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Prioritizing Prevention: Culture, Context, and Cervical Cancer Screening among Vietnamese American Women

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Abstract

Few studies have investigated what Vietnamese American women believe about the Pap smear or how those beliefs might influence behavior. Thirty-one Vietnamese American women recruited through snowball sampling were interviewed about their beliefs regarding the Pap smear. Interviews were qualitatively analyzed using a theoretically informed, inductive approach. The women interviewed emphasized the importance of primary prevention of disease through culturally-informed personal health regimens. They were also largely unfamiliar with the Pap smear, but believed that gynecological exams in general were effective and necessary for disease detection. Finally, when access to gynecological care was difficult, women's faith in their own preventive behaviors helped alleviate their concerns over lack of care. While culturally associated beliefs do not simply "cause" Vietnamese American women to seek or avoid Pap smears, they do influence screening behaviors to a greater or lesser degree, depending on other contextual variables.

Keywords

Cervical cancer; Pap smear CBPR; Vietnamese-American

Introduction

Cervical cancer is one of the most commonly occurring invasive malignancies among Vietnamese American women, who develop the disease at rates much higher than those of non-Hispanic white women (16.8 per 100,000 vs. 8.1 per 100,000) [1]. Since the disease is largely avoidable through secondary prevention with the Pap smear, disparities in morbidity and mortality from cervical cancer are primarily attributable to disparities in the rate of screening [2]. Asian American women generally, and Vietnamese American women

specifically, consistently report some of the lowest levels of Pap test utilization in the United States [2, 3].

These striking disparities in screening and disease have led to efforts to identify and ultimately intervene on factors that contribute to low cervical cancer screening rates among Vietnamese American women. Recognizing that Vietnamese cultural norms, and in particular Vietnamese medical beliefs, often differ from Western biomedical norms, researchers have identified Vietnamese cultural norms and beliefs that might impair effective health care delivery for Vietnamese in the United States [4–8]. However, thus far, studies have failed to find an association between traditional Vietnamese beliefs and Pap testing [4, 9]. Rather, the strongest predictors of cervical cancer screening among Vietnamese American women include having been married, having insurance, having a regular place of care, and having a regular provider [2, 4, 10, 11]. Studies have also demonstrated low levels of knowledge regarding the Pap smear among Vietnamese American women, and that lack of knowledge correlates with low levels of screening [2, 10, 11].

However, very little research has investigated what Vietnamese American women believe about the Pap smear or how those beliefs fit within the context of other health related understandings. This is a significant gap in the literature: how individuals think about medical technologies and procedures has implications in terms of how often they seek exams (or why they avoid them), whether they correctly report receiving the exam, and whether they feel the need to follow-up when diagnostic procedures demonstrate abnormalities [12–14]. Thus, the purpose of this study was to investigate (a) what Vietnamese American women believe about the Pap smear, (b) how those beliefs interact with other health related understandings, and (c) how those beliefs might influence cervical cancer screening behaviors in that population.

Methods

Participants and Data Collection

We collected demographic data and conducted in-depth interviews with 31 Vietnamese women, using a guide developed through the process described below. To be considered for inclusion, individuals had to be at least 18 years old, female, speak Vietnamese or English, and self-identify as Vietnamese. Individuals not meeting those criteria were excluded. Most of the participants were referred by the CAB and IRCO's Vietnamese staff. The rest of the participants were referred by the participants via snowball sampling [16]. Each of the interviewees received a \$20 gift card for coffee or groceries. Interviews were conducted at a site of the interviewees' choosing. All interviews were digitally recorded. Before beginning the interview, participants read and signed a consent form in the language of their choice. Interviews were conducted in Vietnamese or English, depending on which language the participant preferred. Most interviews lasted 1–2 h. Interviews continued until we had saturated themes.

Approach

Developed as a partnership between the Asian Family Center at Oregon's Immigrant and Refugee Organization (IRCO) and Oregon Health and Science University, our research drew on the principles and practices of community-based participatory research in its design and implementation [15]. Health educators at the Asian Family Center identified cervical cancer as a priority problem for the Vietnamese community and asked the academic investigators to help develop a research protocol examining Vietnamese women's uses for and understandings of the Pap smear. Two bilingual, bicultural research assistants for the project were identified by IRCO and were drawn from the local Vietnamese community. A community advisory board (CAB) guided the research via regular meetings. The CAB recommended 7 Vietnamese individuals from diverse backgrounds to serve as "key informants." Interviews with the key informants helped the research team identify cultural and health care related issues to be included in an interview guide, which was then developed by the research team and approved by the CAB. For example, the interview guide contained questions such as, "What do you do to take care of your women's health needs?" "Do you know of any medical exams that only women need?" "Have you ever heard of an exam called the Pap smear or Pap test?" "Can you tell me what you know about it?" All protocols and materials were approved by our Institutional Review Board.

Analysis

All interviews were transcribed by the research staff in their original language and given back to the participants to check for accuracy. The transcribed interviews were then translated and checked by another team member for accuracy. All of the interviews were analyzed in an iterative manner using a theoretically informed, inductive approach [17, 18.]. Team members met at least monthly to review transcriptions and to identify emerging themes. In the first reading we generated broad topical themes. During subsequent meetings we merged themes that overlapped extensively, and identified subthemes. Once themes were agreed upon, the research team agreed on code definitions and coded the transcripts in English using ATLAS.ti software, identifying additional themes as they emerged, in an iterative fashion [16]. The case studies and examples below were selected because they are representative of the richest and best examples of widely held patterns in interviews.

Results

Participant Characteristics

See Table I.

Prioritizing Prevention: Staying Healthy

All participants were asked "What do you do to take care of your women's health needs?" The vast majority of the women we interviewed emphasized the importance of primary prevention of disease, and most provided detailed accounts of their personal preventive health regimens. Generally, these measures included rigorous attention to cleanliness, particularly vaginal cleanliness, as well as maintenance of healthy diets and exercise.

I often clean myself thoroughly and then... for example, after having sex with my husband, then I should also clean myself. Don't leave for a while, then it will ... sometimes, a virus will infect us ... that's why it's best for women when they have sex with their husband, then the best thing is to clean themselves. Practice hygiene before and practice hygiene afterwards. (55 year old housewife)

In the morning I exercise, then I eat. I also avoid things that are hot because women often get white discharge, so I will avoid those things. For example, people say if you eat turnips, then you will have a lot of white discharge. So that's why I avoid that, too. I don't eat it. Or bamboo shoots, they'll give you aches." (41 year old Buddhist nun)

Most women's accounts also resonated with Vietnamese medical theories of health and healing, which have continue to significantly influence Vietnamese and Vietnamese-American popular beliefs about health [5, 19]. These theories stress the importance of humoral balance to health, and frame ill health as a result of internal imbalance from mental or physical stress or external processes such as food, drink, or infection [20–22]. They also stress the role of the individual in maintaining health or allowing illness: each person's day-to-day habits and behaviors determine whether or not he or she will be well, will fall ill, or will improve [19].

Women also noted that the gynecological region is particularly vulnerable to disease due to sexual activity, urination, and menstruation and other potentially dangerous exposures. Thus, they took extra measures to ensure their gynecological health. As a 38-year-old nail technician explained: "every time I wash, then I *clean* so that it's clean. For example, when I wash, it's like my body stays normal... if you have a lot of white fluid/blood then you have to go to the doctor. But with me, I've never had that problem." Similarly, a 50-year widow explained that though she was no longer sexually active, she still worried about maintaining her gynecological health because "I go swimming. So, I'm just afraid that I might get a random infection. So, before I go swimming, I usually buy a tube of antibiotic ointment. Then I use some of it to spread on that area of mine. It's just one simple thing to do. I think that even if a germ were to enter that area, once it touches the ointment it would die, leave, and not be able to go any further."

Detecting Disease

We also asked each participant if she was familiar with the term "Pap smear." If women were familiar with the term, we asked them to describe the procedure. If they were not, we asked them if they had received any exams that only women get, and we requested that they describe those exams. By their descriptions, 24 women in our sample had received at least one Pap smear in their lifetime. Most had received the exams as part of pre-natal care or general physical exams, and sometimes as part of the immigration process. However, only 14 of the women who had apparently received Pap smears were familiar with the term. Women who were unfamiliar with the term Pap smear described "women's exams" as simply "checking" inside for abnormalities or infections, and not specifically for cervical cancer. Additionally, only 9 of the women who were familiar with the term "Pap smear"

could accurately describe the purpose of the exam and its connection to cervical cancer prevention.

However, though women were largely unfamiliar with the Pap smear, and though they never used the terms “primary prevention” or “secondary prevention”, they were quite clear that clinical gynecological exams were *not* primary prevention. As a 26-year-old single woman told us, the Pap smear is “to detect [disease]. And then prevent, you know, you’re gonna have to do that on your own.” Yet, given women’s perception of perceived vulnerability, many felt that the opportunity to detect disease was important. For instance, one 41-year-old waitress explained, “I work in a restaurant, many times I urinate and I can’t wash very thoroughly... I work from morning to night and then I quickly go to the restroom... then I just use Paper to slowly wipe, whereas at home, I would have to wash with soap.” Because of her perception of her increased risk and her inability to practice what she felt was adequate prevention, she sought gynecological exams at least once a year. Furthermore, when she went to the doctor, “they come in ask if I have any problems, why I’m here that day to get an exam, so I lie a little bit... I say that my uterus has an issue so that they’ll check it more thoroughly... I want them to carefully look at it... because if I say nothing’s wrong, then they would just do a cursory exam.”

Like the majority of women in our sample, she had never heard of the Pap smear, but she did believe gynecological exams could detect diseases that might be amenable to treatment. Because she felt that inadequate hygiene meant her risk for disease was high, she sought regular gynecological exams.

Beliefs and Behavior: Contextual Factors

Notably, the extent to which women emphasized either their ability to avoid disease through personal preventive behaviors, or the need to detect disease due to increased risk, varied with context. For instance, during a discussion of the reasons that she had just received her first Pap smear the year before, a 64-year-old widow alternated between emphasizing the value of personal preventive behaviors and emphasizing women’s heightened risk of disease. She noted that she was unlikely to develop disease given her strict attention to her own health.

I’m always taking precautions, I’m always careful to be thoroughly clean. Women have to be thorough, you know. That’s what I think, if we’re just a little bit careless, we can get sick... That’s why we have to keep clean... As for me, the way I eat, I don’t think it will cause any [diseases].

However, when asked why she had recently agreed to a Pap smear, she explained,

I heard that there was a free exam, so I went to get it. Because if it cost money, I would have passed on it... I went into get the exam so that I would know. So, for instance, if I were to know, if I had that disease... I can change my eating and drinking to bring things back into balance.

When asked if she would ever seek the exam again, she was unsure: “If they offer it [a free exam], then I’ll get the exam again.... If not, then forget it. I think probably... I don’t need it...I feel like I’m very normal.” Her beliefs about the efficacy of her own preventive efforts contributed to a sense that gynecological care was less important for her, and not something

she would actively seek. However, given the opportunity to receive a Pap smear at no cost and with little effort, she drew on that same belief system to suggest that she might as well obtain a Pap smear, in order to determine whether or not she needed to bring” things back into balance.” She was also clear that without conditions of easy access, she did not need to, and would not, receive the exam again.

Similarly, a divorced 55-year-old housewife with health insurance told us that she had been raped as a young woman and consequently avoided pelvic exams. Instead, she said, “I keep sanitary,” washing with warm salt water and alum salts. However, a few weeks prior to our interview, she had called her regular doctor, a man, and was told “there is a female doctor that is American who just started and stuff, I said, ‘in that case ... let me have the gynecological exam.’ So automatically [I was] scheduled to do a gynecological exam... I thought I should check a little bit.” She said that the doctor explained that she would need annual exams thereafter, but that she planned on getting them only every 4 years or so. Instead, she will just “keep it clean.” Again, while she believed that her own actions could help prevent gynecological disease, the extent to which she depended on preventive activities as her only protection against disease depended on context. Her attention to cleanliness alleviated urgency she might feel about the need for gynecological exam, but when the opportunity arose for her to have an exam performed by someone with whom she was comfortable, she took that opportunity, just to “check.”

Discussion

We found that the Vietnamese American women we interviewed were largely unfamiliar with cervical cancer screening, but had strongly held culturally associated beliefs and practices regarding preventive health. They respected and valued physicians’ ability to detect and treat disease but they understood that medical care did not prevent disease. Rather, participants prioritized personal habits that they believed were effective in the primary prevention of disease. Furthermore, women who believed strongly in the protective effects of their personal preventive health care regimens were generally less concerned with receiving medical care, including Pap smears. This was particularly true if access to medical care was difficult.

Many of the beliefs held by the women we interviewed have been documented by others [9, 23, 24], and some of those beliefs directly contradict biomedical models of disease. As noted, however, there is no evidence that these discrete cultural beliefs correlate with underutilization of preventive services, including cervical cancer screening [4, 9]. Instead, the strongest predictors of cervical cancer screening among Vietnamese women included having a regular place for care and having a physician recommend screening [2, 25, 26]. Thus, it is possible that cultural beliefs play little to no role in perpetuating disparities in cervical cancer screening among Vietnamese Americans, and that simply improving access to physicians is the key to increasing cervical cancer screening in this population.

Alternatively, others have argued that while beliefs about cervical cancer screening *specifically* may not serve as barriers to screening, cultural attitudes toward preventive care in general are a critical barrier to screening for Vietnamese American women [7, 27, 28].

Prevention, it has been argued, “is a Western concept that the Vietnamese community has not yet adopted” [28]. Thus, even if access to physicians were improved, Vietnamese American women likely would not take full advantage of increased opportunities for preventive care. This apparent lack of interest in preventive clinical care, coupled with acquiescence when such care is recommended by a physician, has also lead some to posit that Vietnamese patients have “a more external locus of control,” waiting until problems arise, and then depending on physicians to solve those problems [24].

Our work suggests Vietnamese American women’s culturally associated beliefs *did* influence their behavior with regard to gynecological care, including cervical cancer screening, but that those beliefs could not be considered outside of the larger context of a general orientation toward personal primary prevention and other critical factors such as having insurance, having a place of care, and personal life history. Though the women we interviewed respected and valued physicians’ ability to detect and treat disease, the need for medical care became less urgent for women who believed in the protective effects of their own personal regimens. It perhaps became less urgent still when terms and procedures like the Pap smear were unfamiliar and when women faced financial, emotional or logistical barriers to care.

New Contribution to the Literature

This study suggests that while culturally associated beliefs about the Pap smear and disease prevention do not simply “cause” Vietnamese American women to seek or avoid Pap smears, they do influence those screening behaviors to a greater or lesser degree, depending on other contextual variables. Furthermore, the more closely Vietnamese American women hold culturally associated beliefs around the efficacy of their own efforts to prevent disease, including gynecological cancer, the less likely they are to seek Pap smears, particularly if they encounter any barriers to accessing the exam. Therefore, as has been suggested, providing women a regular place of care and a regular, trusted, physician will be critical to increasing cervical cancer screening for Vietnamese American women [25, 29]. However, this is *not* because Vietnamese American women’s cultural background does not influence their health care behaviors, but rather because it does. Women who draw on cultural norms stressing personal responsibility for health through the maintenance of balance and hygiene have other options to turn to when medical care is financially, logistically, or even emotionally difficult.

We suggest, then, that interventions to increase cervical cancer screening among Vietnamese American women should not assume that participants are uninterested, or do not believe, in disease prevention. Rather, they should be aware that participants are already often highly engaged in their own efforts at primary prevention and those efforts should not be discounted. Interventions must also target clinicians, reminding them to discuss the purpose of the procedures they perform. Furthermore, to be most effective, interventions must also make the Pap smear easily accessible to women who may otherwise depend only on the protective effects of their own personal preventive care habits to avoid cancer. It is these remarkably self-efficacious women who may require particularly intensive efforts to improve their access to the prevention of an otherwise preventable disease.

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Table I

Participants' demographic data (N = 31)

Age (22 to 70 years old)	N (%)
21–30	6 (19)
31–40	5 (16)
41–50	8 (26)
51–60	7 (23)
61–70	5 (16)
Marital status	
Single	15 (48)
Married	8 (26)
Other (e.g., divorced)	8 (26)
Health insurance	
Yes	24 (77)
No	7 (23)
Years of schooling (0–20 years)	
0–5	3 (10)
6–12	16 (51)
13–16	4 (13)
16–20	8 (26)
Annual income in US dollars	
<10,000	8 (26)
10,000–19,999	8 (26)
20,000–29,999	2 (6)
30,000–39,999	3 (10)
40,000–49,999	4 (13)
50,000–59,999	2 (6)
>60,000	1 (3)
Unknown	3 (10)
Years in US	
<10	13 (42)
11–20	14 (45)
>20	4 (13)
Language at home	
Vietnamese	20 (65)
English	1 (3)
Both	9 (29)
Other	1 (3)