

LEADERSHIP & PROFESSIONAL DEVELOPMENT

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Improving Early Detection of Breast and Cervical Cancer in Chinese and Vietnamese Immigrant Women

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The purpose of this article is to describe a project designed to promote cancer screening among immigrant women in a midsize urban center in south-central Canada. Public health nurses (PHNs) and nursing faculty members developed the project and recruited, trained, and worked with women's health educators (WHEs) and community leaders to raise awareness of cancer prevention among immigrant women and to help eliminate barriers to accessing services. The background, process, results, and lessons learned will be presented.

Background

Three forces motivated the development of the project: (a) government mandate, (b) local needs and service pressures, and (c) research evidence. The provincial public health department required that local municipal departments meet mandatory health program and service guidelines (Ministry of Health and Long-Term Care for Ontario, 1997). The guidelines acknowledged the existence of underserved populations, including immigrants, and focused on the early detection of cancer.

The municipal public health department, in partnership with English-as-second-language (ESL) instructors, multicultural community agencies, and cancer screening services, had been providing information about the early detection of cancer to immigrant women. However, the information usually was delivered to women attending crosscultural groups (e.g., ESL classes, settlement services health days), and no evaluation had been made of the effectiveness of those educational efforts. Furthermore, staff members at a local mature women's health clinic and provincially funded breast screening clinics noted that very few immigrant women accessed their services. Primary disease prevention was available, although limited, through community health centers and primary care physicians. Family physicians were in scarce supply, and newcomers frequently were unable to find a doctor or a caregiver from their home countries (Talbot, Fuller-Thomson, Tudiver, Habib, & McIsaac, 2001).

We had some experience at the health department using peer educators in the child health program and implementing a small project for cancer screening promotion for

Spanish-speaking immigrant women from 1999–2000. We also were aware that projects using peer educators to increase cancer screening had been launched successfully in other centers using volunteers or paid staff. Studies in the United States (Legler et al., 2002; Pasick, Hiatt, & Paskett, 2004) and Canada (Hyman & Guruge, 2002; Taylor et al., 2002) supported the effectiveness of the peer-educator approach to cancer screening. A systematic review of the literature suggested that direct, tailored education to immigrant women coupled with mass media exposure led to increased cancer screening (Black, Yamada, & Mann, 2002). Given those incentives, the Early Detection of Cancer Team, comprised of nurses in the municipal public health department, decided to assess the feasibility of a project using peer educators and system-focused initiatives to reach underserved communities with cancer screening information. Because the words "peer" and "lay" are not known in Asian languages, we chose the term WHEs.

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Leadership & Professional Development

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Process

The process that we used to develop the project was guided by the multiphasic Precede-Proceed Model developed by Green and Kreuter (1999). The model incorporates social, epidemiologic, behavioral, educational, and administrative input in program planning and evaluation. First, we used a focus group approach to gather information on the social, behavioral, and educational factors that affected screening behaviors in immigrant women. Using four criteria (see Figure 1) to guide the identification of ethnocultural groups, we selected four immigrant communities: Asian Indian, Pakistani, Chinese (both Mandarin- and Cantonese-speaking), and Vietnamese. A research assistant contacted key community leaders, who helped recruit women to participate in a series of focus groups. The research assistant obtained informed consent and moderated the groups, using cultural interpreters when necessary. Cultural interpreters take into account the spoken word within context of the culture, because words that have exact matches in another language might not be acceptable or carry the same meaning.

All group discussions were recorded on audiotape, transcribed, and analyzed for key themes. Analysis of the focus group sessions revealed differences and similarities among groups in beliefs about cancer, early detection of cancer, preventive health behaviors, and informational needs (Black & Zsoldos, 2003). Women in all four groups preferred a female physician, preferably one who shared the same culture and language. Their expectations of healthcare services in Canada varied, depending on cultural background and country of origin. However, all believed that healthcare providers needed to recognize that great diversity (e.g., religion, class, language) existed within and across ethnocultural communities. Generally, the women in all four groups were receptive to the idea of a WHE. They indicated that outreach was acceptable and suggested venues such as the media, grocery stores, faith communities, women's groups, and community centers. Analysis of

1. A sufficiently large proportion of immigrant women older than 40 years of age who needed information about cancer screening
2. Relatively high cancer rates, based on provincial and national statistics
3. Communities that have established relationships with other health and social agencies (given the scope and limited resources of the project)
4. Three to five years since arrival in Canada (Priorities during the first three years usually focus on settlement and employment issues, not on health care.)

Figure 1. Criteria to Identify Ethnocultural Communities for Focus Groups

the group discussions also yielded information on predisposing (i.e., knowledge, beliefs, values, preferences), enabling (i.e., skills, resources, barriers), and reinforcing (i.e., rewards or punishments following behavior) factors for cancer screening.

In addition to focus groups, the Early Detection of Cancer Team created a brief survey to gauge physicians' awareness of the need for cancer screening and to question them about their current screening practices. Nine local family physicians whose practices included large numbers of immigrant women were invited to complete the survey. Of the four who participated, three provided care mainly for Chinese women and one primarily for Vietnamese women. The physicians identified language as a key barrier to screening of immigrant women. They reported that the best ways to increase screening behaviors were to develop trust and to engage in health-related conversations with their patients. All four physicians approved of the concept of a WHE and believed that the role could complement their practices and give them more time for patient care.

Next, key immigrant community leaders (e.g., an immigrant program director at a community health center) were invited to dialogue with members of the project team at a series of neighborhood meetings. Individuals attending the meetings were encouraged to describe factors that influenced their health and health care. As a result of the discussions, we became acutely aware that screening often was influenced by population health determinants external to individuals (e.g., poverty, child care, transportation difficulties) and healthcare system barriers (e.g., provider gender, overcrowded physician offices, lack of physician availability).

To collect epidemiologic data for the project, we completed an extensive review of the evidence on cancer incidence, mortality, and screening rates among immigrant women in the area (Green & Kreuter, 1999). Hamilton in Ontario, Canada, population 662,401 in 2001, had a diverse mix of residents, with secondary migration from a nearby, larger city, resulting in an immigrant population of 24% (Statistics Canada, 2001). However, the size of specific ethnocultural communities was small in comparison to cities such as Toronto, Vancouver, and Montreal. Healthcare services program planning and financial and human resource allocation often were difficult when the programs were tailored to specific communities. The focus of those who were working with immigrant women was to help them meet basic needs for living or to help with training for employment, rather than health education.

The final step in the process was to gather input from important administrative and policy sources. The team devoted time to an examination of potential community resources (e.g., a local agency provided a van to transport women to the breast screening

clinic) and the degree of congruency between the project goals and the directives of the related community organizations. For example, a local heart health program, whose mandate to reach underserved groups was similar to ours, could supply food vouchers to purchase refreshments for the educational sessions. Cooperation among organizations allows finite resources to be shared more equitably (Green & Kreuter, 1999).

Results

The data drawn from the focus groups, physician surveys, and community meetings formed the basis for a WHE training curriculum (Black & Zsoldos, 2003). The actual training of the WHEs consisted of a four-day program (see Figure 2). After the training was completed, members of the project team provided follow-up meetings for the WHEs at two-week intervals to discuss issues and answer questions. Limited funding, however, meant that we could hire and pay only two WHEs for the initial project. The selection of the Chinese and Vietnamese communities was based on community needs.

The WHEs used individual and community approaches to recruit immigrant women into the program and help promote cancer screening. The individual approach consisted of inviting women to attend a small group meeting dubbed a "tea party." Women were invited to the meetings via the WHEs' own personal networks, newly developed community contacts (e.g., Chinese owners at the downtown farmers market, the master at the Vietnamese Buddhist temple), and flyers distributed to local agencies. The meetings were identified as tea parties because socializing and sharing refreshments such as juice, tea,

Day 1

- Overview of project, health department organization, and settlement agencies
- Discussion of health promotion and personal safety

Day 2

- Verbal and nonverbal communication
- Learning styles
- Adult learning principles
- Facilitation role
- Dealing with problem people and situations

Day 3

- Presentation training (Pap test, clinical breast examination, mammograms)
- Community resources
- How to find a doctor
- Speaker from Children's Aid
- Beliefs, attitudes, values, and cultural themes

Day 4

- Overview of documentation forms
- Visit to breast screening program

Figure 2. Training Schedule for Women's Health Educators

and fruit are important to the cultural groups. We thought that the nomenclature might be more appealing to potential participants. At each tea party, a WHE discussed healthy living, risk factors for cancer, cancer screening, and how to access healthcare services. Tea parties were held in various locations, such as churches, the YWCA, a downtown library, and grocery store demonstration spaces. Attendance ranged from 5–30 women, with child care provided at some locations. Most women attended only one session, although some returned with friends.

The WHEs followed up with individual “booster” telephone contacts to every attendee who agreed to participate in the program evaluation approximately four to six weeks after each tea party. The purpose of the telephone calls was to determine whether the women had participated in new or ongoing screening and to help them overcome barriers to obtaining health care. When needed, the WHEs helped book appointments for health care and cancer screening. The WHEs also accompanied some women to their appointments to provide language and emotional support.

Additionally, members of the project team worked with key neighborhood leaders to help increase their awareness of systemic barriers that hindered the provision of health care to immigrant populations. Meetings were held periodically during the year at community facilities to share issues related to health care for immigrant women, problem solve, and generate possible sources of funding for the project. Additional means of highlighting the healthcare barriers that faced immigrant women included presentations by the PHNs to the municipal board of health, articles in the local newspaper, and television clips that profiled the WHEs and the services that they offered. The project team provided progress reports to academic family medicine facilities, the regional cancer center, and public health and community health offices.

From October 2003–February 2005, the WHEs delivered 50 presentations to more than 500 immigrant women. At baseline, 38%–45% of women in the two cultural groups reported that they had never had a Pap test and 35%–46% of women 50 years of age and older stated that they had never had a mammogram. Of those who participated in the evaluation at four months, 74%–83% had obtained Pap and clinical breast screening tests since attending the presentations. Of the women 50 years of age and older, 64%–67% had a mammogram; of those who did not, most planned to make an appointment.

Lessons Learned

The initiation of the project was more challenging than we had imagined. Training staff, gaining the trust of the participants, allotting time for documentation, and assessing the results of our efforts required careful consideration. We learned that planning for

program evaluation from the beginning was essential. We also learned the importance of sharing our results with community leaders, policy makers, and the media. To publicize our work with immigrant women, we provided ongoing information to the municipal council and invited local media to showcase the project. The activities led to funding of the WHE project by the public health department for an additional two years.

Although the focus of the project was on early detection of cancer, we realized that immigrant women had many other unmet health information needs. During the project, a Women’s Health Day was organized. More than 100 women (and their families) from the Vietnamese and Chinese communities attended. Educational sessions about heart disease, diabetes, contraception, menopause, and healthy eating were provided because the groups frequently requested information on those topics. In addition, a recognition event with a certificate ceremony was held for the numerous community members who had assisted the WHEs during the project.

Barriers

Major barriers to the project’s success included insufficient funds to pay staff, shortage of space, a lack of educational resources, and limited funds for evaluation. Potential supporters often viewed the project as either not meeting their funding criteria or as covered under the public health mandate. Although the project was congruent with the aims of the provincially and municipally funded public health programs, the resources required to support the salaries of the WHEs could not be financed through public health programs. Other organizations serving immigrant women also had insufficient funds to support paid positions for peer educators. As a result, we reexamined staffing resources and sought short-term funding that would allow us to continue the project. For example, we negotiated with a local heart health coordinator to support the educational events with project incentives (e.g., bus tickets, food vouchers). In addition, we received a small grant from a local women’s service club. Other barriers included a lack of family physicians, particularly female physicians, who accepted new clients; inadequate or insufficient educational materials in appropriate languages; difficulty identifying immigrant women who needed screening; immigrant women’s busy lives and competing priorities; and transportation difficulties.

Physician support and recommendations for screening are strong enablers for women to obtain screening (Black, Stein, & Loveland-Cherry, 2001; Zapka, Stoddard, Maul, & Costanza, 1991). Even so, some physicians provide only minimal primary preventive care (Mirand, Beehler, Kuo, & Mahoney, 2003). In fact, some women in the project told the WHEs that their doctors were too busy to listen to their concerns. Other women

said that physicians advised them that they didn’t need to be screened, even though they met screening guideline criteria (e.g., age). Still other women were hesitant to undergo screening with male physicians.

Facilitators of Success

Facilitators to success included establishing strong connections with community leaders and gatekeepers (informal and formal). Initially, the WHEs sought leaders in their personal groups to promote screening. As the project progressed, they developed skills that enabled them to network with others, establish their credibility as community leaders, and improve their ability to reach immigrant women.

Another facilitator was the support and mentoring provided for the WHEs. PHNs provided ongoing training, support, and consultation to help build liaisons between the healthcare sector and the WHEs. New educational sessions were developed throughout the project to address issues identified by the WHEs (e.g., child protection legalities, follow-up for abnormal Pap test results, and answers to questions related to breast cancer diagnosis). In collaboration with the local breast screening clinic, the intake form was translated into Chinese and Vietnamese, and a process for recalls was developed for non-English-speaking women. An added benefit was increased cultural competency among nurses and other community partners as a result of their work with the project.

Conclusion

The project not only has increased cancer screening among immigrant women but also has transformed PHNs’ work with underserved women in the city. Public funding will enable us to extend screening to other communities and to develop screening strategies in a chronic disease perspective. We have learned the importance of listening as immigrant women tell their stories, and we understand more fully the barriers they face in accessing health care, including early detection of cancer. We must direct future efforts toward building healthy public policy that will address inequalities and develop sustainable programs.

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