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Developing a Culturally Responsive Breast Cancer Screening Promotion with Native Hawaiian Women in Churches

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Abstract

This article presents findings from research to develop the promotional component of a breast cancer screening program for Native Hawaiian women associated with historically Hawaiian churches in medically underserved communities. The literature on adherence to health recommendations and health promotions marketing guided inquiry on screening influences. Focus groups and individual interviews patterned on the culturally familiar practice of *talk story* were conducted with 60 Hawaiian women recruited through religious and social organizations. Text data were analyzed with an incremental process involving content analysis and Airhihenbuwa's PEN-3 model. Key informants and senior colleagues reviewed preliminary findings to ensure accuracy of interpretation. Findings reflect collectivist values at the intersection of indigenous Hawaiian culture and religiosity. Inclusion of messages that encourage holistic health across the intergenerational continuum of extended family and fictive kin, reinforcement from spiritual leaders, and testimonials of cancer survivors and family members may facilitate Hawaiian women's screening intent.

Keywords

cancer; culture; indigenous population; screening; spirituality

Breast cancer is the second most commonly detected carcinoma among women in the United States and primarily affects older, postmenopausal women (American Cancer Society, 2003). Although women of all ethnicities and socioeconomic backgrounds are affected by breast cancer, the disease burden falls heavily on women of color, especially those living in socioeconomically disadvantaged, yet culturally rich, communities (Haynes & Smedley, 1999). Among those most affected by breast cancer disparities are Native Hawaiian women or descendents of the Polynesian voyagers who settled Hawai'i (US. Census Bureau, 2000).

Disparities in breast cancer mortality and survival rates persist among Native Hawaiian women (American Cancer Society, 2003). In comparison with other ethnic groups living in Hawai'i, Hawaiians have the highest rate of mortality; mortality rates for Hawaiian women are 31 per 100,000 in comparison with women of other races for whom the mortality rate is 18.1 per 100,000. Five-year relative survival rates for Hawaiian women are the lowest of all groups in the state and are 9 percent shorter than for all races of women in the United States. Disparate outcomes are attributed to a larger proportion of advanced disease at diagnosis and associated with low participation in routine mammography (Hawai'i State Department of Health, 2000).

Increasing Hawaiian women's use of routine mammography is crucial to reducing current disparities (Santos et al., 2001). Guidelines from the American Cancer Society (2003) suggest that women (40 years of age and older) receive annual mammograms. Participation in mammography is emphasized because it offers women the best prospect of detecting cancer at an early stage when treatment outcomes are likely to be most successful. Notably, Hawaiian women's low or no participation in screening is understood to be, at least partially, the result of cultural conflict experienced in conventional, Western mainstream health care services (Hawai'i State Department of Health, 1998). Published research suggests that culturally responsive approaches may be needed to increase Hawaiian women's screening participation. Called for are evidence-based screening interventions tailored on Hawaiian cultural strengths, including those related to spirituality and collectivist-oriented norms (Santos et al., 2001).

The developmental study described in this article was part of a larger research intervention to test the efficacy of a multifaceted and culturally responsive breast cancer screening intervention offered through a partnership of historically Hawaiian churches and university-based researchers. Study aims were to identify older Hawaiian women's beliefs and attitudes toward use of mammograms, assess influences on screening participation, and describe cultural constructs for inclusion in screening promotions.

THEORETICAL AND CONCEPTUAL FRAMEWORKS

The theoretical and conceptual frameworks informing this study include the following: the health belief model, social marketing theory, and the PEN-3. The health belief model (Becker, 1990) was developed by the U.S. Public Health Service to enhance popular acceptance of early detection screening. Generic beliefs associated with behavioral intent are identified. Intent to participate in routine mammography is correlated with beliefs that screening is efficacious in detecting breast tumors and that screening mitigates the severity of consequences by detecting tumors early, when the latter are most amenable to treatment (Cole, Bryant, McDermott, Sorrell, & Flynn, 1997). Among women with no family history of breast cancer (that is, no first-degree relative affected), those reporting moderate levels of belief in susceptibility to breast cancer risk or worry are more likely to participate in annual mammograms than are women with mild or severe worry (Andersen, Smith, Meischke, Bowen, & Urban, 2003). In our study, beliefs and attitudes related to breast cancer and mammography were explored with a view toward informing promotional efforts.

Social marketing theory (Lefebvre & Rochlin, 1997) is based on the concept of market segmentation and involves tailoring promotional communications to the specific group or market for whom an intervention is intended. Tailored promotions rely on an assessment of persuasive communication in the following three domains: (1) the message or substantive content, (2) the messenger or credibility of "who" delivers the message, and (3) the channel or medium for "how" a message is disseminated. Breast-cancer-related promotions have been tailored on various consumer characteristics (for example, spirituality, collectivism, racial price) and have generally had a positive influence on medically underserved women's use of mammography (Kreuter et al., 2004). In the current study, we sought to identify elements of communication persuasive to Hawaiian women.

The PEN-3 model for developing culturally appropriate health interventions (Airhihenbuwa, 1995) is ecological in perspective and, as such, identifies individual, family, community, and systemic influences to behavioral change. PEN-3 is also a mnemonic for the categories highlighted in the three dimensions that are posited as essential to culturally appropriate health programming. The health education domain is the first dimension and includes identification of **P**ersons who are the primary focus of the intervention; **E**xtended family members who may influence or be influenced by the behavioral change and therefore, need to be considered in

intervention design; and Neighborhoods or communities in need of the intervention. The second dimension for consideration involves the educational diagnosis, or those factors that influence health behavior change. These factors include Perceptions or beliefs and attitudes about a health behavior, Enablers or systemic factors related to behavioral enactment, and Nurturers or cultural norms of the individual's social network. The third dimension specifically focuses on assessment of how cultural factors influence the health behavior. Perceptions, nurturers, and enablers are assessed as having either a Positive influence on change, an Existential influence (that is, neither positive nor negative but nonetheless fundamental to the culture of individuals and groups of concern), or a Negative influence to behavior. In cancer prevention and control, PEN-3 has been helpful in aligning health promotions with a community's existing beliefs and practices about early detection screening (Abernathy, Magat, Houston, Arnold, & Bjorck, 2005; Erwin, Johnson, Feliciano-Libid, Zamora, & Jadorf, 2005).

Airhihenbuwa (1995) also stressed for those using PEN-3 the importance of culturally grounded interactive processes to engage groups in dialogue about how behavior changes may be influenced. Thus, the current study engaged women in group and individual dialogues patterned on *talk story*, a culturally familiar style of discussion (Gotay & Wilson, 1998). PEN-3 dimensions and categories were used to develop discussion topics and in data analysis.

CULTURALLY RESPONSIVE SCREENING PROMOTIONS

Findings from evidence-based screening promotions indicate that participation of diverse and medically underserved women is enhanced by aligning promotions with a group's values and practices (Hiatt et al., 2001). In addition to inclusion of relevant values and practices, culturally responsive screening promotions have emphasized the use of natural networks as promotional channels, culturally familiar communication medium, and use of linguistically appropriate terms. For example, the *kokua* (help, helper) group involved women's family and friendship networks and effectively increased screening intent in one socioeconomically disadvantaged Hawaiian community (Gotay et al., 2000). Credible messengers, including culturally similar cancer survivor role models and lay health workers have been used to great effect in screening promotions offered to women in diverse communities. Screening messages diffused through familiar media, such as witnessing (E.J. Bailey, Erwin, & Belin, 2000), talking circles (Burhansstipanov et al., 1998), and talk story (Gotay & Wilson, 1998), have been positively received by African American women in churches. Native Americans, and Asian and Pacific Islander women in Hawai'i, respectively.

NATIVE HAWAIIAN HEALTH, SPIRITUALITY, AND THE FAMILY COLLECTIVE

Prior to Western contact and colonization, the indigenous people of Hawai'i established a thriving society with a tradition of holistic health and well-developed practices for maintaining wellness and curing sickness (Bushnell, 1993). Holistic health (*ola pono*) was enunciated as harmony (*lokahi*) in a triad of three vital realms: spirituality, physical well-being, and relational well-being within the intergenerational family of blood-related (*'ohana*) and fictive kin (*hoahanau*). Ensuring health in the *lokahi* triad was viewed as a dynamic process that involved attention to *pono*, a morality of mutuality in all relations (Rezentes, 1996). Sickness (*ma'i*) was understood as a state of disharmony and lack of *pono* relations in one or more realms of the *lokahi* triad. Thus, healing of physical ailments included spiritual and relational components, as well as attention to bodily symptoms. For example, *ho'oponopono*, a spiritually grounded practice of family discussion, was conducted to identify and then to resolve spiritual or interpersonal disharmonies that might compromise the efficacy of herbal medicines used to treat physical ailments. During the culturally intolerant period of Western colonization, indigenous health and healing practices were denigrated and in some instances outlawed.

Despite such sanctions, the view of health as the three-part harmony of physical, spiritual, and relational well-being endured as a cultural preference for many Hawaiians (Bushnell, 1993).

Cultural dissonance and distrust of allopathic medicine and research are frequently identified as factors that discourage contemporary Hawaiians' use of conventional, Western health care services. Efforts to promote health practices have often failed to demonstrate an adequate understanding of the cultural norms and barriers involved in the enactment of behavioral change. Such efforts, albeit well-intentioned, have been perceived by some Hawaiian communities as a cultural imposition and have met with resentment (Wegner, 1989). Breast cancer screening promotions that focus on the individual to the exclusion of the family collective, disregard the role of spirituality in health and illness, or fail to consider culturally patterned support may be experienced as dissonant. These types of promotions are understood to contribute, at least in part, to current patterns of Hawaiian women's low or no use of routine mammography (Meng, Maskarinec, & Wilkens, 1997).

Diverse spiritual perspectives, including the Judeo-Christian tradition, are represented among Hawaiians living in contemporary times. Historically Hawaiian churches are those chartered by congregational missionaries in the 19th century that perpetuate a unique blend of religiosity and indigenous culture with faith expressed through Hawaiian values and language (United Church of Christ, 1996). These churches are located throughout Hawai'i, with most located in communities designated as medically underserved areas (U.S. Department of Health and Human Services [HHS], 2003). Congregants tend to be adults in the second half of life (United Church of Christ, 2001), and it is estimated that older women (40 years and over) of Hawaiian ethnicity comprise about 60 percent to 65 percent of the active membership (Rev. K. Lee, executive director, Association of Hawaiian Evangelical Churches, personal communication, October 28, 2003). This is the age cohort for whom routine mammography is recommended (American Cancer Society, 2003).

METHOD

A brief survey and semistructured schedule of discussion questions were developed for gathering sociodemographic information and perceptions of mammography, respectively. After receiving approval from relevant institutional review boards, recruitment proceeded through the use of purposive theoretical sampling methods (Miller & Crabtree, 1992). To gain the perspective of older Hawaiian women, four predominantly Hawaiian communities designated as medically underserved areas were identified (HHS, 2003). Religious and social organizations in each area were approached. Researchers presented study information to groups of older Hawaiian women and invited participation in a single talk story session. Those unable to participate in a group were offered an individual interview.

Fifty Hawaiian women participated in one of seven group discussions; 10 completed individual interviews. The final sample comprised 60 women, all of whom reported full or part-Hawaiian ethnicity. The mean age was 65 years ($SD = 14.9$). The majority lived in a rural community (91.6 percent) and identified as culturally Hawaiian (92 percent) and Judeo-Christian (90 percent). Discussions were conducted by a female facilitator qualified by a master's degree in social work or a related field, with extensive background in social service or community health in Hawaiian communities and training in study protocols. All discussions were patterned on talk story and began with friendly introductions (*ho'olauna*). The latter involves finding shared experiences or mutual acquaintances between individuals and groups meeting for the first time. Such commonalities are understood to strengthen social connections among Hawaiians meeting for the first time and to prepare a relational context in which sensitive discussion may occur. Facilitators disclosed relevant personal and professional information (for example, family background, work in Hawaiian communities, experiences with breast cancer). Before

obtaining informed consent, facilitators offered a brief overview of how breast cancer affects Hawaiian women, explained the purpose of the research, and discussed how findings would be used to develop breast cancer promotions. Risks and benefits, as described in the consent form, were highlighted. Given the distrust of research prevalent in some Hawaiian communities, questions were encouraged and sufficient time allowed for addressing the women's concerns.

Surveys were administered after written informed consent was obtained from participants. The survey elicited sociodemographic characteristics (age, neighborhood, ethnicity, cultural identification), experience with breast cancer (survivor, family member of survivor), spirituality (spiritual beliefs and practices, religious affiliation), and other information for marketing the screening promotion (for example, preferred venue for receiving screening education). Next was talk story, or conversation-like discussions that move at a pace more leisurely than that of conventional focus groups (Ka'opua, Mitschke, & Lono, 2004). Talk story discussions focused on health beliefs, attitudes, and experiences related to breast cancer and screening, views of spirituality/religiosity relevant to health practices, and suggestions for developing breast cancer screening promotions. Discussions averaged about 90 minutes in length and were audiotaped and transcribed verbatim. Vouchers for use at a sundry store were presented as tokens of appreciation.

Analysis of text data involved incremental use of content and PEN-3 analyses. First, a content analysis (Krippendorff, 1980) was performed to examine general patterns and themes. Each transcript was independently coded by two research team members and subsequently discussed at weekly meetings of the full team. Themes emerging across interviews were continuously noted and compared. After all transcripts were reviewed, the team developed a summary of preliminary findings and arrived at a consensus agreement. This summary served as the basis for a second analysis using PEN-3 dimensions and categories (Airhihenbuwa, 1995). Through co-coding and team discussion, researchers categorized findings relevant to the education domain and diagnosis of the health behavior. Upon completion, researchers assessed influences on screening participation as either positive, existential, negative, or both positive and negative. Findings from the second analysis were summarized with implications for promotions. To ensure accuracy of interpretation, six informants and three colleagues reviewed all findings. Informants were qualified by their leadership in historically Hawaiian churches, knowledge of the culture and language, and personal experience as either a breast cancer survivor or a first-degree relative of a survivor. Senior colleagues were knowledgeable of Hawaiian culture, cancer prevention and control research, and qualitative methods.

FINDINGS

Health Education Domain

Participants viewed older women as the primary focus for intervention. However, inclusion of younger women and male relations was also emphasized. Participants reasoned that younger women needed to "prepare" (*makaukau*) for seeking routine screening when age appropriate and that male family members needed to better understand how tangible and emotional support could facilitate screening. Several cultural constructs relevant to the educational domain were identified as follows: emphasis on the mutual needs of women and the intergenerational family of blood relations (*'ohana*) and fictive kin (*hoahanau* or "church family"), caring for each other (*malama ke kahi i ke kahi*), and responsibility to the collective (*kuleana*) for the sake of the children and future generations. This was expressed in statements such as, "I stress prevention and regular check-ups to my adult children. They need to take care of themselves for their children's sake."

Educational Diagnosis

The second PEN-3 dimension includes the categories of perceptions, enablers, and nurturers. Perceptions involve beliefs, knowledge, attitudes, and cultural values. Among participants, mammography was believed to be beneficial in detecting breast cancer when it is most treatable. Only two women expressed the belief that screening was physically harmful (long-term effects of radiation). Knowledge about screening varied with most women being uncertain of screening guidelines and reporting the tendency to rely on provider reminders. Attitudes toward clinical breast examinations and mammograms were associated with physical discomfort (for example, “don’t like having boobs squished”) and invasion of personal space (for example, examination of private parts, embarrassment about disrobing). These attitudes functioned as inconveniences rather than as screening deterrents. Fear of detecting cancer was most commonly stated as a deterrent. Despite perceived benefits of early detection screening, participants were worried about the psychosocial effect and financial burden that diagnosis and treatment might have on the woman and her family. According to one woman, “You don’t want to find out that you have cancer because then there’s all this trouble to deal with.” Women who viewed health as the absence of physical symptoms tended to seek health care only when “sick.” The attitude, “If I feel okay, then I must be okay” was reported as preemptive of screening.

Enablers are the second category of the health diagnosis and refer to systemic factors. In this sample, screening was enabled by access to routine care, transportation to facilities providing mammography, positive relations with a primary care provider, capacity of clinical staff to demonstrate cultural sensitivity, and providers’ verbal and written reminders. In some instances, participation was disabled by reliance on family members for transportation. Women with inadequate health care insurance expressed some hesitation toward the use of free services and feared that there might be a “catch.” Concern was expressed that they might “feel shame,” be “asked for donation,” be negatively evaluated, or be treated with discrimination.

Nurturers are beliefs, attitudes, and actions mediated by family and other reference groups. Responsibility (*kuleana*) within the family or collective functioned as both a negative and a positive influence to screening. Women’s responsibilities (for example, care of young children) could conflict with self-care and in some instances specifically disabled screening. For other women, responsibility to family was expressed in ways that promoted screening. The importance of staying healthy for the sake of the children and grandchildren is explained by one participant:

The old folks used to say ‘*ka mo’opuna i ke alo*, keep the face of the grandchild before you.’ Take care of all you have, including your health, or your children and grandchildren won’t have it.

Practicing one’s spirituality (*ho’omana*) was stated as a fundamental conviction and tantamount to well-being. The majority of women in the sample viewed well-being as a holistic phenomenon that included attention to spiritual, social, and physical health. However, some women admitted that their present efforts involved improving their spiritual health to the exclusion of their physical health; attention to physical health would come “later.” For most women, the church was viewed as a place of “spiritual *piko*” (umbilical connection to spirituality and family traditions). In this “safe haven” or “home,” fellow congregants were referenced as “church family” or “*hoahanau*” (fictive kin). Over the course of their lifetime, women who “grew up in the church” developed “*pili*” or “close” and enduring relations with members of the church family. These were relationships in which sensitive issues related to health and illness might be discussed and influenced.

Ministers (*kahu*) and lay leaders (minister’s wife or *mama kahu*, deacons or *kiakona*) were identified as influential. Participants referenced the tradition of female leadership and identified

ministers and minister's wives who were breast cancer survivors and, thus, potential messengers for encouraging screening participation. Also suggested were "face-to-face" or "alo alo" testimonies from survivors and family members who might reinforce the hopeful message that cancer need not be a "death sentence." The culturally familiar practice of talk story as a preferred communication medium for screening messages was explained:

Taking time to share your history, stories about 'who' you are, 'what' you've been through, this comes naturally to us. It's in our blood. Out of this comes understanding of what we've been through. As a survivor, hearing from another survivor was helpful, hopeful.

Inclusion of spiritual practices in screening promotions was recommended to reinforce strengths derived from spirituality and the positive meaning imbued in life's challenges. Recommended were the inclusion of "spiritual food," including practices such as prayer (*pule*), singing hymns (*himeni*), and reading of biblical scripture (*Heluhelu Haipule*). Although participants were fluent in English, the purposeful use of common Hawaiian terms (such as, *malama ke kahi i ke kahi* or caring for each other) was suggested. Demonstration of unconditional positive regard, sociability, and actions that supported women and families were emphasized.

DISCUSSION

In talk story sessions, women from underserved communities described influences on mammography use. In general, mammograms were viewed as beneficial, not harmful, and important to health. However, other influences were also identified that could compromise behavioral enactment. Participation in routine screening was disabled by lack of knowledge specific to screening guidelines and resources, fear of finding breast tumors, concern that health care insurance might not adequately cover screening and treatment costs, hesitation to participate in free screening programs, and deferment or procrastination in seeking screening. Our findings are consistent with results from a knowledge, attitudes, and practices (KAP) survey of 117 Hawaiian women living in one medically underserved community (Tsark & Braun, 2001) and with the greater body of health promotions literature indicating that positive intent alone is often insufficient to support behavioral change (Airhihenbuwa, 1995).

Particular sensitivity is indicated when referring uninsured or underinsured women to free screening services. Participants suggested that women in such situations may regard with suspicion those services advertised as "free." This suspicion may be due to past experiences of discrimination, concern that no-cost care may be substandard, and concern that free services are synonymous with medical research. Similar concerns were raised in prior research efforts with Hawaiian and other medically underserved women (Ka'opua et al., 2004). However, a few screening intervention studies suggest that the use of vouchers for free mammograms may be positively received by medically underserved women, including those of Hawaiian ethnicity. The critical caveat to use of free services may be promotion through outreach by trusted community members (T. M. Bailey, Delva, Gretebeck, Siefert, & Ismail, 2005; Tsark & Braun, 2001).

Talk story discussions reveal that the credibility of screening promotions may be advanced through social marketing strategies that reflect culture-specific value preferences. Frequently referenced were the cultural constructs of holistic health (*ola pono*), which include the concepts of spiritual, physical, and relational harmony (*lokahi* triad) and of individual responsibility (*kuleana*) within the intergenerational family collective of blood-related and fictive kin (*'ohana* and *hoahanau*, respectively). These concepts functioned in both positive and negative ways on screening participation. Strongly indicated is the need to distinguish the function of cultural beliefs such that those that operate in positive ways are reinforced and those that present

barriers to screening are mediated (Simon, 2006). Such a strategy may be particularly salient when referencing Hawaiian values like *kuleana*. Participants suggested that screening be framed as a commitment to family well-being and one that likely involves emotional and concrete support from family members.

Study findings extend prior Hawaiian health research by describing the ways in which Hawaiian women influence and are influenced by spirituality/religiosity and the multigenerational family system of blood relations and fictive kin from church networks. Emphasis on the value of responsibility, as situated in this family system, is consistent with previous research on the role of the Hawaiian family in adherence to health recommendations (Ka'opua & Mueller, 2004) and the inclusion of spiritual and collectivist values in social work practice and cancer-related communications with Hawaiians (Gotay et al., 2000; Mokuau, Browne, & Braun, 1998).

IMPLICATIONS FOR SOCIAL WORK PRACTICE AND RESEARCH

Practice implications for developing culturally responsive screening promotions for Hawaiian women in churches are detailed in Table 1. Older women are the primary focus of family-oriented education, with men and younger women as secondary foci. Thus, educational sessions would be open to all family members. Messages of hope (such as how screening has benefited women and families) and of help (examples of family support, useful community resources) are suggested. Encouragement from spiritual leaders may facilitate screening intent, and the influence of leaders who are also cancer survivors or loved ones of survivors may be especially valuable. Inclusion of spiritual practices and time for talk story may further enhance the cultural responsiveness of promotions.

Methodological limitations restrict use of findings. Participant recruitment through formal organizations skews findings toward those more likely to participate in organized activities such as screening. Furthermore, findings may not represent the experiences of all participants. Social desirability may exert a powerful influence in Hawaiian groups as traditional culture emphasizes respect for elders and maintenance of harmonious group relations. Younger women may have chosen not to disagree with older women; thus, the perspective of younger women may be disadvantaged. Finally, failure to collect detailed sociodemographic (income, education) and service-related information (health insurance, use of routine mammography) on the survey allows for reporting women's screening intent and behavior in only a general way. Because of time constraints, researchers chose to allocate less time to the survey and more time for discussion. The team also believed that collecting income-related information might be viewed by participants as unnecessarily intrusive (*niele*). Future research might assess the influence of cultural beliefs, psychosocial factors, and socioeconomic characteristics on screening intent and behavior in a more representative sample. Underscored is the need to develop quantitative measures that adequately reflect the cultural and linguistic needs of Hawaiian women. Limitations notwithstanding, culturally responsive approaches to data collection yielded information rich in cultural and social detail. This is noteworthy given historic distrust of Western health care services and research. Furthermore, accuracy of findings was ensured through key informant interviews and senior colleagues' review.

CONCLUSIONS

Systematic assessment of influences on health behavior is fundamental to effective practice in health. Such an assessment is particularly warranted when addressing the complex array of factors associated with health disparities. In this regard, Airhihenbuwa's PEN-3 model may be a helpful framework from which social workers may systematically identify considerations for culturally responsive promotions. Inherent in a perspective on cultural responsiveness is

the premise that each culture has strengths, often originating from ethnic and spiritual traditions. Respectful and appropriate integration of these strengths in health promotions remains a key challenge. Meeting this challenge behooves meaningful dialogue and ongoing involvement with communities for whom an intervention is intended. Such involvement ensures cultural responsiveness and, by extension, increases the likelihood of positive, sustainable health outcomes. It is through such collaborations that those burdened by disparities might invest themselves in developing solutions that ultimately advance the prospect of health equity.

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Table 1**Hawaiian Cultural Preferences, Promotional Strategies, Practice Implications**

Cultural Preferences	Promotional Strategies	Practice Implications
' <i>Ohana</i> (intergenerational blood-related kin) <i>Hoahanau</i> (fictive kin)	Educational domain to focus on women and their families, as broadly defined.	Focus on older women, their needs and concerns. Include family members: younger women, adult men (husbands, partners, adult children), fictive kin.
<i>Ola pono, lokahi</i> (holistic health, harmony of physical, relational, spiritual Wellness) <i>Ho'omana</i> (spirituality) <i>Malama ke kahi i ke kahi</i> (caring for each other) <i>Kuleana</i> (responsibility in collective) <i>Makaukau</i> (being prepared) <i>Pule</i> (prayer) <i>Himani</i> (hymns)	Promotional messages to emphasize screening in the context of holistic health, as specifically defined by the culture. Frame cultural preferences as strengths that might mobilize families to work together in ensuring breast health	Address breast cancer risk, increase knowledge of recommended screening guidelines, and link with steps women and families can take to stay healthy. Acknowledge screening challenges and emphasize role of family support. Reinforce cultural strengths related to spirituality and family collective. Integrate common spiritual practices such as prayer and hymns in educational sessions. As possible, use church sanctuary as promotional venue. Foster activation of social networks to care for each other through specifically encouraging routine mammograms.
<i>Alo alo</i> (face-to-face) <i>Mo'olelo</i> (stories) <i>Talk Story</i> (discussion)	Use culturally familiar learning medium and include promotional messengers to personalize the breast cancer experience and encourage routine mammograms.	Use interactive education and allow time for <i>talk story</i> . Include face-to-face sharing of personal stories by survivors, family members, church leaders.