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Building Capacity to Address Women's Health Issues in the Mixtec and Zapotec Community

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Abstract

Introduction—Mixtecs and Zapotecs are indigenous populations from Mexico. Many are unable to read and write and speak only their native non-written languages, Mixteco and Zapoteco. About half of California's indigenous farm worker population is estimated to be Mixteco-speaking (82,000-125,000), and about 20,000 Mixtecs and a smaller number of Zapotecs live in Ventura County.

Objectives—A community-academic partnership conducted mixed-methods research with the aims of (1) collecting preliminary data on women's health needs; (2) training promotoras to assist with this effort; and (3) engaging community members and obtaining their input through community dialogues.

Methods—Promotoras who were bilingual in Spanish and either Mixteco or Zapoteco were trained to conduct surveys that included questions on breast feeding and receipt of breast and cervical cancer screening exams. Barriers to and facilitators of women obtaining these cancer screening tests were discussed in small groups.

Results—In 2013, 813 Mixtec and Zapotec women completed surveys. Although most women reported breast feeding (94%), and receipt of a pelvic exam (85%) and a breast exam (72%), only 44% of women 40 years and older had ever heard of and 33% had ever had a mammogram. Community members recommended offering free mammograms on the weekend by female providers, having women accompanied by promotoras who can translate, conducting door-to-door outreach, advertising cancer screening on the radio and providing small incentives to women.

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No conflicts of interest were reported by the authors of this paper.

Discussion—Trained bi-lingual promotoras can assist in increasing the capacity of indigenous communities to conduct collaborative research by engaging community members and collecting local data.

Introduction

Many racial and ethnic groups in the U.S. experience health disparities that are well documented and result in increased mortality and low survival rates after disease onset (Institute of Medicine 2012). Health disparities research has become a priority for many funders and studies often utilize a community-partnered research approach that builds on partners' strengths and assets, focuses on locally relevant problems, incorporates local capacity building, facilitates co-learning and power sharing, and balances research and action (Israel, Schulz et al. 1998, Israel, Schulz et al. 2001). We established a community-academic partnership to work with the Mixtec and Zapotec community in the greater Oxnard area, Ventura County, California. Mixtec and Zapotec are indigenous populations from western Oaxaca, Guerrero, and Puebla, some of the poorest populations of Mexico, with high rates of infant mortality and illiteracy, and some villages lacking potable water and basic services such as schools and roads. Entire communities have migrated in search of work and Mixtecs have become one of the largest indigenous groups of workers in California (Anguiano 1993, Palacio-Mejia, Lazcano-Ponce et al. 2009). The Indigenous Farmworker Study estimates that half of California's indigenous farmworker population is Mixteco-speaking (82,000-125,000), and that 1/3 of indigenous farm-workers are located in the Central Coast (Oxnard and Santa Maria; <http://www.indigenousfarmworkers.org/>). An estimated 20,000 Mixtecs and a smaller number of Zapotecs live in Ventura County. These populations are culturally and linguistically isolated. Many are unable to read and write even at a basic level in any language, and speak neither Spanish nor English, but only their native non-written languages, Mixteco and Zapoteco. Due to the challenges of surveying a population without any written language, little hard data exists on the demographics of this community in California. Therefore, their presence is often overlooked.

Mixteco/Indígena Community Organizing Project (MICOP) serves as community partner for this collaboration. MICOP was founded in 2001 and provides referrals to health and social services, case management, food and other basic necessities of life, trainings and educational workshops, language interpretation services, along with cultural pride and awareness events. MICOP contracts with Ventura County agencies to provide direct services to more than 5,000 individuals annually and collaborates with numerous local organizations including school districts, migrant educational programs, Ventura County Health Care Agency, Interface Children and Family Services, Food Share, and the Ventura County Partnership for Safe Families & Communities. MICOP has provided training on a number of health topics, including breast and cervical cancer screening to more than 25 promotores, bilingual in Spanish and Mixteco (and several with English fluency as well), who have helped families access medical care, enroll their children in school, and engaged in other activities that promote health and self-sufficiency (<http://www.mixteco.org/>, accessed 7/10/2014). The majority of the promotores are female.

In partnership with the University of California at Los Angeles, MICOP obtained funding for a collaborative research study that aimed to develop the capacity of this community to address women's health issues. We conducted mixed-methods research to (1) collect preliminary data with respect to women's health needs; (2) train promotoras to assist with this effort; and (3) engage community members and obtain their input through community dialogues. This paper reports findings of these efforts.

Methods

Development of Structured Questionnaire in English, Spanish and Two Indigenous Languages

MICOP, UCLA and a Mixtec Advisory Board worked together to develop a community needs assessment questionnaire that included questions on women's health issues (breast feeding, breast and cervical cancer screening) and demographic information. Questions were developed in English and Spanish. Eight promotoras discussed and made revisions to the Spanish language survey to ensure that the questions were understood by the local population. Subsequently, one of the promotoras who came from the same town and municipality in Oaxaca (San Martin Peras) as the majority of the Mixtec population in the Oxnard area was chosen to translate the survey into Mixteco. Her version was discussed by all eight promotoras, edited by consensus of the entire group, and audiorecorded with copies given to all promotoras so they could practice administration of the survey in Mixteco. This was not done for the Zapoteco version, because a single promotora administered all Zapoteco surveys.

Training of Promotoras

MICOP identified 8 Mixteco/Spanish and one Zapoteco/Spanish speaking promotoras, who attended a 6 hour training session in Spanish. The training agenda included purpose of the study, informed consent for promotoras who completed pre- and post-tests (see below), principles of research including voluntary participation and confidentiality, recruitment of participants and determining eligibility, how to obtain informed consent, the interviewing process, what-if scenarios, interview role playing, and forms to be used.

A Spanish language pre- and post-test for promotoras assessed demographic information (age, year of immigration, language skills) and 6 knowledge questions regarding the protection of human subjects in research that were adapted from prior research (Hatcher and Schoenberg 2007). The knowledge questions tested promotoras' understanding of the voluntary nature of participation and the right of participants to withdraw from the study at any time (2 questions) and the need to keep the names of participants and their responses to survey questions confidential (4 questions). Two 2 hour follow-up trainings/debriefings were conducted to review the survey process and to answer questions and to allow promotoras to exchange their experiences and to share how they handled various situations in the community. Promotoras received a stipend for attending the training and for conducting interviews.

Survey of Mixtec and Zapotec Community members

Between May and September 2013, promotoras recruited community members who self-identified as Mixteco or Zapoteco in the greater Oxnard area which includes Oxnard, Port Hueneme and El Rio. Promotoras explained that this survey was done to learn about health needs in the Mixtec and Zapotec community, administered a short screening survey to assess eligibility and obtained oral consent prior to administering a face-to-face survey using a structured questionnaire. They conducted the majority of surveys going door to door (37%), at parks (53%), and at a school (5%) and noted responses on the Spanish language surveys. Each promotora conducted between 115 and 136 surveys during the week (total of 850 surveys, 86%) and on Saturdays and Sundays (total of 139 surveys, 14%). Surveys were conducted anonymously on the advice of the Mixtec Advisory Board that feared that many community members would not participate if they had to give their name. Community members who completed the survey received a plastic folder for document storage as a token of appreciation.

Survey content

Promotoras asked all women if they had ever had a breast exam and a pelvic exam. They asked women 40 years and older if they had ever heard of a mammogram, ever had a mammogram, when they had their last mammogram, if they thought they needed a mammogram, if a doctor ever recommended to get a mammogram and if they knew where to obtain a no cost mammogram. When asking about medical procedures (breast exam, pelvic exam, mammogram), promotoras had to use Spanish terms since there are no words in the indigenous languages for these procedures. For clarification, promotoras showed pictures of a woman undergoing the procedure and explained the procedures using an agreed upon script. MICOP staff recommended to ask about receipt of a pelvic exam rather than a Pap test because many women would remember whether or not they had received a pelvic exam but may not know if a Pap smear was taken. Women who reported having a child were also asked if they were breast feeding.

All questions were asked in simple yes/no format to facilitate administration of the survey in indigenous languages and recording of the answers in the Spanish language questionnaire. Only limited demographic information was collected, including age, marital status, place of birth, languages spoken at home, and whether or not respondents spent part of the year in another city. Based on advice of the Mixtec Advisory Board, we did not collect information on participants' educational attainment and legal status.

Community dialogue groups with women and men

We conducted separate community dialogues with men and women from the Mixtec and Zapotec community to discuss cancer and specifically women's cancers and the importance of cancer screening tests. Men were included because in a previous study some promotoras had suggested that husbands may not allow women to undergo medical examinations that require disrobing (Maxwell, Young et al. 2014). MICOP promotores recruited participants for the community dialogues. Trained MICOP staff obtained verbal informed consent from participants and moderated four community dialogue groups. All groups followed a common outline of topics (see **Box 1**) but allowed for flexibility based on questions and

interest of participants. Translators were available to facilitate participation of Mixteco and Zapoteco monolingual community members.

Three groups were conducted bilingual in Spanish and Mixteco and one group was conducted trilingual in Spanish, Mixteco and Zapoteco. Anatomical charts and pictures of cancer, mammography and cervical exams were shown to clarify concepts. Each community dialogue group lasted 2 hours and each participant received a \$20 gift card for a local store. Three dialogue groups with women were co-facilitated by two females, a Mixteco-Spanish bilingual promotora/MICOP staff, who had helped to coordinate all aspects of this study from the inception, and a Spanish-English bilingual nurse practitioner, who served as the community principal investigator for this project (SY). The dialogue group with men was co-facilitated by two males, a Hispanic medical doctor who is active in MICOP and involved in many MICOP activities, and a Mixteco-Spanish bilingual promotore. For each group, one of the facilitators took notes and prepared a report in English in consultation with the co-facilitator.

Analysis

A MICOP staff member entered the data from the community survey into Excel and research staff performed data checking and cleaning and conducted descriptive analysis using SPSS. Analysis for this report was limited to women with complete data for age (N=813) which comprised 82% of the total sample that was interviewed. Written reports from community dialogues were used to summarize participants' comments and recommendations on how to increase mammography screening in their community. All project activities were approved by the Institutional Review Board of the University of California Los Angeles and by the Mixtec Advisory Board.

Results

Evaluation of promotora's human subjects training

Nine promotoras completed the pre- and posttest at the initial training. The promotoras were 20 to 44 years old (mean age 31 years) and had resided in the United States from 10 to 28 years (mean duration of U.S. residency 19 years). On average, promotoras correctly answered 4 out of 6 questions at pre-test and 5 out of 6 at post-test. Five out of 9 promotoras improved their knowledge score from pre- to posttest, one had a perfect knowledge score at pre- and posttest, and 2 provided identical answers at both tests. The human subjects scenarios were again discussed at the follow-up training, especially the following question about confidentiality of subjects that was answered incorrectly by 6 out of 9 promotoras at post-test: "You may tell your family who is in the study as long as you don't tell what the participant said.[incorrect]"

Findings from debriefing of Promotoras

At the debriefing meeting, promotoras stated that they were having no problems recruiting participants. During the recruitment process, they emphasized the importance of getting community opinions, especially for planning future programs to help the community. The promotoras stated that almost all of the people they asked were willing to participate; only a

total of 10-12 people they approached refused to be interviewed. Many people wanted assurances that the survey was anonymous, and others raised questions about whether they would receive a bill at a later date. Promotoras stated that they were comfortable administering informed consent, including respondents' rights to withdraw from the survey and to refuse to answer any question they did not wish to answer.

Survey findings

Women who completed the survey were on average 31 years old, 87% were married or living together, and 82% had lived at the same address for at least one year. All were born in Mexico and most of them spoke either Mixteco and Spanish at home (54%) or were monolingual Mixteco speakers (25%). A small number of women stated that they spoke Spanish and Zapoteco at home (7%) or a combination of these languages and English (see **Table 1**).

Most women reported breast feeding (94%), and receipt of a pelvic exam (85%) and a breast exam (72%), but only 39% of women knew where to obtain a free or low cost pelvic or breast exam. Only 48% of women 40 years and older had ever heard of and 33% had ever had a mammogram, and 22% of women had a mammogram in the past two years. Although 68% of women 40 years and older thought they needed to get a mammogram, only 36% had received a recommendation to get screened from a doctor and 24% knew where they could get a free mammogram (see **Table 2**).

We also compared responses of women from Spanish-speaking and monolingual indigenous-only speaking households. Women from monolingual indigenous-only households were significantly less likely to report receipt of a pelvic exam and a mammogram than women from Spanish-speaking households and were less likely to report a doctor's recommendation to obtain a mammogram (data not shown). Some of these comparisons may be unstable due to small numbers in some cells.

Findings from Community Dialogue Groups

Four community dialogue groups were conducted at the MICOP office and each group was attended by 5-8 community members. Participant characteristics, comments and recommendations are summarized in **Table 3**. The first group was comprised of women 50 years and over who either had a mammogram or were planning to have a mammogram. The second group was comprised of women 40 years and older who never had a mammogram. The 3rd group was comprised of younger women 30 to 40 years of age, and the fourth group of men.

All groups expressed that they lacked knowledge on cancer and screening tests. In general, it was difficult to explain cancer to community members since they were unfamiliar with the fact that the body is made of cells. Participants of community dialogues were very interested in anatomical charts that were used and stated that they had never seen the inside of the body.

Another concept that was foreign to most community members was going to the doctor for preventive or routine services in the absence of disease. Instead, going to the doctor was

associated with sickness and receipt of bills. Women were fearful about going to the doctor, not knowing what to expect and because some had heard negative experiences from other women. Barriers to obtain a mammogram included cost, lack of knowledge, lack of time and transportation, fear and lack of trust in the medical system and lack of interpreters. In addition, the role of husbands was discussed in all four groups. While there was a general belief among women that husbands' jealousy is a barrier, most women stated that *their* husband was supportive or neutral and men stated that they personally had not prevented their wives or partners from having a breast exam or mammogram. Women in one group mentioned that fear and spousal negativity were greater barriers for pelvic exams and Pap tests than for breast cancer screening.

Recommendations to increase cancer screening included holding a screening event in a local community setting or van on Sunday afternoon, having female providers for breast exams and mammograms, having interpreters available, conducting door-to-door outreach and advertising screening through the radio, and to provide small incentives to women who complete screening.

Discussion

This study started to build the capacity of the indigenous community in Ventura County to engage in cancer prevention by training promotoras, by obtaining preliminary data about cancer screening using a mixed-method approach, and by engaging community members in a dialogue about the value of preventive care, including breast and cervical cancer screening. Through a community-academic collaborative research project, we determined that Mixtec and Zapotec women from Mexico who are residing in Ventura County have extremely low mammography screening rates, even compared to other underscreened populations. For example, in a sample of low-aculturated Latinas residing in Wisconsin (Martinez-Donate, Vera-Cala et al. 2013), lifetime receipt of mammogram among women 40 years and over was 74% (compared to 33% in our sample) and last 3-year receipt was 40% (compared to 22% who had a mammogram within the past 2 years in our sample). The proportion of indigenous women in our sample who reported breast feeding (94%), on the other hand, was extremely high compared to rates reported by African American women (47%), white women (72%) and Latinas (78%) (Centers for Disease and Prevention 2013). The project generated local data on health needs that were disseminated to health care providers and will serve as a baseline for future attempts to increase screening in this population. In addition, promotoras explained the study and presented findings at monthly community meetings organized by MICOP, that frequently attract several hundred community members.

This study demonstrates that a collaborative research team consisting of an academic partner and a well established and trusted community organization can obtain data from an immigrant community that is largely undocumented and has low levels of income and education. Promotoras who were bilingual in Spanish and one of the indigenous languages were crucial for the engagement of the community and for conducting the surveys and community dialogue groups. Over the last 10 years, MICOP has trained over a hundred Spanish and indigenous language-speaking promotoras on a variety of topics, including HIV, interpretation in medical settings, domestic violence, the rights of research

participants, how to conduct focus groups and interviewer training. Training topics and compensation for training are usually tied to funding for a specific project, and MICOP does not guarantee employment after the training.

Promotoras or Community Health Advisors have been employed in health promotion studies in many different racial/ethnic communities, including indigenous communities (Ramirez, McAlister et al. 1995, Navarro, Raman et al. 2007, Han, Lee et al. 2009, Kobetz, Menard et al. 2009, Nguyen, Love et al. 2010, Nelson, Lewy et al. 2011, Maxwell, Danao et al. 2013, Messias, Parra-Medina et al. 2013, Pelcastre-Villafuerte, Ruiz et al. 2014). To our knowledge, this is one of the first studies that employed promotoras for conducting research among indigenous immigrants from Mexico that have settled in California. The promotoras concept fits very well with the indigenous concept of “tequio” meaning community service which is expected in indigenous southern Mexican communities (Cohen 2004). Tequio is a call to perform communal work for a mutual benefit; it is essentially a mandatory community service project that asks residents to contribute their labor free of charge. Tequio dictates that members of a community should provide materials or labor to build something that is needed for the community such as a school, a well, a fence or a road. In addition to the traditional concept of tequio, promotoras have been active in some indigenous villages in Oaxaca (S. Young, personal communication 7/13/2014). Therefore, the community is quite comfortable interacting with promotoras.

Barriers to obtaining cancer screening tests and other preventive health care services are similar to those described by other populations with low levels of income and education that lack access to health insurance (Gany, Herrera et al. 2006, Daley, Alio et al. 2011, Ahmed, Winter et al. 2012, Stanley, Arriola et al. 2013, Fernandez, Savas et al. 2014). For example, a recent review of the literature on barriers to breast cancer screening among minority women identified pain and embarrassment associated with mammography, low income and lack of health insurance, poor knowledge about breast cancer screening, lack of physician recommendation, lack of trust in hospitals and doctors, language barriers and lack of transportation as frequent barriers (Alexandraki and Mooradian 2010).

In addition, findings in this and other studies suggest that men, e.g., husbands, may potentially play an important role in supporting breast and cervical cancer screening or in hindering it. A recent study among Mixtec women in Mexico suggested that some indigenous women may use their husbands as an excuse to avoid a medical procedure that they do not trust (Garcia-Perez and Merino 2015). MICOP trained Mixtec interpreters who have been working at community clinics for more than 10 years have first informed us that husbands’ lack of support is an important barrier to women undergoing breast and pelvic exams and mammography screening. However, community dialogues with men and women for this study have yielded more nuanced information on this topic and most men and women reported that this potential barrier does not apply to them *personally*. One reason for this discrepancy could be that community members don't feel comfortable sharing this information. It is also possible that this traditional view about protecting women's modesty is in transition and that we received somewhat conflicting information from community members who are at various stages of this transition. Although we may not fully understand

the role men and husbands play in women undergoing certain medical exams, it appears that it is crucial to include men in women's health promotion programs.

Limitations

Survey data may not be representative of indigenous women residing in Ventura County since we only conducted interviews in two indigenous languages and in Spanish in a convenience sample. While the overall survey sample was quite large and promotoras reported excellent participation rates, the number of women 40 years and older was more limited. Only a small number of community members engaged in community dialogues and the Zapotec community was underrepresented in the dialogue groups. In addition to self-selection bias, opinions expressed in the dialogue groups may suffer from social desirability bias. For example, men may not want to admit that they are uncomfortable if their spouses are examined by a male doctor, given that their group was facilitated by a male doctor. Community dialogues were conducted by trained community members who were fluent in Spanish and/or indigenous languages and only the major discussion points were summarized in English for the research team. This prevented a more detailed analysis of the community dialogues.

Implications for Practice

Trained bi-lingual promotoras can assist in increasing the capacity of indigenous communities to conduct collaborative research by engaging community members and collecting local data. Promotoras can play an important role with subject recruitment, consenting, facilitating community dialogues and in a more general way introducing indigenous community members to research. We envision that promotoras will be crucial for promoting women's health in this community in future projects, including breast and cervical cancer screening.

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Box 1: Outline for Community dialogue groups with Mixtec and Zapotec women and men

Goal: inform intervention strategies to increase acceptability of breast cancer screening in the community, including in men, and to increase breast cancer screening among age-eligible women.

Discussion topics:

1. Who knows someone with breast cancer? What have you heard about it?
Explain: breast cancer is the most common cancer among women. Women over 50 are at higher risk than younger women. Therefore, clinical breast exam and mammogram are recommended every 1-2 years. The majority of women in California and in the US get screened regularly, but new immigrants like the Mixtecs often underutilize screening. Explain what screening is. Show picture of woman getting mammogram.
2. Who had ever had a mammogram (show picture) – have woman share her experience. Why did she do it? How did she feel about it? Would she do it again? What did her husband say to it?
3. What kind of information would Mixtec women like you need in order to get a mammogram? / What kind of information would Mixtec men like you need in order to support your female family members in getting a mammogram?
4. What are barriers to getting a mammogram? Display pictures representing the barriers and ask women have to put stickers on the 3 barriers that are most important for them.
5. It is important for all women over 50 to get regular breast exams and mammograms. How can we address these barriers?

Table 1

Demographic characteristics of female respondents of community survey (N=813)

Age	Mean or Frequency
Mean ($\pm$ sd)	31. 1 ($\pm$ 8.9)
Range [Minimum - Maximum]	61 [18 - 79]
18 - 39 years old	690/813 (85%)
40 years old	123/813 (15%)
Marital status	
Single	92/805 (11%)
Married	317/805 (39%)
Living together	386/805 (48%)
Divorced/separated/widowed	10/805 (1%)
Lived at same address for one year	
Yes	663/811 (82%)
No	148/811 (18%)
Spent part of the year in another city	
Yes	104/791 (13%)
No	687/791 (87%)
Place of birth (State)	
Oaxaca, Mexico	676/797 (85%)
Guerrero, Mexico / Other	121/797 (15%)
Languages spoken at home	
Spanish and Mixteco	431/800(54%)
Mixteco only	199/800 (25%)
Spanish and Zapoteco	58/800 (7%)
Spanish and English	10/800 (1%)
Spanish only/Zapoteco only/Spanish + Mixteco + English/Spanish + Zapoteco + English	102/800 (13%)

denominator varies due to missing values

Table 2

Survey findings on women's health issues

<i>Women with at least 1 child (n = 795)</i>	Frequency
Had breastfed children	746/795 (94%)
<i>All women (n = 808 with responses)</i>	
Ever had breast exam	580/808 (72%)
Ever had pelvic exam	682/800 (85%)
Knows where to obtain no cost breast/pelvic exams	307/796 (39%)
<i>Women 40 and over (n = 122 with responses)</i>	
Ever heard of mammogram	57/119 (48%)
Ever had mammogram	39/119 (33%)
Had a mammogram within the past 2 years	26/119 (22%)
Woman thinks she needs to get a mammogram	82/121 (68%)
Doctor ever recommended to get mammogram	42/116 (36%)
Know where to obtain mammogram at no cost	29/122 (24%)

denominator varies due to missing values

Table 3

Summary of Community Dialogue Groups

Attendees	Participant Comments	Participant Recommendations
<p>Group 1: 8 women >50 years of age; 7 Mixtec, 1 Spanish-speaking Zapotec; 7 had a mammogram, 1 was planning to obtain a mammogram; 2 women unable to sign own name;</p>	<p>Cost: In Mexico, we only go to the doctor when we are very sick, it's too expensive. We are afraid of getting bills. If you don't pay a medical bill, you can be deported.</p> <p>Lack of knowledge of cancer and screening tests</p> <p>Fear: Fear of going to the doctor; what are they going to do? How are they going to touch me? Heard negative experiences from other women.</p> <p>Time: Women work long hours with long transportation times to their jobs, then have to care for family. Clinics are not open on Sundays when they could go for care.</p> <p>Screening location: Some said it would help a lot if screening exams were local; others said that the same barriers would exist in any setting.</p> <p>Husbands: Men were not a barrier for getting a mammogram. Two women did not have husbands, two women had husbands that were supportive, two women said their husbands were jealous but the women did not care.</p> <p>Barriers: There are more barriers for Pap screening than breast screening (fear, spousal negativity).</p>	<p>Hold screening in a local community setting or local van on Sunday afternoon.</p> <p>Female providers should do breast exams and mammograms. Have interpreters available for monolingual indigenous women.</p> <p>Conduct door-to-door outreach and advertise screening through radio.</p> <p>Have visual materials since people do not read Spanish or English.</p> <p>Have promotoras go to homes of those identified as interested in screening to accompany them.</p> <p>Provide small incentive to women who complete screening (e.g., a bandana, a pen and tablet, or a hat).</p>
<p>Group 2: 8 women 40 years of age and older; 7 Mixtec of which 3 were monolingual, 1 monolingual Zapotec; women never had a mammogram;</p>	<p>Lack of knowledge of cancer and screening tests</p> <p>Availability of free mammography: Women did not know about the availability of free mammography and there was a general belief that "free" services are not really free.</p> <p>Barriers to mammography screening: Women mentioned lack of information, lack of trust in the medical system, transportation, time, lack of support from husbands, and cost.</p> <p>Husbands: Women felt it was important for husbands to understand these issues.</p>	<p>Not discussed.</p>
<p>Group 3: 6 women 30-40 years of age; 5 Mixtec of which 1 was monolingual, 1 Spanish-speaking Zapotec;</p>	<p>Lack of knowledge of cancer and screening tests</p> <p>Cost: Cost was identified as the most important barrier to screening by 5 out of 6 women.</p> <p>Barriers to mammography screening: Women mentioned lack of information, fear, transportation, time, husband does not want me to go, doctor never advised me, cannot get appointment at clinic.</p> <p>Husbands: Women said that their husbands were supportive or neutral, but stated that generally, husband's jealousy is a barrier.</p>	<p>Hold screening in mobile van in neighborhoods on Sunday afternoon, or at work sites, with management approval.</p> <p>Have bilingual promotoras provide information.</p> <p>Have visual materials of clinical breast examination and mammogram.</p>
<p>Group 4: 5 Mixteco men of which 2 were monolingual Mixteco speakers, 40 years and older</p>	<p>Lack of knowledge of cancer and screening tests: men were interested in learning more about cancer.</p> <p>Barriers to mammography screening from the men's point of view, in order of importance: cost, lack of interpreters, lack of knowledge (unaware of need to be screened and unaware of where to get screened); lack of transportation; fear of going to the doctor (correlating sickness and disease to seeing the doctor);</p> <p>Husbands: all participants said they personally have not prevented their wives/partners from having a breast exam or mammogram.</p>	<p>Weekend or evening clinics should provide screening.</p> <p>One man was strongly against setting up mobile units at the field to provide service after work. He preferred his wife to be clean and feel at ease when going to the doctor.</p>