

Using Mammography Screening: Hmong Women's Perceptions and Beliefs

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ABSTRACT

Breast cancer is the second leading cause of cancer deaths among all women in the United States. Although mammography screening has been shown to be effective in detecting breast cancer, Hmong women, one of the Asian American/Pacific Islander subgroups, have a very low screening rate. The purpose of this study was to explore factors that influence Hmong women's willingness to be screened for breast cancer. Grounded Theory methodology guided the analysis of fifteen qualitative interviews with Midwestern Hmong women between the ages of 40-64. Regardless of age, length of US residency, and language spoken, the results showed one core theme and three interrelated themes regarding the women's decision to seek mammography screening. The three interrelated themes of Breast Health Messages, Screening Barriers, and Screening Facilitators can have negative and/or positive influences on the core theme of mammography-screening decision-making processes. The first related theme of Breast Health Messages included professional and lay breast health messages. The second related theme, Screening Facilitators, included breast health messages from professionals, abnormal findings, social support, risk for getting breast cancer, doctor's recommendations, and insurance. The third related theme, Screening Barriers, identified symptomatic health seeking behavior, instrumental barriers, fear, social influence (which included lay breast health messages), use of traditional Hmong healing practices, embarrassment, and perception of breast cancer risk. This study suggested that the healthcare professionals need to use a culturally sensitive and multi-disciplinary approach to provide breast health education as well as to assess and provide instrumental support, while encouraging social support to influence Hmong women to attain mammography screening.

Introduction

Breast cancer is the second leading cause of cancer deaths among all women in the United States (National Center for Health Statistics, 2006). This type of cancer affects women of different ethnic groups to varying degrees. Caucasian women have the highest incidence rate of breast cancer followed by African Americans, Asian Americans/Pacific Islanders (AAPIs), Hispanics/Latinos, and American Indians/Alaskan Natives (America Cancer Society [ACS], 2006). Over the years, the age-adjusted death rate for AAPI women has consistently increased (ACS, 2004; 2005; 2006), although the death rates have decreased for other ethnic groups in the

United States due to “earlier detection through screening, increased awareness and improved treatment” (ACS, 2006, p. 11).

Many different Asian groups comprise AAPI women in the United States. Among the top five largest AAPI subgroups are Chinese, Filipinos, Asian Indians, Vietnamese, and Koreans, whereas Hmong are among one of the smaller subgroups (Khan, Fung, Giang, Wong, & Tantoco, 2009). This research study focused on the Hmong community and the specific factors that may influence the mammography-screening behavior of Hmong women in the Milwaukee area. The unique culture of the Hmong people makes it necessary to explore the issues specific to Hmong women. Only two studies were found related to Hmong women and mammography screening (Tanasiri, Kagawa-Singer, Foo, Chao, Linayao-Putman, Nguyen, et al., 2007; Tanasiri, Kagawa-Singer, Foo, Chao, Linayao-Putman, Lor, et al., 2001). However, many such studies were found with other AAPI women (Lee, Kim, & Han, 2009; Suh, 2008; Purc-Stephenson & Gorey, 2008; Wu, Hsieh, & West, 2008; Islam, Kwon, Senie, & Kathuria, 2006; Kandula, Wen, Jacobs, Lauderdale, 2006; Leong-Wu & Fernandez, 2006; Wu, West, Chen, & Hergert, 2006; Wu, Guthrie, & Bancroft, 2005; Ko, Sadler, Ryujin, & Dong, 2003). Cultural factors may influence Hmong women's attitudes and behavior toward mammography screening, which will be explained in the next section.

Traditional Hmong culture is patriarchal, patrilineal, and patrilocal (Cooper, 1984; Donnelly, 1994; Geddes, 1976, Leepreecha, 2001; Lemoine, 1972b; Tapp, 1989; Yang, 1975, 1993; as cited in Culhane-Pera and Xiong, 2003). Consequently, Hmong men have more power and a higher status than women (Cooper, 1984; Donnelly, 1994; as cited in Culhane-Pera & Xiong, 2003). Along with this privilege, Hmong men have primary responsibilities to both their family of origin and family of marriage. The many responsibilities and obligations include

performing spiritual rituals needed for health and healing, settling disputes, arranging marriage agreements between clans and conducting marriage ceremonies, and supervising and overseeing many aspects of funerals (Culhane-Pera & Xiong, 2003).

In contrast, the traditional woman's role in the Hmong culture was to be the 'hands and feet' of her husband. The women spend their time assisting their husbands and their extended families with farming, the household chores, and raising the children. Living with her husband's family, a Hmong woman, as a wife, has even less authority than her unmarried sister-in-law, in matters pertaining to the decision-making processes of everyday life (Culhane-Pera et al., 2003).

Upon immigrating to the U.S., Hmong people maintain many of their traditional ways of living. This is especially true when it comes to how healthcare decisions are made in regards to mammography screening. It is possible that certain sociocultural characteristics, such as the patriarchal family structure, could reduce a Hmong woman's willingness to attain mammography screening. It is also possible that the level of acculturation and the number of years a woman has lived in the United States might enhance her willingness. A culturally sensitive breast cancer education program may improve a Hmong woman's willingness to be screened as well. Greater knowledge of the impact of sociocultural factors can lead to the development of a culturally sensitive breast cancer education program and an increase in the mammography-screening rate for Hmong women. This study explored the factors that influence Hmong women's willingness to obtain mammography screening.

Methods

Research Design

The researcher used grounded theory, a qualitative research method developed by Glaser and Straus (1967; as cited in Creswell, 2005). Creswell defined grounded theory as a "qualitative

procedure used to generate a theory that explains, at a broad conceptual level, a process, an action, or interaction about a substantive topic” (p. 396). In qualitative research, researchers seek to understand the process of how people create meanings of the events in their lives. Because people construct meanings from their interactions with others, this experience becomes their reality. Accordingly, reality is ‘socially constructed’ (Berger & Luckmann, 1967; as cited in Bogden & Biklen, 1992, p. 34). Therefore, each person’s reality is perceived differently from another person’s depending on the social environment that influenced and shaped that reality. A qualitative grounded theory was ideal for this study because a unique social environment shapes and influences how Hmong women view mammography screening.

Recruitment of Participants

In April 2007, the researcher recruited fifteen Hmong women from a community nursing center in Milwaukee. Demographic information from the nursing center’s past breast-health class rosters were reviewed to determine eligibility. Three criteria for participation in the study were age, length of US residency, and attendance at a breast health class in the past.

The first criterion was that a woman must be between the ages of 40-64 years old. The United States Preventive Services Task Force (USPSTF, 2002) recommends annual mammography screening for women starting at age forty. The nursing center refers women who are younger or older than the age criterion to other providers because of programming and/or insurance issues. The second criterion for participation was for Hmong women who had lived in the US for less than five years or greater than ten years. Length of U.S. residency may determine whether the level of acculturation affected Hmong women’s decision-making about mammography screening as established by three relevant studies (Wu, & Ronis, 2009; Wu, Hsieh, & West, 2008; Wu, Guthrie, & Bancroft, 2005). The third criterion was attendance at a

breast health class in the past. This criterion provided an indication as to whether breast health education influenced the women's decision to seek mammography screening. Once all the participants were identified, a telephone call was made to the qualifying participants inviting them to be a part of the study. The location and time for the interview, arranged for the convenience of the participant, were also set during the call.

At the beginning of each interview, the researcher explained the purpose of the study and interpreted the informed consent form for the participants who were not literate in English. The informed consent form was not translated because of the low literacy rate of this group of Hmong women (Hmong National Development, and Hmong Cultural Center, 2004). Two past studies involving Hmong women and breast cancer screenings, Tanjasiri, Kagawa-Singer, Foo, Chao, Linayao-Putman, Nguyen, et al. (2007) and Tanjasiri, Kagawa-Singer, Foo, Chao, Linayao-Putman, Lor, et al. (2001) used verbal consent to obtain their participants' permission to be in their studies. Once the participant agreed to the information on the informed consent form, she had the option of either signing the form with her signature or putting an 'X' on the signature line if she was illiterate. The researcher witnessed the signing with her own signature and dated the consent form. The participants were given pseudonyms to protect their privacy.

Data Collection

To collect the data during the interview, the researcher used an adapted semi-structured interview guide from the work of Fowler (2006). Fowler used an interview guide in her grounded theory research pertaining to African American women and mammography screening. The first part of the interview guide used a semi-structured method to obtain demographic data. These questions asked the participant information about her age, marital status, type of health

insurance, length of US residency, and primary language spoken at home. The second part of the interview guide used an informal format that contained questions that were more open-ended.

This second part of the interview guide was translated into the Hmong language to ensure a consistent phrasing of the questions to each participant. When interpretation of the questions was not done during the early phase of the study, the researcher noted inconsistency in how the questions were asked. See appendix A for the questionnaires that were part of the adapted interview guide used in the study.

Rigor in Qualitative Studies

As with all credible research, the trustworthiness of a study depends on the extent to which the researcher has accounted for its reliability and validity. Reliability is the first facet of establishing trustworthiness in qualitative research. It is concerned with “whether or not the results are consistent with the data collected” (Merriam, 1998, p. 206). In general, qualitative researchers determine reliability by looking at the correlation between the data collected and the substantive phenomenon under investigation (Bogden & Biklen, 1992).

Three suggestions made by Merriam to increase reliability are the investigator's position, triangulation, and audit trail (1998). The first suggestion, the investigator's position, involves detailing the premises behind the study, describing the researcher's attitude toward the participants, specifying the criteria used for sampling, and delineating the social environment in which the data were collected (Merriam, 1998). All of these elements were achieved through the detailed description of the need for this study in the introduction section.

Triangulation or the second suggestion by Merriam (1998) to increase reliability is accomplished through using different instruments to gather the data, such as the interview questions, observation, field notes, and gathering the data from multiple participants who have

different levels of acculturation. This method not only enhances reliability, but internal validity which may be defined as the degree to which the research findings reflect reality (Merriam, 1998).

The third reliability method suggested by Merriam (1998) is using an audit trail. With this method, the researcher describes “how the data were collected, how the categories were derived, and how decisions were made throughout the inquiry” (Merriam, 1998, p. 207). This researcher accomplished an audit trail by detailing the data collection process under the “Methods” section, keeping field notes and a diary of the researcher’s feelings about the research process, and using grounded theory to sort and analyze the data.

The second facet of establishing trustworthiness involves validity. It has two components: internal and external. Techniques used to strengthen internal validity were discussed above. In contrast, external validity is concerned with the generalizability of the findings to other situations. However, in a qualitative study using grounded theory design, the objective is to determine the process that “appeared clearly in one particular setting” (Bogden & Biklen, 1992, p. 45). Thus for this study, the concern is not whether the theory generated can be applied to other groups of women, but to another situation in which the concern is to understand how women’s sociocultural factors influence their usage of mammography screening.

Data Analysis

Data analysis began immediately after the first interview to delineate the direction of the study. Constant comparative data analysis, a grounded theory technique, was used to sort the many specific data collected from the women into broader categories (Creswell, 2005).

Grounded theory recommends using “in vivo codes” or using the participants own words to label the emerging categories instead of scientific terms when analyzing data (Creswell, 2005). Coding

is described as “the process of segmenting and labeling text to form descriptions and broad themes in the data” (Creswell, p. 237). Because this study involved participants who speak a different language than English, this concept of coding was harder to achieve due to translation differences.

The steps to coding in grounded theory studies to arrive at the broad theory are outlined here. First, the use of open coding allows the researcher to divide the data into initial categories related to the phenomenon under investigation. This process involves using all the data collected including the interview and observational field notes or memos. Second, the axial coding process entails choosing one open coding category that is central to all the other categories. By creating a coding paradigm, which is a visual display of the different types of relationships of the open coding categories, the researcher can distinguish the “causal conditions, strategies, contextual and intervening conditions, and consequences” (Creswell, 2005, p. 398). Finding a ‘core category’ from among all the categories or themes is the foundation for theory generation.

Selective coding is the third phase. At this stage of the coding process, the researcher develops a concept of the intricacies and relationships between the categories from the axial coding phase. The theory generated should be broad enough to confer “an abstract explanation for the process being studied in the research” (Strauss and Corbin, 1998; as cited in Creswell, p. 398). Once a theory has been created, the researcher validates this emerging theory with the literature by scrutinizing the similarities and differences (Pandit, 1996).

Results

Participant Demographic Background

In this study, fifteen Hmong women, between the ages of 40-64 years old, were interviewed. Eleven of the fifteen women were married. Two of the women were divorced; of

the other two, one was separated from her husband, and one was a widow. Regarding years of U.S. residency, eight of the women had lived in the United States for ten years or longer and the remaining seven women had resided in the U.S. for three years or less. All the women had some type of health insurance, except for three. The language category options ranged from speaking only Hmong to speaking English fluently. Seven of the women spoke only the Hmong language whereas none of the women reported speaking English fluently. The other eight women reported speaking a little to some English.

This study focused on these fifteen participants' decision-making processes around three interrelating themes pertaining to their mammography-screening behavior. In grounded theory, a core theme is identified and explored in relationship to related themes (Creswell, 2005). The three related themes were Breast Health Messages, Screening Barriers, and Screening Facilitators. The following section reports findings for the three interrelated themes and how each supports the core theme of a mammography screening decision-making process.

Related Theme One: Breast Health Messages

The researcher used this theme to explore the everyday breast health messages that the participants hear out in both the professional and lay community. This theme is important because it illustrates that what people hear may become a part of their belief system and thus influence their breast cancer screening behavior. Furthermore, gaining insight into the participants' perceptions of what they hear from professionals will assist health educators in tailoring their breast health education programs.

Breast health messages from Professionals. From the data collected, all of the fifteen participants mentioned that they had heard some types of breast health messages from the professional community. The professional community encompasses any provider, who teaches

and educates the lay community about health and disease. Of the fifteen participants, five described strong professional influences in their decision-making process to obtain a mammogram. Moreover, an equal amount of both the newer refugees and the ones who lived in the U.S. for longer than 10 years indicated this influencing factor. Ka Mee, one of these five participants, described the breast health message she heard from her 'American' doctor as a motivating factor that influenced her to obtain a mammography screening. Not surprisingly, most of these five participants also acknowledged that they had not heard much about breast health, whether it be a positive or a negative message, from the lay community.

Lay breast health messages. Eight of the fifteen participants indicated that they had heard breast health messages from the lay community. Again, the length of U.S. residency did not matter: all the participants expressed the same opinions about how the lay community breast health messages affected their decision-making process related to mammography screening. Dissimilar to the professional breast health messages, most of these participants cited the lay community's breast health messages as discouraging them from receiving a mammogram.

The researcher also explored the sources of these lay breast health messages. These sources can provide additional insight about the decision-making process regarding mammography screening among these women. Some of these eight participants cited relatives, friends, and experiences with breast and other types of cancer among relatives and friends as sources of lay messages. The lay breast health messages that these eight participants had heard and had influenced their decision-making process about mammography screening derived mainly from their social environment.

Related Theme Two: Screening Barriers

The participants identified seven significant barriers influencing their decisions to obtain mammography screening. Those barriers are symptomatic health seeking behavior, instrumental barriers, fear, social influences, use of traditional Hmong healing practices, embarrassment, and perceptions of breast cancer risks. The barriers are discussed in the order most to least mentioned by the participants.

Symptomatic health seeking behavior. Symptomatic health seeking behavior is the leading barrier that all but one of the participants mentioned. Because there is not one specific semi-structured or informal question that would have elicited this answer, that most of the participants identified this as a barrier makes it even more significant. This behavior is described as seeking health care only when there is a visible sign or symptom of illness. However, most of the participants mentioned that this symptomatic health seeking behavior is a barrier for other people, but not for themselves. In addition, these participants noted that this behavior is the norm for Hmong people.

Instrumental barriers. According to Glanz, Rimer, and Lewis (2002, p. 186), instrumental support includes “the provision of tangible aide and services that directly assist a person in need.” Thus, instrumental barriers are a lack of tangible aide and services which enable people to obtain the needed services. Eight of the fifteen participants affirmed the three instrumental barriers of language, lack of insurance and transportation as factors affecting their decision to seek mammography screening. Of these participants, five cited a lack of insurance and the rest mentioned language barriers and a lack of transportation. The participants who indicated transportation and language issues as barriers were all newer refugees. On the other

hand, the majority of the participants, who had lived in the U.S. for longer than ten years, cited the lack of insurance as a barrier.

Although the other participants did not mention the lack of insurance and transportation and language barriers, it was derived from the memos and the observations that most of the participants did not speak English well and that some did not drive. Therefore, some of these participants reported using either their own family members or the services of some of the clinics to obtain the needed healthcare services. However, there still existed hardships in using these services.

Of the eight participants, some identified the hardships of coordinating healthcare services with their relatives' busy schedules for transportation and interpretation help. Chi described her frustrating experience with going to a local hospital to obtain a mammography exam when neither she nor her husband knew how to speak English:

We, who are new refugees—when we want to go [to get healthcare services]—we would think for a long time about the fact that we don't speak the language, car—we don't know how to drive it; and we don't know when we get to the place, which room to go to or what to say to them [the hospital personnel] so they know the reason we are there. For example, the other day when I went with my husband for my mammogram appointment, we went to the place [a local hospital] downtown and they [hospital personnel] have to call a Hmong interpreter to come. But, she was not able to come, so they just called and she interpreted from the telephone. Afterward, they [hospital personnel] said since she couldn't come, they cannot give me the mammogram. So we just came back home and they rescheduled my appointment to another time when she [the interpreter] could come

over there to interpret for me—so that I could get my mammography screening. It was very hard.

Fear. Fear is another barrier that influenced Hmong women's decision to seek mammography screening. Four subcategories of fear were identified by some of the participants: fear of surgery or operation, fear of a positive finding, fear of treatment and/or experimentation, and fear of pain.

Nearly half of the participants acknowledged the first subcategory of a fear of surgery. Most of these participants described a general sense of not wanting to be operated upon unnecessarily as a barrier in their decision-making process about mammography screening. This perspective may be a result of the idea that the purpose of screening is to detect abnormalities, which will lead to further diagnostic tests/biopsies.

Phoua, one of the women, elaborated her perception of not wanting to get a mammogram for fear of surgery. Her reason was that the doctors might make the disease or illness worse by operating on it. Mai Vue also concurred with the viewpoint of a fear of surgery. She shared a story of her female relative's ordeal with cancer. Mai Vue conveyed the thought process of her female relative and her husband's preference to seek alternative treatment for the cancer instead of following the treatment recommended by the Western doctors. She stated, "They chose not to get any treatment in this country, because in this country they [the doctors] want to just cut it off, so they went to get treatment in Burma and China." However, Mai Vue sadly concluded that the cancer was getting worse because the use of an alternative treatment did not work.

Fear of a positive finding is the second subcategory. Almost half of the participants acknowledged this subcategory as a barrier for mammography screening. Most of the participants noted that this fear is a barrier for other women, but not for themselves. A couple of

the women mentioned that this fear is pervasive even if it involves another disease or illness, not just breast cancer.

In addition to the fear of surgery and a positive finding, the third subcategory distinguished was the fear of treatment and/or experimentation. This subcategory was not classified under the fear of surgery because it involved not only surgery as treatment, but also other drugs. Ka Mee articulated this fear of treatment by describing how other Hmong women feel about Western doctors using Hmong people for various drug experimentations:

There are some women who do not agree with the recommendation [the need to get a mammogram], and they would get scare. Scare that if they would go, even if they are not sick, they [the doctors] will tell them [the women] that they are sick. Then they [doctors] will experiment on them.

Fear of pain is the last subcategory. Only two of the fifteen participants noted this barrier, but it is vital to explore it. As stated above, when discussing lay messages, reports of pain experienced during a mammogram by friends and family members may have an enormous influence on the decision-making processes of women. Cha expressed how she decided not to receive mammography screening because of the reports of pain experienced by her friends. Shoua agreed with Cha's opinion. She stated, "So now, I think that getting a mammogram, they compressed it so hard and it hurts, and my breasts are not big like other women's, it's small and they would pull very hard on it, so it was painful." Shoua added that this is one reason she will not get another mammogram in the future, unless she feels some symptoms.

Sociocultural influence. A little less than half of the participants attested to the barrier of not obtaining a mammography screening because of the influence of family and/or friends. Family influences included both the family of origin and the family of marriage. Within the

woman's family of marriage, the main person that wields the most influence is her husband. Although some of these participants cited husbands as a possible barrier to receiving mammography screening, only one participant, May Kao, was strongly impacted by her husband. Even though she stated that this is not a barrier for her anymore, she passionately recounted how her co-workers husbands' feelings of control and jealousy could influence their decisions to seek mammography screening.

Furthermore, May Kao declared that the reason for the husbands' stern opinions was they did not want their wives to be touched by someone else. May Kao estimated that this issue of husbands controlling their wives' lives affects about half of the Hmong women living in the U.S. This continual control by their husbands may cause women to give up on trying to take care of themselves and engaging in preventive measures such as getting mammography screenings. For the older participants, the main people who influence their decision-making processes are their sons and daughters. Two newer refugee participants stated that they depended on their family of origin to inform them of what screenings and/or health checks were needed. This dependence is attributed to their family members having lived in the U.S. longer and having more knowledge of these issues.

Besides family influences upon decision-making about mammography screening, friends and/or the general Hmong community can affect some of these participants' decisions. A couple of these participants expressed how their friends and the larger Hmong community affected their decisions whether to seek mammography screening. As discussed previously under theme one, subcategory "Lay breast health messages", the main lay messages from these participants' friends and community were pain from the mammography procedure and a fear of treatment and/or experimentation. Additionally, some of these participants mentioned that family and

friends must be consulted when additional diagnostic screenings were required because of abnormal findings from the mammography screening. This consultation is important to determine the course of follow-up care and/or treatment.

Use of traditional Hmong healing practices. Five of the fifteen participants asserted that the use of Hmong herbal medicine is a barrier to Hmong women's decision-making processes in reference to obtaining mammography screening. Three of these participants mentioned that a reason for not going to get a mammography screening is that women seek help from Western doctors only after Hmong herbal medicine fails to work. One participant stated that a delay in seeking Western health care for cancer treatment might have caused her female relative's cancer to worsen.

Moreover, some of these participants stated that Hmong people who used alternative treatment tend to use it first, and then turn to Western medicine when the former did not work. Sometimes, they would use both modalities of treatment simultaneously. Most of these participants mentioned that the older Hmong generation is more likely to use herbal medicine than the younger Hmong generation. Some participants agreed that using herbal medicine is a barrier to getting mammography screening. One participant added that because Hmong herbal medicine has worked for them, they trust this method of treatment to a greater extent.

Embarrassment. Several participants identified embarrassment as a barrier to not obtaining a mammogram. These participants stated that with this barrier, most Hmong women are conscientious about their female anatomy parts and do not want anyone examining them. When probed, most of these participants did affirm that breast screenings may not be as embarrassing as the Papanicolaou smear and pelvic exam, which involve examining the vaginal canal.

Perception of breast cancer risk. A few participants cited the perception of having no risk for breast cancer as a barrier to obtaining mammography screening. Shoua ascribed her reason for not perceiving any risk for breast cancer as to having breastfed her children. May added her opinion that Hmong people are not prone to being sick from breast cancer. It was only recently that she had heard on rare occasions about a few Hmong women getting breast cancer. Additionally, May stated that her sister-in-law, who had been in the U.S. longer, reinforced that perception by discouraging her not to go and get a mammogram. May's sister-in-law told her that she does not get mammograms, so May should not do so either. May expressed slight confusion because she had been to a breast health class and was instructed as to the importance of getting a mammography screening. However, she concluded that she would not get one unless she felt some symptoms.

Although there were additional participants who had mentioned breast cancer risk perceptions, these were in the context of a factor that would facilitate mammography screening. The following theme will address factors that most of the participants designated as "Screening Facilitators" which may play a role in decision-making processes to attain a mammography screening.

Related Theme Three: Screening Facilitators

The researcher used this theme to elucidate factors that would encourage decisions of participants to attain mammography screening. Each participant may have acknowledged one or more factors. Screening facilitators have also been noted under the barriers theme in the previous section. To avoid confusion between the two themes, the researcher used different phrasing to differentiate screening facilitators from screening barriers. The participants identified six subcategories in this Screening Facilitators theme: breast health education, abnormal findings,

social support, risk for getting breast cancer, doctor's recommendation, and insurance. These factors were discussed based on those most to least mentioned by the participants.

Breast health education. Thirteen out of the fifteen participants described that the benefits of breast health education resulted in increasing both their awareness of the disease and their awareness of the need for screening. Only two of the participants stated that breast health education had minimal benefits. As previously noted, some of the participants mentioned that if their doctor provided them with breast health education along with an appointment or a referral, they would get a mammography screening.

Specifically pertaining to the strategies of breast health education, most of these participants had various recommendations as to what might most influence Hmong women to get a mammography screening. A frequently mentioned strategy was to conduct breast health education at various agencies throughout the community and as part of home visits. Some of the participants asserted the importance of including men in the education session. A few of the participants stated that to affect behavioral change, the breast health message needed to be reiterated by different providers.

A couple of the participants emphasized gender appropriateness in the conduct of breast health education. They agreed that breast health is a sensitive topic to be teaching to the Hmong community. However, the fact remains that the community needs to be educated about the importance of cancer detection and screening. Thus, for women's health, a female provider educating and conducting the exam is preferred.

Abnormal findings. Eleven out of fifteen of the participants described this second factor, abnormal findings (consisting of having signs and symptoms and/or having past abnormal mammography results) as screening facilitators for future mammography screening. The

antithesis of this screening facilitator subcategory is the screening barrier of symptomatic health seeking behavior. A participant stated that an annual mammography screening is unnecessary when the result is always normal. Furthermore, there is the belief that getting an annual mammography exam might also cause cancer to develop because of the frequent compressions involved.

Social support. Although a little less than half of the participants mentioned social influences as a barrier, more than half of the participants cited social support as a screening facilitator. As previously stated under the barrier theme, some of these participants have mentioned that a few of their main social influences are their husbands, families of birth, and friends. Thus, if these same people were to give the women support and encouragement to obtain mammography screening, it could serve as a powerful screening facilitator.

For the screening facilitator of husbands' support, some of the participants stated that in addition to husbands' encouragement for women to obtain a mammogram, it is equally important to have their support when there is a need for diagnostic tests. Further diagnostic tests include a follow-up mammogram and/or other breast cancer detection methods. Additionally, the women stated that when diagnostic tests are needed, the decision-making processes regarding follow-up care will become a family matter, usually spearheaded by their husbands and/or family members. Thus, having their husbands' support is vital because most women identified husbands, family of origin, and/or friends as major barriers for not obtaining mammography screening.

Risk for getting breast cancer. The first subcategory consisted of five participants' views of their risks for getting breast cancer. Of these participants, four had gotten a mammogram in the past and had some kind of plans to obtain another mammogram in the future. From their reports, all of these participants viewed breast cancer as a disease that any woman might have a

chance of getting. Although four of these participants had attended at least one breast health class in the past, only Phoua and Chi mentioned what they had learned about breast cancer risk factors from the class. Ka Mee and Phia cited their doctors as the facilitators of their mammography screening through education and referral.

Doctor's recommendation. Five out of the fifteen participants acknowledged that if their doctor had recommended mammography screening, they would have gone. Three of these participants attributed their first mammography screening to their doctor's breast health education, recommendation, and referral. Some of these participants also stated that if their doctor recommended that they get a mammogram, there would then be no need to consult with family and relatives. It is an individual decision. Conversely, only one out of all the participants adamantly stated that even if her doctor recommended a mammography screening she would not go because of embarrassment. This participant had never received a mammogram before and had no plan to acquire one in the future, unless she experienced some signs and symptoms of breast cancer.

Insurance. While five of the fifteen participants acknowledged not having health insurance as a barrier, only a few participants mentioned having it as a screening facilitator for them to acquire a mammography screening. This factor had a direct affect on two participants who did not have health insurance and did not know where to access alternative sources for woman's cancer screenings.

The other participants commented that having Medicaid, or Wisconsin public health insurance, and not having to make a co-pay or deductible made their decision to get a mammogram easier. Many of the participants who were newer refugees noted the hardship of

living in the United States because of limited financial resources. These participants firmly stated that without Medicaid they would not be able to seek any type of health care.

Discussion and Conclusion

Extrapolating from the results of the fifteen participants' expressions of their feelings, beliefs, and experiences about the factors that function as barriers and facilitators in their mammography-screening decisions, the following propositions are offered:

1. Breast health messages from the lay and professional community have a significant influence on Hmong women's decisions to seek preventive breast care. Exposures to messages from the professional community tend to have facilitative effect, whereas exposures to the lay community have an opposite (barrier) effect.
2. There are psychosocial, cultural beliefs, educational, instrumental, and social (environmental) factors that can either function as barriers and/or facilitators to influence Hmong women's decision-making process about preventive breast health care.
3. Breast health education offers benefits of an increased awareness of disease formation and the need for screening. However, education does not necessarily lead to a decision to seek preventive breast health care.

Hmong women, as a subgroup of Asian American/Pacific Islanders (AAPIs), have one of the lowest screening rates for mammograms in the United States (Liao, Tucker, Okoro, Giles, Mokdad, & Harris, 2004). The data analysis from this research showed that to influence Hmong women to acquire mammography screening, healthcare professionals need to use a culturally sensitive and multi-disciplinary approach to provide breast health education and assessment, while also providing instrumental support and encouraging social support. Although some of the participants did not mind having a Western male provider conducting the breast cancer

screenings (which included mammography screening and a clinical breast exam), some participants did. Some of the participants also indicated that they preferred having a female educator teach about breast cancer because of the sensitive nature of the topic. Furthermore, when breast cancer education is taught and is followed up by the provider making an appointment or a referral, the participants reported a higher probability of obtaining a mammography screening. Therefore, the researcher recommends that women who meet the recommendations of the United States Preventive Services Task Force (USPSTF, 2002), receive breast cancer information and a referral for a mammography screening.

Moreover, because women depend upon family to assist with instrumental support as well as with decision making, engagement of these family members is crucial. Some participants recommended seeking out these family members at their place of work. Further research on how to initiate and maximize educational opportunities in the work place is needed.

Another recommendation that would increase the mammography-screening rate of Hmong women involves addressing the sociocultural factor of symptomatic health seeking behavior. As previously mentioned, this behavior is the tendency to obtain health care only when experiencing signs and symptoms. From the data analysis, this was the main barrier for Hmong women to seeking breast cancer screenings. Consequently, the participants recommended increasing breast cancer education and outreach to the Hmong community. From these educational sessions, community knowledge of breast cancer and awareness of the need for screening can be increase.

Since this study's goal was to only explore the participants' feelings, beliefs, and experiences of the sociocultural factors that may influence their use of mammography screening, further research to investigate women's behavioral change after attending breast health classes

would be beneficial. This type of inquiry would provide information about the effectiveness of breast health education in changing the belief system and thus, the behavior of the Hmong women. Additional research is also needed to illuminate how different providers, such as primary medical doctors, community health educators, and nurses conducting breast cancer education impact the decision-making processes of Hmong women in relation to preventive breast health care. By understanding the influence of these relationships, resources may be appropriately allocated.

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Appendix A

Interview Questionnaires

1. How old are you?
2. Are you married, single, divorced, or widowed?
3. Do you have health insurance? If "Yes"-What kind of health insurance do you have?
4. How long have you been living in the United States?
5. What language (s) do you and/or your family primarily speaks at home?
6. What have you heard about breast cancer screenings, such as breast self-exam (BSE), clinical breast exam (CBE), and mammogram?
7. If, "Yes"-Who was the person that provided you the information about BSE, CBE, and/or mammogram? Or where did you learn about BSE, CBE, and mammogram?
8. From what you have heard about a mammography exam, have you gotten one? Or would you get one?
9. What do you think other women think and feel when they hear the word mammogram or mammography exam?
10. What sort of things do you think that other women consider when making decisions about getting a mammography exam?
11. Do you think other women involve others when making decision about mammography screening? How does that affect or not affect their decision to seek a mammography exam?
12. How did the breast health education class that you attended help or not help when making decision about getting a mammography exam?

13. What are some things that can help influence Hmong women to obtain a mammogram as recommended by Western health care providers?
14. What are some things that you think of when making decision about mammography screening? (optional)