentioned the importance of spreading information and awareness of cancer and cancer screening tests, highlighting the purpose of cancer screening may be an important factor in developing cancer screening interventions. This information may serve not only as encouragement but as a method for dispelling myths and addressing common concerns such as fear. In analyzing participants’ responses, it seemed that, although their experiences may be associated with discomfort, embarrassment, or inconvenience, understanding the purpose and benefits to cancer screening tests compelled them to continue screening. In addition, participants who engaged in cancer screening tests regularly seemed to eventually disregard negative associations, deeming the tests as routine or habit.

Self-efficacy refers to a person’s belief about her own ability to perform a behavior. It seemed that having healthcare coverage played an important role as to whether or not a participant or her social contacts would engage in cancer screening. Furthermore, some of the
participants who mentioned receiving screening reminders from their healthcare providers also indicated that the absence of such reminders could cause them to delay the screening or forget about them altogether. On the other hand, social contacts did not play a significant role in participants’ decision to screen or not screen for cancer. So, although hearing another individual mention their experiences may raise awareness about an issue, it did not directly correlate with the participant’s decision to engage in cancer screenings.

In terms of observational learning, participants frequently mentioned referring to family and friends who had particular health experiences for their health concerns, in which participants were able to form a basis for comparison as well as receive advice. Participants listed social contacts, such as family members and friends, as their main source of health and cancer information. Other common sources of information were the internet and media, which includes newspapers, television, and the radio. Some participants also mentioned receiving information from their healthcare provider or print materials provided by the healthcare provider (e.g. brochures, pamphlets, news bulletins). Participants who reported receiving information from social contacts mentioned only asking, or hearing from, family members, friends and/or co-workers who have been affected by cancer. When asked about situation(s) in which participants retrieved cancer information, the majority responded that only hearing information and/or purposely seeking information occurred when they knew of somebody affected by cancer. When it came to retrieving cancer information from the media or print materials, almost all participants stated that they did not actively seek such information but that it just happened to catch their attention, whether on the news or in a healthcare facility.

**SECONDARY FINDINGS**

Findings from this study also highlighted the differences existent in subgroups, including age, acculturation, and health communication preferences. It is interesting to note, especially in designing future health promotion interventions tailored toward AA women, that acculturation plays a significant role in their approach to. For example, participants noted that less acculturated women may be more resistant and hesitant to engage in cancer screening and other health promoting behaviors due to commonly held health beliefs and
barriers from their country of origin. Participants generally believed that women who are more acculturated may face other barriers, such as access to care.

Although the majority of participants in this study were of Filipino descent, it is also important to note that differences were realized between racial subgroups. For instance, unlike other participants, when asked about perceptions of health, each Chinese participant mentioned her aim of balance and moderation as her approach to health. There were also differences in types of health beliefs. For example, Filipino, Chinese, and Vietnamese participants more commonly mentioned alternative, or more traditional, medicine including the healing properties of food, whereas other participants focused more on the stigma of being diagnosed with a medical condition.

Personalization of health information messages and settings is also another factor that may be important to consider for future health promotion activities tailored towards AA women. It was commonly expressed that to effectively reach particular groups of women, programs need to know commonplace settings in which they may gather and share information. Examples of women they can relate to was also noted. Suggestions to make health messages as personal as possible suggests that, in order for other women to understand their own personal risk, any statistics shown or other information shared related to cancer or screening must be expressed in a manner that will catch their attention and mean something personal to them.

Although research findings may not significantly differ from current research held about AAs, understanding each factor associated with AA health decisions is crucial in developing effective health communication interventions. As Kreuter and Wray (2003) suggest, health messages that are more relevant to a recipient, in that they are matched according to certain characteristics such as cultural markers, reading levels, and is a response to his or her own personal circumstance, the more effective that health message may be received. Tailored messages also have the advantages of being more effective when the awareness and knowledge of a health issue is high and when there is significant variability within the target audience (Kreuter & Wray, 2003).
CONCLUSION

This study helped provide insight into the perceptions and knowledge of health, cancer, and cancer screening tests in Asian American women. Findings showed that although women may not initially report their social contacts as influential in their health decisions, social contacts may be valuable resources in the health decision-making process. From casual conversation during a social gathering to purposely seeking information from experienced family and/or friends, social contacts may be an effective resource for exchanging health information and encouragement of healthful behaviors, including engaging in cancer screening tests. However, providing information and encouragement may not be possible unless accurate and effective health information and communication are available. Direct access to cancer screening tests via healthcare coverage and healthcare provider recommendation is critical for women in the study’s population. Finally, the seemingly cultural perception of viewing healthcare providers as authority figures show that healthcare providers are important instruments in AA women’s health decision-making process.

IMPLICATIONS FOR RESEARCH AND HEALTH PROMOTION PRACTICE

Findings from this study may help lay the groundwork for follow-up studies regarding cancer screening behaviors and health decision-making factors in Asian American women. In support of Kreuter and Wray’s (2003) effective tailoring approaches, a formal assessment should be conducted to thoroughly understand the interpersonal and environmental factors that affect behavior. A recent report from the President’s Cancer Panel (Reuben, Mililiken, & Paradis, 2011) noted the urgency in “expanding research and improving understanding of cancer among minority populations.” It is hoped that increasing understanding not only of genetic factors but also of socio-cultural factors related to Asian Americans’ health, as well as regular disaggregation of data, is necessary in order to better implement specific and effective preventive measures.
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APPENDIX A

BRIEF HEALTH SURVEY
DIRECTIONS: Please check or write in the answer that best applies to you.

1) What is your age? Specify. ___________ Years

2) Have you lived in the United States your whole life? Check one. □ Yes □ No

3) How long have you lived in the United States? Specify. ___________ Years ___________ Months

4) Select the primary ethnicity that best describes you. Check one.

- □ Asian Indian
- □ Cambodian
- □ Chinese
- □ Filipino
- □ Korean
- □ Laotian
- □ Japanese
- □ Hmong
- □ Vietnamese
- □ Other (specify): ____________________________

5) In what language do you prefer getting health information? Specify. ____________________________

6) In what way do you prefer getting health information? Check all that apply.

- □ Word of mouth (friends, family, co-worker)
- □ Brochure or pamphlet
- □ Email
- □ From my doctor
- □ Poster
- □ Radio
- □ Newspaper and/or magazine
- □ Text (cell phone)
- □ Television (ads, shows, news)
- □ Website
- □ Other (specify): ____________________________

7) If you wanted to find out information about health, where would you go? Check one.

- □ My doctor/health care provider
- □ Radio announcement
- □ From my doctor
- □ Books
- □ The Internet
- □ Newspaper and/or magazine
- □ Television (ads, shows, news)
- □ Family and/or friends
- □ Other (specify):

8) Have you ever had a medical test that helped check for cancer (such as a mammogram, pap smear or colonoscopy)? Check one.

- □ Yes
- □ No
- □ I don’t know

9) If you have had a medical test that checked for cancer, which test did you get? Check all that apply.

- □ Breast self-exam
- □ Clinical breast exam
- □ Mammogram
- □ Stool test
- □ Colonoscopy
- □ Pap test
- □ Other (specify): ____________________________
10) When was the last time you had at least one of these medical tests (colonoscopy, mammogram, pap test or other test that checks for cancer)?

- [ ] Within last 12 months
- [ ] More than 1 year but less than 2 years ago
- [ ] More than 2 years but less than 3 years ago
- [ ] More than 3 yrs ago
APPENDIX B

INTERVIEW GUIDE
1. What do you think it means to be healthy?
2. What do you think are some of the things that affect your health?
3. What thoughts come to mind when you hear the word cancer?
   Probe: What do you think causes cancer?
   Probe: Where do you get cancer information?
4. What do you think are ways to help prevent cancer?
   Probe: Have you ever done anything yourself to prevent cancer?
There are different medical tests that help find certain cancers, also known as cancer screening tests. These next set of questions will ask about your thoughts on cancer screening tests.
5. Could you tell me what you know about cancer screening tests?
   Probe: What do you think are the positive things about having a cancer screening test?
   Probe: What do you think are the negative things about having a cancer screening test?
   Probe: Where do you get your cancer screening information?
6. Do other [racial/ethnic group] women you know get cancer screening tests?
   Probe: What have you heard other women say about their cancer screening experience?
7. Has any information that you’ve heard other women say affected your decision to screen or not screen for cancer?
   If participant indicated ‘Yes’ in having a cancer screening test (survey question #8), ask questions 8-10. Then proceed to question 14.
8. How was your experience in having a cancer screening test?
   Probe: What feelings did you have before you had your screening test?
   Probe: What feelings did you have after you had your cancer screening test?
9. Would you get this cancer screening test done again? Why or why not?
10. What convinced you to get screened for cancer in the first place?
   If participant indicated ‘No’ in having a cancer screening test (survey question #8), ask questions 11-13. Then proceed to question 14.
11. Have you ever been told to get a cancer screening test before?
   Probe: [If yes] Who told you to get the screening test? Which screening test did they tell
12. Why did you decide to **not** get this cancer screening test done?
13. What would convince you to get a cancer screening test done?

**Go to Question 14.**

14. Who do you talk to most when you have health concerns?
15. What role does your family play when it comes to your health?
16. What role do your friends play when it comes to your health?
17. What role does your religion and/or spirituality play when it comes to your health?
18. In the [racial/ethnic group] culture, are there any common health beliefs that may affect the way people look at cancer or screening?
19. If you wanted to encourage a group of [racial/ethnic group] to screen for cancer, how would you do it?