

Cancer Screening Among Racial/Ethnic Minority Women

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- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planners

John M. Leonard, MD

Jane C. Norman, RN, MSN, CNE, PhD

Director of Development and Academic Affairs

Sarah Campbell

Division Planners/Director Disclosure

The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all mental health and healthcare providers who may intervene to improve cancer screening adherence among racial/ethnic minority women.

Accreditations & Approvals



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NetCE designates this continuing education activity for 5 ANCC contact hours.



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Social workers completing this intermediate-to-advanced course receive 5 Clinical continuing education credits.

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Special Approvals

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About the Sponsor

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Disclosure Statement

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Course Objective

Race and ethnicity appear to influence disparities in cancer screening among women. The purpose of this course is to increase practitioners' knowledge and awareness of how culture, race, and ethnicity influence women's behaviors and attitudes toward cancer screening.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define culture, race, and ethnicity.
2. Explain demographic trends that lend to a multicultural landscape in the United States.
3. Describe trends in diagnoses and fatalities due to cervical and breast cancer for racial/ethnic minority women.
4. Explain how cultural beliefs influence racial/ethnic minority women's knowledge and beliefs about cancer and cancer screening.
5. Identify barriers to cancer screening for racial/ethnic minority women.
6. Discuss how cancer screening promotion can be tailored to be more culturally sensitive and relevant for racial/ethnic minority women.
7. Identify culturally sensitive practice guidelines for practitioners in relation to cancer screening for racial/ethnic minority women.



Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

In general, cancer screening behaviors have increased in the United States over the past few decades. According to the National Health Interview Survey, approximately 29% of women older than 40 years of age reported having had a mammogram in the last two years in 1987; by 2019, this increased to 66.7% [1; 25]. However, what explains the 30% who have not been screened or who are underscreened? Research indicates that race and ethnicity play a role in the disparities in mammography and other cancer screenings [2].

In Healthy People 2030, launched in August 2020, the goal for cervical cancer screening (i.e., Papanicolaou [Pap] test) is 84.3% for women 21 to 65 years of age. In 2018, the screening rate was at 80.5% [26]. Among racial and ethnic minority women in this group, the rates also fall short of national goals (**Table 1**) [4]. The Healthy People 2030 goal was for 93% compliance with screening guidelines, so the update is a significant reduction in the goal [3].

Culture, race, and ethnicity influence many health dimensions, including how health information is received, where and how health services are obtained, how a health problem is defined, what type of treatment is believed to be warranted, and how symptoms are manifested and expressed [6]. Because culture, race, ethnicity, and gender are intertwined and create intersections of power, oppression, and marginalization, this influences the health experiences of women of color [7; 8]. Given the ever-increasing multicultural diversity in the United States, culturally competent and sensitive practice is essential for practitioners, and it is inevitable that practitioners will work with clients from diverse racial and ethnic backgrounds.

This course will explore current trends in cancer screening among racial and ethnic minority women, their cultural beliefs and perceptions about cancer and health care, attitudes toward cancer screening, how culture might specifically influence these attitudes, and structural, cultural, and personal/cultural barriers to cancer screening. To keep the

CERVICAL CANCER SCREENING COMPLIANCE ^a AMONG WOMEN 21 TO 65 YEARS OF AGE BY RACE	
Racial/Ethnic Group	Compliance Rate
African American/Black	83.5%
Hispanic	80.3%
Native American/Alaska Native	73.7%
Asian/Pacific Islander	67.7%
^a Compliance is defined as having had a Pap test within the past three years.	
Source: [4]	Table 1

course focused, it will only cover breast and cervical cancer screenings. As in any discussion about cultural groups, it is crucial to keep in mind that there is tremendous diversity within racial and ethnic minority groups and practitioners should be aware of the limits of their knowledge and seek assistance and consultation from cultural experts when needed.

Please note that persons with cervixes, uteruses, vaginas, and/or breasts are referred to as women throughout this course. While most persons in this group are cisgender women, it is important to acknowledge that persons of many gender identities may have some or all of these body parts. Further, there is some evidence that sexual minority women may be at greater risk for late diagnosis and mortality related to the cancer discussed in this course, indicating a possible role of sexual identity-based stigma and stress [34]. It is important to that patients be questioned regarding their preferred pronouns and titles and that this information be respected. This is an essential aspect of patient-centered care and will improve rapport and patient outcomes.

DEFINITIONS OF CULTURE, RACE, AND ETHNICITY

Culture has been conceptualized as a diversity domain, characterized by distinct value systems, norms, and social and behavioral patterns [36]. Culture refers to the values and knowledge of groups in a society; it consists of approved behaviors, norms of conduct, and value systems [9; 10]. Culture involves attitudes and beliefs that are passed from generation to generation within a group. These patterns include language, religious beliefs, institutions, artistic expressions, ways of thinking, and patterns of social and interpersonal relations [11]. Culture can also represent worldviews—encompassing assumptions and perceptions about the world and how it works [12]. Culture has two components: the observable and the unobservable [47]. The observable include things such as language, customs, and specific practices, while the unobservable include beliefs, norms, and value systems. Culture helps to elucidate why groups of people act and respond to the environment as they do [13].

On the other hand, race is linked to biology. Race is partially defined by physical markers, such as skin or hair color [14]. It does not refer to cultural institutions or patterns, but it is generally utilized as a mechanism for classification. In modern history, skin color has been used to classify people and to imply that there are distinct biologic differences within populations [15]. Historically, the census in the United States defined race according to ancestry and blood quantum; today, it is based on self-classification, with some scholars arguing that race is also a social construct, not merely biologic [21]. Racial characteristics are also assigned differential power and privilege, lending to different statuses among groups [16]. The American Anthropological Association views race as “an ideology of human differences” that then “became a strategy for dividing, ranking, and controlling colonized people used by colonial powers everywhere” [57].

Ethnicity is also a complex phenomenon and has been defined in many different ways. Alba identified four components of ethnicity [17]:

- Social class
- Political process
- Traditions
- Symbolic token

When ethnicity is viewed as social class, the individual's ethnicity is compared to or equated with their socioeconomic class (e.g., working class or lower class). This is most clear in ethnic enclaves, the residents of which have strong cultural and familial ties [18].

Ethnicity may also be associated with persecution, both political and social. Ethnic unity may serve as a tool for social change and political reform [18]. Several famous ethnic movements took place in the 1960s, such as the unification of farm workers headed by César Chávez. Ethnicity has also been viewed as a return to traditions, characterized by a renewed interest in ethnic foods, traditional religious practices, native language, and folklore [18]. Finally, ethnicity is also acknowledged as being a symbolic token, a way for individuals to maintain a nostalgic connection to their homeland [18].

The role of race, ethnicity, and culture in the development of health disparities is controversial. In part, this stems from a lack of consensus of how race, ethnicity, and culture are defined and how these concepts are used as variables in research [22]. In many cases, researchers develop their own measures, which can reflect personal biases and fail to fully capture the dynamic nature of these concepts [22].

Although a discussion of the many causes of health disparities is beyond the scope of this course, it is important to know that it is a complex, multi-faceted issue rooted in biological vulnerabilities, differential access to resources, environmental conditions, and a range of social, cultural, and economic factors [19]. Some of these factors will arise when discussing cancer screening among racial and ethnic minority women.

RACIAL AND ETHNIC MINORITY GROUPS IN THE UNITED STATES: DEMOGRAPHIC PATTERNS

In 2018, 13.5% of the U.S. population was foreign-born [20]. Three states—California (10.7 million), Texas (4.9 million), and New York (4.5 million)—have the largest immigrant populations in the United States [24]. In California, 39% of the population is Latino; 35% is White [67]. By 2044, the United States is expected to become majority-minority country [27; 69].

In 2020, Hispanics were the largest minority group in the United States, accounting for 18.7% of the population [71]. They reside primarily in California and Texas. African Americans are the second largest group, accounting for 12% of the total population [71].

AFRICAN AMERICANS

“African American” is a classification that serves as a descriptor; it has sociopolitical and self-identification ramifications. The U.S. Census Bureau defines African Americans or blacks as persons “having origins in any of the Black racial groups of Africa” [23]. It includes people who indicate their race as “Black, African American, or Negro,” or provide written entries such as “African American, Afro American, Kenyan, Nigerian, or Haitian.” As a group, African Americans have struggled for civil rights, liberty, cultural pride, and identity, giving the term sociopolitical weight as well.

According to the U.S. Census, as of 2019, 48.2 million persons in the United States identified as African American [37]. By 2060, it is projected they will number 74.5 million [37]. This group tends to be young; 30% of the African American population in the United States is younger than 18 years of age. In terms of educational attainment, 84.7% of those 25 years of age and older have a high school diploma and 19.7% have a Bachelor's degree or higher [37].

ASIAN AMERICANS

In 2019, the U.S. Census indicated that 22.9 million Americans identify as solely Asian [48]. Between 2000 and 2019, Asians experienced the greatest growth compared with any other racial group at 81% [155]. It is estimated that there will be 35.7 million Asian Americans by 2040 (10% of the U.S. population) [60]. California has the greatest Asian American population, followed by New York [48]. The largest Asian subgroup is Chinese Americans, followed by Asian Indians and Filipinos [48].

As of 2019, 22.9 million Americans identified as Asian [48]. California has the largest concentration of Asian residents (6.5 million) followed by New York (1.8 million) [138]. Chinese Americans represent the largest Asian subgroup in the United States, and it is projected that this population will grow to 35.7 million between 2015 and 2040 [32; 33].

“Asian” is a single term widely used to describe individuals who have kinship and identity ties to Asia, including the Far East, Southeast Asia, and the Indian subcontinent [28]. This encompasses countries such as China, Japan, Korea, Vietnam, Cambodia, Thailand, India, Pakistan, and the Philippines. Pacific Islander is often combined with Asian American in census data. The Pacific Islands include Hawaii, Guam, Samoa, Fiji, and many others [28]. There are more than 25 Asian/Pacific Islander groups, each with a different migration history and widely varying sociopolitical environments in their homelands [29].

In 2019, 54.6% of the Asian American population 25 years or older have a Bachelor’s degree or higher, compared with 30.1% of the general population [48]. The median age for this group is 33.8 years [48].

Asian American groups have differing levels of acculturation, lengths of residency in the United States, languages, English-speaking proficiency, education attainment, socioeconomic statuses, and religions.

For example, there are approximately 32 different languages spoken among Asian Americans, and within each Asian subgroup (e.g., Chinese), multiple dialects may be present [29; 30]. The diversity of this group makes generalizations difficult.

HISPANICS/LATINOS

The terms “Hispanic” and “Latino” are used to identify individuals who self-identify as having origins in Spain or Spanish-speaking countries, such as Mexico, Guatemala, Peru, Ecuador, or the Dominican Republic [31]. In 2019, there were 60.6 million Hispanic individuals in the United States [27]. The majority of the Hispanic population in the United States (63.3%) identify as being of Mexican descent [32]. The second largest group is Puerto Ricans, followed by Salvadorans, Cubans, Dominicans, Guatemalans, and Colombians [66].

In 2010, Hispanics represented 16% of the U.S. population; by 2019, they comprised 18% [176]. By 2050, Hispanics are expected to represent 29% of the U.S. population [33]. In 2019, the three states with the largest Hispanic population also had the most growth, with Texas leading at a 2 million increase, California with 1.5 million, and Florida with 1.4 million [176]. Approximately 34.5% are foreign-born. Of those 25 years and older, 14.8% have a Bachelor’s degree or higher [27].

NATIVE AMERICANS

The Native American population is extremely diverse. According to the U.S. Census, the terms “Native American,” “American Indian,” or “Alaska Native” refer to individuals who identify themselves with tribal attachment to indigenous groups of North and South America [35]. As of 2015, in the United States, there are 574 federally recognized tribes and 324 federally recognized reservations [177].

As of 2019, Native Americans and Alaska Natives numbered 6.9 million, constituting 2% of the total U.S. population [177]. By 2060, this number is projected to increase to 10.2 million, or 2.4% of the total U.S. population [177]. In general, this group is young, with a median age of 31 years, compared with the general population median age of 37.9 years. The states with the greatest number of residents identifying as Native American are Arizona, California, New York, Alaska, Oklahoma, New Mexico, South Dakota, Texas, North Carolina, and Montana [178]. In 2020, this group had the highest poverty rate (21.4%) of any racial/ethnic group [177].

DYNAMICS OF RACE, ETHNICITY, CULTURE, GENDER, AND HEALTH

The theory of intersectionality argues that it is not only culture, race, ethnicity, and gender (or other social constructs like social class, sexual orientation, or religion) that influence behaviors; no one single factor acts independently. Gender, culture, and race/ethnicity work synergistically to influence patterns of societal, community, familial, and individual expectations; processes of daily life; intrapsychic processes; and social interactions [38].

Gender is defined by existing institutions and ideologies and is imbued with views about power differentials. In terms of health care, patriarchal ideologies about women's roles can interfere with women's autonomy and decision-making behaviors regarding financial issues or even the determination of a condition's severity and the need for medical attention [39]. For example, South African women in one study reported they were not permitted by their husbands to visit women's health clinics for contraception, and some were even beaten for visiting mobile health clinics for cervical screenings without having obtained their husband's permission [40]. In a survey study with 768 of childbearing-age women in Nigeria, obtaining husband's permission (a common practice) was a statistically significant predictor of breast cancer screening [179]. In order

for systemic change to occur, government, local traditional rulers, and community and religious organization leaders will need to be involved to reduce the stigma of cancer screening for women [180].

Similarly, culture influences how individuals respond to or perceive a particular health issue. The role of culture or traditionality in cancer screening is very complex, and the findings are mixed, in part because researchers have defined these terms differently. On one hand, adherence to one's cultural traditions may impede cancer screening. Some of this is due to traditional spirituality. For example, certain Native American groups believe talking about cancer will somehow invoke the spirits and cause one to get cancer [41]. Other cultures may have strict sexual taboos and an emphasis on modesty. For example, the Chinese emphasize cultural values of sexual modesty, and knowing too much about one's body, particularly one's sexuality, is considered socially inappropriate [42]. In another study, Vietnamese women reported being embarrassed and shy in participating in cervical cancer screening because they were socialized to believe that genitals should only be exposed to their partners/spouses [181]. In the Hmong culture, patriarchal norms can influence women's healthcare decisions for cancer screening [124]. Similarly, Muslim immigrant women have reported privacy concerns regarding routine gynecologic prevention care [43]. Indigenous Mayan women also expressed fear that rumors and gossip will ensue if they went for screening because they would be labeled promiscuous [182]. Finally, preferences for traditional medicine approaches can also influence cancer screening behaviors, particularly for many Asian women [44].

Yet, there have been some studies that demonstrate the positive influence of culture on cancer screening. In a study with members of the Hopi tribe of Native Americans, researchers found that Hopi women who attended cultural ceremonies were almost twice as likely to have had a mammogram in the past two years as those who did not attend [45].

CANCER DIAGNOSES AND FATALITY TRENDS AMONG RACIAL AND ETHNIC MINORITY WOMEN

AFRICAN AMERICAN WOMEN

According to the American Cancer Society, African Americans have the highest death rate and shortest survival for all cancers compared with other racial minorities in the United States [50]. There are many reasons for this disparity, including socioeconomic, cultural, and institutional factors that contribute to health disparities in general for this group. There is concern that the COVID-19 pandemic has further aggravated these disparities [183].

Cancer is the second leading cause of death for African Americans [50]. In 2019, it was projected that 202,260 new cancer cases were expected for African Americans, with 104,240 of these cases occurring in women [50]. Although the overall cancer incidence is 8% lower for African American women compared with White women, the mortality rate is 12% higher [183]. The leading sites of new cancer cases among African American women are the breast, lung/bronchus, and colorectum [50]. Beginning in the 1980s, the breast cancer incidence rates among African American women increased significantly, in part because of the increased education in early detection. The incidence rates have now stabilized. Between 2006 and 2015, the breast cancer incidence rate for African American women was 0.9%, compared with 0.4% for non-Hispanic white women [50]. The death rate for breast cancer for this group is still 40% higher than for white women [50]. African American women also tend to develop breast cancer younger (e.g., before 40 years of age) [50]. African American women tend to have later-stage diagnoses of breast cancer compared


with White women [183]. Furthermore, the five-year survival rate for breast cancer is the lowest for African American women compared with all other racial/ethnic minority groups and white women (82% vs. 92%) [51; 183]. Cervical cancer rates are 30% higher among African American women than their non-Hispanic white counterparts [50]. This disproportionate burden is believed to be related primarily to unequal access to health care extending to a lack of screening.

Cancer Screening Trends Among African American Women

In the past, African American women had lower mammography screening rates than white women, but these rates are now only slightly higher for African American women 40 years of age and older (69% vs. 64%) [50]. Yet, this higher rate may be due to over-reporting [50]. Similarly, Pap test use is slightly higher, at 85% for African American women compared with 83% of white women [50]. In a study of 5,060 women who had scheduled Pap test appointments at a women's health clinic in Missouri, African American women had the highest percentage of "no shows" among all racial minority participants [184]. In a 2011 study of African American women who frequented beauty salons in North Carolina, several demographic variables were found to predict Pap test and mammography use [53]. African American women who had an annual household income of at least \$50,000 had health insurance, were currently working, and reported being in excellent/very good health tended to have had a Pap test in the past three years. For mammography screening, age (i.e., 50 years or older), having health insurance, having had a Pap test, and reporting having excellent/very good health predicted having a mammogram in the past year. A 2021 study found that health insurance and patient-provider communication were the two main variables that predicted breast cancer screening for African American women [185].

Overall health status may also be a factor. African American women with higher body mass indices (BMIs) are less likely to have had a Pap test compared with those with lower BMIs [126].

Communication of mammogram results may perpetuate screening disparities among African American women. In a study comparing the adequacy of the communication of mammography results to African American and white women, African American women were more likely to report receiving inadequate communication of their results compared with white women [54]. This was especially true when results were abnormal.



Race and ethnicity is a factor that has prompted concern because of a growing disparity in breast cancer mortality rates, particularly among African American women. However, the U.S. Preventive Services Task Force has found no high-quality evidence to conclude that screening African American women more often or earlier than already recommended for the overall population of women would result in fewer breast cancer deaths or a greater net benefit.

(<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening>. Last accessed December 12, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

ASIAN AMERICAN WOMEN

In general, Asian Americans have the lowest cancer rates of all racial/ethnic minority groups. There were approximately 57,740 new cases of cancer among Asian Americans, Native Hawaiians, and Pacific Islanders in 2016. Approximately 34% of these cases were breast cancer, the most common site [68]. Generally, Asian American women are 20% less likely to have breast cancer compared with non-Hispanic White women [186]. However, it is the leading cause

of death for this population, largely due to health disparities in seeking preventive care and differences in cancer site frequency. Asian American women are 30% less likely to develop breast cancer compared with white women, but they are three times more likely to be diagnosed with stomach cancer [55]. They are also 2.5 times as likely to die from stomach cancer compared to their White female counterparts [186]. Compared with other racial groups, Asian and Pacific Islander women have the highest five-year breast cancer survival rates [125]. Specifically, Asian American women have a 91% survival rate following stage 0 to stage 2 breast cancer diagnoses [187].

There is tremendous diversity within the Asian American population, and this extends to cancer rates as well. Chinese women have the highest lung cancer death rates among Asian American subgroups, and Cambodian and Vietnamese American women have 40% to 70% higher rates of cervical cancer [56; 68]. Asian American women have experienced an increase in breast cancer rates for the past two decades, as rates in many other groups have decreased [146]. A study of Asian American women in California found significant increases in breast cancer diagnoses in this group between 1988 and 2013, with the greatest increases noted among Korean and Southeast Asian women [146]. Korean American women reported the fourth highest incidence in breast cancer among the Asian American subgroups [188].

Filipina women also tend to be diagnosed with breast cancer at a younger age compared with other Asian subgroups (53.2 years vs. 55.1 years), and their breast cancer tends to be more aggressive at diagnosis [127]. In addition, Filipina women are least likely of all racial groups to have received a mammogram within the last two years, with 67.7% complying with recommendations for screening, compared with the national rate of 72.5% [131].

It appears that acculturation and years of residing in the United States are variables that affect cancer rates among Asian immigrant women. In a 2019 study, Asian women who have lived half or more of their lives in the United States were almost three times more likely to be diagnosed with breast compared to their U.S.-born counterparts [147]. In another study, for Asian women who immigrate to the United States, their risk of developing breast cancer increases six-fold, and Asian women who have lived in the United States for at least one decade have an 80% higher risk of breast cancer compared with more recent immigrants [51]. It is speculated that this is due to the changes in diet, physical activity, and the environment.

Cancer Screening Trends Among Asian American Women

In 2019, the rate of Asian American women 40 years of age or older having a mammogram within the past two years was 57.8%, compared with 68% for White American women [186]. In one study, researchers found that the gap between the highest and lowest rates of breast cancer screening among Asian American women was more than 30% [44]. Japanese women had rates of 70.6% for mammograms within the past two years, but South Asian and Korean American women had rates of 40.3% and 46%, respectively. Another study found that 54% of Korean women reporting having breast cancer screening every two years [148].

In a 2015 study, overall mammography rates appeared to have increased for Asian American women [128]. This increase was particularly demonstrated with Vietnamese, Chinese, and Japanese women. Mammography rates also declined for South Asian women. For Asian American women 40 years of age and older, the rate of cervical cancer screening with the past two years was 62.8%, nearly the rate of White American women (63.7%) [186].

Overall, the rates of cervical cancer screening within the last three years were higher than mammogram use among the Chinese, Filipina, Korean, Japanese, and South Asian women, although Korean women scored the lowest for cervical cancer screening [44]. For both mammograms and cervical cancer screenings, having higher income, being married, being born in the United States, having health insurance, and having perceived good health predicted the likelihood of having had breast and cervical cancer screenings [44]. Not surprisingly, healthy lifestyle patterns (e.g., frequent walking) was also correlated with having a mammogram. For example, Korean American women who walked at least 10 minutes per week were 61 times more likely to have had a mammogram compared with those who did not walk [149].

HISPANIC/LATINA WOMEN

The American Cancer Society estimates that one-third of Hispanic men and women will be diagnosed with cancer during their lifetime [189]. In 2021, there were an estimated 176,600 new cases of cancer among this group, 54.7% of which occurred in women [189].

Cancer is the leading cause of death for Hispanics, accounting for more than 20% of all deaths among Hispanic/Latina women [189]. In general, Hispanics have lower all-site cancer incidence and mortality rates compared with non-Hispanic whites. For example, Hispanic women have a 30% lower breast cancer incidence and mortality rates than non-Hispanic White women [189].

Data show that breast tumors in Hispanic women tend to be localized and larger at diagnosis compared with their non-Hispanic white counterparts, perhaps explained by lower mammography screening rates among Hispanic women [59; 150]. The five-year breast cancer survival rate for Hispanic women is 86%, compared with 91% for white women [51].

Hispanic women are 40% more like to be diagnosed and 30% more likely to die from cervical cancer than their non-Hispanic White counterparts [190].

Cancer Screening Trends Among Hispanic/Latina Women

As discussed, the breast cancer incidence is lower for Hispanic/Latina women compared with white women, but Hispanic women tend to have larger tumors and be at a more advanced stage at diagnosis. They are also more likely to have cervical cancer than white women. In a 2009 study, researchers asked Hispanic and non-Hispanic white woman whether they obtained mammograms annually according to the screening guidelines established by the American Cancer Society [58]. Among Hispanic women 45 years of age and older, 62.8% had a mammogram within the last two years, compared with 68% of non-Hispanic white women [190]. Hispanic women who had a family history of breast cancer, who were younger (50 to 59 years of age), who had hormone replacement therapy, and who performed regular breast self-examinations were more likely to adhere to the guidelines.

In general, Hispanic women are also less likely to engage in cervical cancer screening compared with white women, but the rates have improved. In 2013, 77% Hispanic women were up-to-date with their screening, compared with 83% of white women [59]. Language barriers are a major predictor of non-utilization [62]. In 2018, 71.1% of Hispanic women 18 years of age and older reported having had a Pap test within the past three years, compared with 63.7% non-Hispanic White women [190]. Hispanic women who are proficient in English are more likely to report obtaining a Pap test within the last three years compared with those less proficient in English [62].

Screening rates for Hispanic/Latina women from lower socioeconomic areas are even lower. An estimated 36% of Hispanic/Latina women with lower incomes had received a mammogram within the past year and 55% had a Pap test within the past three years [63; 64]. Foreign-born Hispanic women are 1.63 more likely to report never having had a Pap test compared to U.S.-born Hispanic women [191].

Like other racial/ethnic minority groups, age, income, employment, and health insurance predict mammography and Pap test use in this group. However, when a healthcare provider, particularly a physician, recommends a mammography and/or a Pap test, the likelihood of having received these screenings increases [65].

NATIVE AMERICAN/ ALASKA NATIVE WOMEN

In general, cancer rates are lower for Native American women when compared with whites. In 2020, rate of cancer diagnoses for Native American women was 6.0%, compared with 11.7% for non-Hispanic White women [192].

Breast cancer is the most diagnosed cancer among Native American women, followed by lung and colorectal cancers [152]. The breast cancer mortality rate was also slightly lower for Native American/Alaska Native women compared with white women (21.6 vs. 26.5 per 100,000) [153]. Overall, the five-year survival rate for breast cancer is 90% among this population [193]. However, there are geographical variances. For example, the breast cancer mortality rate is higher among Native American/Alaska Native women 40 to 49 years of age in Alaska compared with white women in the same area [153]. Furthermore, when they are diagnosed with breast cancer, it tends to be at a more advanced stage [154].

The rate of new cervical cancer cases for Native American/Alaska Native women in 2016 was 5.3 per 100,000 population, compared with 7.5 per 100,000 population for white women [151]. When diagnosed, they tend to be in later stages, and the cancer-related mortality rate is twice as high as that for white women [130]. This has resulted in a disproportionately high cervical cancer mortality rate in this population. The cervical cancer-associated mortality rate for 2014–2018 was 2.4 per 100,000 population for this group, compared with 2.0 for non-Hispanic White women [194]. There also appear to be regional differences for this group. Native American women living in the northern plains have the highest cervical cancer mortality rates [70].

Cancer Screening Trends Among Native American Women

Like other racial and ethnic minority groups, women from Native American populations have low mammography and Pap test rates. Level of education, health insurance status, and access to health providers all impact screening rates. An estimated 16.9% Native American/Alaska Native women have not had a Pap test in the past five years [131]. In 2018, 65.3% of Native American/Alaska Native women 40 years of age and older reported having had a mammogram within the past two years, compared with 68% for White women [194].

The overall Pap test rate for Native American/Alaska native women 40 years of age and older in the past two years was 58.6%, compared with 63.7% of White women [194]. Cancer screening rates also vary based on tribal affiliations and geographic regions. In a study of 559 Hopi Indian women living on reservations, researchers found that although 95% had ever had a Pap test, only 65% reported consistent annual screenings [73]. Younger women (18 to 24 years of age) were more likely to have had an annual Pap test compared with those older than 25 years of age. Furthermore, women with less than high school education and those who refused to be screened by a male physician were less likely to report annual screenings.

IMPACT OF CULTURAL BELIEFS ON CANCER SCREENING

Because breast cancer is the second leading cause of death for women in the United States but is treatable if diagnosed early, the American Cancer Society has recommended [46]:

- Women 40 to 44 years of age: Given the choice to start annual breast cancer screening with mammograms
- Women 45 to 54 years of age: Annual mammograms
- Women 55 years of age and older: Mammograms every one to two years

Screening should continue as long as the patient is in good health and is expected to live at least 10 years [46].

Once one of the most common cancers affecting women, cervical cancer now ranks 14th among all cancers in women, and this decrease is attributed largely to improved screening practices and the introduction of the human papillomavirus vaccine [132]. Pap tests can reduce the lifetime risk of cervical cancer by 40% [156]. However, non-screening rates remain high among some populations due in part to limited access to or participation in screenings. The American Cancer Society recommends [46]:

- **Screening should start by 25 years of age.** Younger people should not be tested.
- **People 25 to 65 years of age** should have primary HPV testing every five years. If a primary HPV test is not available, a co-test (HPV and Pap test) every five years or a Pap test every three years are second-line options.
- **People older than 65 years of age** who have had regular cervical cancer testing in the past 10 years with normal results should not have regular testing for cervical cancer. Those with a history of a serious cervical pre-cancer should continue to be tested for at least 25 years after that diagnosis, regardless of age.

- **People whose cervix has been removed by surgery** for reasons not related to cervical cancer or serious pre-cancer should not be tested.
- **People who have been vaccinated against HPV** should still follow the screening recommendations for their age groups.

Adherence to these guidelines would be ideal, but disparities in the use of cancer screenings exist, and the reasons are multifaceted and complex.

Beliefs about health and illness are influenced by a variety of historical, cultural, and geographical factors [74]. Cultural norms and values affect racial and ethnic minority women's beliefs about cancer and screening, and this is especially true among immigrant populations. This section will highlight recurrent cultural themes that appear to impact beliefs about cancer and cancer screening.

LANGUAGE MANIFESTS ILLNESS

Many cultures believe that language has power to shape reality and change the course of life events [157]. For example, some Native American tribes believe that if someone talks about cancer, particularly in the first person, this can bring about cancer [41]. Many Asian cultures also believe that speaking about taboo topics will bring about the feared event. In a study of Chinese Australian women, participants reported that thinking and speaking about cancer would bring it to fruition [75]. In the African American community, this process is referred to as "claiming;" by discussing cancer, one takes ownership of it, and therefore, there is the possibility of it happening. Conversely, if one does not discuss illness, the possibility is significantly reduced [76]. In a survey study of Muslim immigrants, some participants reported being unaware of family history of cancer, in part because information was withheld to prevent family from worrying or because speech was believed to influence health outcomes [158].

FATALISM

Fatalism is defined as the belief that one's fate is beyond his or her individual control [75]. This belief is common in collectivistic cultures, which place emphasis on the larger community and social forces, versus individualistic cultures, which emphasize the notion of the self, autonomy, and self-determination. Fatalism is also intertwined with religious and spiritual beliefs.

Fatalism can influence beliefs about cancer and cancer screening among racial and ethnic minority groups. African Americans, for example, may believe that cancer is part of God's will and is a predetermined course for one's destiny. Because the cancer is destined to happen, one merely needs to accept it [76; 133; 159]. Similarly, Asian Indians have a belief in karma and the idea that their destinies are not theirs to control. In these cultures, cancer (or any illness) may be considered necessary to balance karma. Korean immigrants often believe that cancer is a punishment from God or spirits for not living a moral life [76; 77]. For others, fatalism is rooted in philosophical beliefs regarding yin and yang. For persons who include the concept of yin/yang in their belief systems, harmony with the environment is important, which translates to accepting the events of life that are predestined to occur [75].

However, it is important to remember that fatalism is a cultural theme and may not always apply; there is tremendous diversity within groups. In a focus group study with Hispanic Catholics, self-agency emerged as a prominent theme [134]. Participants reported believing that while God plays a role in determining their fate, they also maintained the importance of self-determination and personal assertiveness in the outcomes of cancer. This reinforces the notion that cultural fatalism does not necessarily connote powerlessness; rather, it is a coping mechanism [160]. Interestingly, some stress that an expression of fatalism may be way for patients to reassert individual autonomy and reject constraints placed by the medical establishment [161]. Furthermore, there may be a variety of other individual and cultural

factors that mediate between fatalism and cancer screening. For example, in a study with 240 Korean American immigrant women, those who scored high in measures of fatalism were more likely to have had a mammogram in the past two years compared to those with low fatalism scores [195]. The authors found that family history of breast cancer and perceived barriers to mammogram affected the relationship between fatalism and preventive care [195].

CONSERVATIVISM RELATED TO SEX AND MODESTY

In many cultures, discussions about sex and sex-related matters are considered taboo, and sex and gender roles are often intertwined. For example, in some Hispanic cultures, particularly traditional Puerto Rican families, *marianismo* is highly valued. *Marianismo* is a cultural value that stems from the Catholic belief in the Virgin Mary as the ideal of true femininity; it is considered the female counterpart to *machismo* [78]. While unmarried, women are expected to be chaste, passive, and pure, and when married, women are not supposed to demonstrate interest in sex, although having children and being a mother are prized [78]. These ideas regarding female sexuality and women's role as enforcers of moral purity can influence beliefs about breast and cervical cancer. For example, Hispanic women are more likely than white women to believe that breast cancer is caused by breast fondling, promiscuity or having multiple sexual partners, or initiating sexual activity at an early age [49; 79]. In a qualitative meta-synthesis study, some Latinas reported feeling that cervical cancer screening constituted "indecorous behavior" [135]. Similarly, a study of Nepalese women found that cervical cancer screening was considered on par with promiscuity and adultery [162]. Laced with this is the belief that breast cancer is a sign of God's divine punishment for immoral behavior [79]. Therefore, women may feel that a breast or cervical cancer diagnosis is a sign that they have engaged in immoral behaviors and be shamed at having to tell their husband or family.

This same cultural taboo about discussing sexual matters applies to many Asian cultural groups. Cultural beliefs about modesty and inappropriate public discourse make discussions about and screenings for women's cancers difficult. Many Chinese women believe that talking about breast health is inappropriate and embarrassing [80]. A study of Korean women indicated the women never thought about breast health or breast cancer because the term "breast" is not used in everyday conversations as it would be perceived to be inappropriate [77]. Some women felt breasts or genitalia should not be exposed in the presence of strangers [163; 164; 196; 197]. Older Korean women, in particular, associated cervical cancer with immoral behaviors. For example, these women were more likely than younger Korean women to believe that they were more susceptible to cervical cancer if they had abortions or had multiple sexual partners or if their husbands had promiscuous lifestyles [77].

Nudity can also be an issue, particularly if the healthcare provider is a man. In one study, Native American women tended to object to getting fully undressed and being exposed in an examination room. Having a male stranger conduct an exam was considered intrusive by these women [81; 82].

GENDER ROLES

Several studies have highlighted the role of male family members in women's engagement in breast and cervical cancer screening. In a qualitative study involving Latinx farm workers, some community health workers noted that convincing men to allow their wives to access cancer screening was often a necessary step to improving screening rates for this population [198]. This was related to both *machismo* attitudes as well as cultural taboos regarding modesty. Similarly, a 2019 study found that some Hispanic men would not allow their wives to attend gynecological exams because of their traditional views of sexuality and modesty [199].

In Ghana, some women talked about how they first needed their husbands' permission to go to screenings. Because their husbands were the key decision-makers in the area of finances, some husbands felt they could not afford screening and did not allow their wives to get screened. Furthermore, they also believed that strangers should not touch their wives [200].

CULTURALLY LADEN HEALTH BELIEFS/MYTHS

A variety of health beliefs arise in various cultures and may result in cancer screening disparities. Misconceptions regarding the causes and manifestations of cancer are particularly damaging and can be difficult to dispel.

Asymptomatic is Healthy

Preventive care is not a familiar concept for many racial/ethnic groups. Instead, medical care is only sought when symptoms arise [158]. In one study of Chinese immigrant women, participants reported that if they felt healthy, they must be healthy. If no symptoms were present, they did not believe they could have cancer [75]. This can be particularly damaging for cancers (like breast and cervical cancers) that are treatable if identified in early stages.

Improper Hygiene

In several studies, ethnic minority immigrant women reported believing that proper hygiene reduced the risk of cervical cancer [83]. In a study of Vietnamese immigrant women, the majority believed that cervical cancer could be prevented by proper hygiene, including cleaning procedures and observances of behaviors during menstruation [5]. A study of Malaysian women revealed similar beliefs, with the women asserting that "dirtiness" in the vagina could lead to cervical cancer and the necessity for cleaning the vulva and vagina area after sex and during menses [84]. Older Chinese immigrant women have reported that unhygienic conditions in China caused germs that then mutated to cervical cancer [83].

Research involving Latina immigrant women have found that some women believed that improper care of the womb or inadequate feminine hygiene could lead to infections, which could then place one at greater risk for cervical cancer [49; 165]. Attributing the development of cervical cancer to sexual activity during menstruation was also adhered to by some Latina women [85].

Foods Increase Risk for Cancer

Some Asian cultures believe that certain foods, including deep fried foods and preserved foods (e.g., dried fish, canned foods), may cause cervical cancer [84]. In a study of Latina women, sugar substitutes, spicy foods, and foods that have been microwaved were believed to cause breast cancer [85].

Medical Procedures are Harmful

In a focus group study with African American women, some participants expressed fear that a mastectomy could cause cancer to spread [86]. In another study of Haitian immigrant women, participants shared the belief that x-rays from mammography screening could cause breast cancer [74]. Latinx farmworkers were concerned the mammogram machine was dangerous and could harm the breast [198].

Form of Punishment

Some groups may attribute the onset of cancer to immoral behavior [200; 201]. In one study, Arab women reported believing that cancer may be a form of punishment for violating religious rituals or engaging in improper behaviors [136]. In a survey study with Mexican immigrant women, some reported a belief abortion could lead to cervical cancer [165]. In interviews with Vietnamese service providers, some reported that their clients believed that cervical cancer was a punishment for immoral behavior (e.g., having sexual relationships outside of marriage) [166]. Some Nigerian women did not necessarily believe that cancer was a direct result of immoral behavior. However, they did believe that their husbands could bewitch them with cervical cancer if they were displeased with them [202].

DISSONANCE IN BELIEFS ABOUT ILLNESS AND HEALING

Western medicine is based on the biomedical perspective and the disease model, which focuses on biological dysfunction and symptoms [87]. According to this model, the physician handles the care of the patient and legitimizes that a disease is present [87]. However, many cultures do not necessarily adhere to the biomedical approach. Instead, racial and ethnic minorities tend to have a more holistic view toward health, with a community aspect to illness and healing. There are several general common denominators underlying these health beliefs. First is the belief that diseases are caused by an imbalance between oneself and one's environment, such as bodily imbalance, problems in interpersonal relationships, or even sin [88]. In a study of Chinese women in Australia, participants attributed the etiology of breast cancer to a lack of balance in the life force that runs through the body (referred to as chi) [89]. Thus, daily life for many traditional Chinese women involves eating a "balanced" (from the yin and yang perspective) diet that includes herbal remedies and soups and being attentive to how wind, cold, and dampness affect the body [90]. Such practices are viewed by Chinese women as more beneficial for the prevention of cancer than obtaining annual gynecological exams [90]. Similarly, some groups (e.g., Haitian immigrants) believe that the centrality and equilibrium of blood that runs through the body and ensuring that the blood flow remains free by adhering to the proper temperature and digesting certain foods will prevent cancer [74]. The use of herbs and other home remedies is an initial (or preventive) solution rather than a final resort.

Because racial/ethnic minority groups often believe the causes of disease are multifaceted and holistic, there is an emphasis on the self in relation to one's social environment and network [88; 91]. It is typical to find a patient's social support network involved in the illness and problem solving; community ties are incorporated into the care of the patient. For

example, spiritual and religious traditions and practices may be integrated into the healing process, and community or spiritual leaders are often involved in treatment [91].

BARRIERS TO CANCER SCREENING

INDIVIDUAL BARRIERS

At the individual level, barriers to cancer screening include issues related to access to care and health literacy. Racial and ethnic minorities in the United States are significantly less likely to have health insurance, making it difficult, expensive, and inconvenient for women to obtain regular mammograms and Pap tests [92]. Over the past decade, co-payment requirements have increased with most insurance plans, and this increase is correlated with a decrease in cancer screenings [93]. Less than 70% of women in cost-sharing plans were screened, compared with nearly 80% of fully covered women. This disproportionately affects African American women, women with lower levels of education, and women in lower socioeconomic levels. Those who are uninsured are even less likely to receive screenings [94]. Lack of health insurance and higher co-payment costs emerged as barriers for Hmong women engaging in appropriate breast and cervical cancer screening [124].

Lack of a regular physician can also reduce screening rates. In one study, recent immigration and lack of a regular physician were the greatest risk factors for not having a recent Pap test among minority women [95]. Another issue is the amount of time and resources that women have to devote to their health care. In one study, Malaysian women reported being stressed by the competing demands of life, which resulted in their health being a low priority [84]. In some cultures, the patriarchal social structure limits women's decision-making authority, which can negatively impact health-seeking decisions [162]. In such cases, the well-being of others may be valued above one's own [167]. In two separate

studies, South Asian and Iranian women indicated that familial responsibilities did not allow time for cancer screenings [163; 167]. This may be partially the result of stricter adherence to traditional gender roles, with women responsible for all home and child care. Hispanic women in focus groups discussed similar issues regarding relegating their health needs due to their daily struggles with life maintenance issues (e.g., caring for children, cooking) [96]. Even for older women, childcare issues may remain if they are caring for grandchildren. Creating a stable home life for their families is considered more urgent for African American women than preventive health care [96; 99; 133].

One qualitative study noted that cancer screening is still costly in terms of time and finances for older women because they often rely on family members for transportation, resulting in absence from work and arrangements for childcare [97]. For many immigrants, family members attend healthcare appointments to serve as interpreters [98]. The perceived inconvenience is exacerbated by the locations of clinics and long waits for appointments [84; 96]. Health clinics that are easily accessible or known to immigrant women have been associated with an increased probability of screening [163].

Being unable to communicate well in English is a barrier in the context of obtaining transportation, locating the clinic or office, and filling out forms [124; 163]. Similarly, Native American women have reported wanting information presented verbally or in simple, easily comprehensible written language [137].

Lack of accurate knowledge about cancer and screenings also contributes to the lower rates of screening in minority populations. Fear and anxiety, stemming from misconceptions, inaccurate information, and the general unknown, often impede women from adhering to screening guidelines [168]. For example, a survey of Latina women found a common belief that breast cancer is incurable and that mammography is only necessary when symptoms emerge [61].

In one qualitative study, some African American participants did not have an understanding of the difference between self-breast exam and a mammogram [159]. Others did not know where to obtain screening [200].

As discussed, the absence of symptoms is a prevalent justification for avoiding screenings [96]. Other women may simply be unfamiliar with mammography and how it can detect cancer. In a focus group with Filipina immigrant women, participants discussed inaccessibility of mammograms in the Philippines, where they are considered luxuries and are only available in large cities like Manila [100].

Degree of sexual activity also predicts Pap test and mammography use. In a study of Asian and Latina college students, Latina students who were sexually active were five times more likely to obtain breast cancer screening than their non-sexually active counterparts; Asian students were nine times more likely to obtain a mammogram if they were sexually active [101]. Researchers posited those who are sexually active are more likely to see a gynecologist and be referred for screening.

Fear is another possible barrier. In one study, 30.3% of African American women, 35.5% of Latina women, and 24.2% of Arab women stated that they believed Pap tests were very painful. This predicted the likelihood of scheduling a Pap test [138]. In another study, some African American women reported fear of pain and/or radiation associated with a mammogram [159]. Similarly, a 2022 study found that some African American women were fearful of mammograms and potential pain associated with the procedure [203]. In another study, African American reported being fearful of a breast cancer diagnosis and a wish not to know [204]. This attitude reflected the role of fatalism in individual-related barriers to screening.

SYSTEMIC BARRIERS

Many racial and ethnic minorities feel that the healthcare system is marginalizing, making it difficult to access health services. A survey of Mexican immigrant women described long waits at clinics, and women who sought mammography screening reported feeling the process was impersonal and uninformative [96]. Ultimately, these women felt they were disrespected because of their poverty, and their experiences reinforced their reluctance to seek health services. Others talked about how providers were rude and disrespectful [204].

In a focus group study with Native Hawaiian women with inadequate or no health insurance, participants were reluctant to access free screening services. This unwillingness stemmed from fears that they would be judged negatively and be discriminated against [102]. They were also suspicious of the free services, with these fears stemming from past experiences with discrimination. Other minority groups have reported feeling like “second-class citizens” in the healthcare system [103].

Medical discrimination can adversely impact access and quality of care. In a literature review focusing on Asians and cancer care, four themes surfaced related to medical discrimination [205]:

- Institutionalized discrimination: Perception that lack of income negatively impacted access and quality to care.
- Personally mediated discrimination: Perception that they are “outsiders” because of their race/ethnicity, income, and/or English language proficiency, all of which affected how they were treated.
- Internalized discrimination: Discriminatory behaviors on the part of providers were internalized and resulted in feelings of inadequacy and even blame.

- Personal or group discrimination: Perception of marginalization as outsiders because of their minority status resulted in poor care and lack of access to certain services (e.g., interpreter services).

In a focus group study with African American women about barriers to mammography screening, they expressed anxiety about the interactions with their providers [86]. They were concerned they would be treated with disrespect and did not have much faith and trust toward their physicians; most had a history of poor healthcare encounters, particularly with failures in communication. This reinforced their negative perceptions about the healthcare system and their fears about screenings [86; 133].

Another reason women may not seek medical services is general mistrust of Western medical institutions. Fears about medical incompetence and historical events involving the intentional harm of some groups, particularly African Americans, contribute to this barrier [86]. General mistrust also applies to other ethnic minority groups like Korean American women. In one study, Korean American women who reported higher levels of trust with their healthcare providers were more likely to have breast cancer screening [148].

The logistics of scheduling appointments can be a barrier as well. The automated scheduling can be a challenge for those whose first language is not English, as they may have difficulty following the automated instructions [124].

The model minority myth has been proposed as a possible systemic barrier to cancer screening for Asian Americans [139]. The model minority myth is the stereotype that Asian Americans have achieved success compared with other racial minority groups largely because they have been industrious, particularly in academics. Consequently, healthcare provid-

ers may be less likely to recommend cancer screening to Asian American women because they assume they are already aware of screening recommendations or are more likely to be healthy [139].

The types of barriers may vary for women who have never had a mammography compared with those who have had a mammogram but are not on schedule [140]. In one study of women 40 years of age or older (83% African American), breast cancer knowledge predicted previous mammogram. However, structural, emotional, and communication barriers predicted whether the women were in compliance with screening schedule recommendations. For example, failure to receive a mammogram recommendation from a healthcare provider was a powerful predictor to being off-schedule [140]. Ultimately, understanding these barriers can inform interventions.

CULTURAL BARRIERS

As discussed, the cultural values of fatalism, modesty, and manifestation through language serve as strong cultural barriers to seeking cancer screenings for many racial and ethnic minority women. The cultural value of collectivism can also serve as an impediment. Small communities (e.g., immigrant communities) make anonymity difficult, and some women may feel they will disgrace their families and be shamed if others find out about a diagnosis of cervical cancer, as this is believed to imply sexual immorality and promiscuity [97].

The cultural emphasis on family can also serve as a barrier to preventive care. A survey study with 401 Ugandan women found that those who had high levels of family obligation were less likely to participate in breast cancer education and screening [206]. Putting family first has also been identified as a barrier for some Hispanic women in participating in cervical cancer screening, but it can also be an enabling factor for cancer screening for others [199].

Communication patterns and styles can also inhibit racial and ethnic minority women from fully maximizing the time with their provider. For example, Asian communication styles tend to be more indirect, relying on nonverbal cues. In Japanese culture, *omioyari*, which refers to the cultural concept of empathy and intuition, is an important part of communication [104]. Some Japanese women rely on physicians to sense what they need rather than inquiring directly; questioning is perceived to be asking for favors or a waste of the physician's time [104]. In a qualitative study with Filipinas, the women indicated that they preferred a more "soft," indirect way of communicating. Among this group, being forthright and direct in communicating their needs or questions was equated with begging [105].

Some racial and ethnic minority women have a strong preference for a female physician or provider to conduct mammograms and/or Pap tests. For some women, female providers were associated with increased comfort and mediated modesty and embarrassment issues [199]. Other women prefer a physician from their own racial/ethnic minority group. In a study of Korean American women in Hawaii, participants expressed a desire for a female gynecologist, some even travelling back to South Korea to obtain preventive care [207]. In another study, Hispanic women stated that they preferred to have a provider who was also Hispanic, but it was more important that the provider could speak Spanish [99]. Asian and Muslim women preferred a female provider due to their feelings of embarrassment and privacy about having a male provider touch them [158]. Some Asian women expressed a preference for physicians with training from prestigious medical schools; this could be partially explained by the emphasis on education in Asian cultures [99].

Another barrier is physicians not referring racial/ethnic minority women for Pap tests or mammograms. New immigrants or those who are not proficient in English may not know where to seek screenings, and a physician referral to a specific location increases the odds of seeking preventive care. In a study with African American women, the best predictor to getting a mammogram was having had a screening in the past [106]. Past health behaviors appear to be salient in influencing future health behaviors. For immigrants who may not have legal status, they may be fearful that they will be deported if healthcare practitioners become aware of their undocumented status [135].

ECONOMIC BARRIERS

The high perceived cost of cancer screening is a barrier for many women from racial and ethnic minority groups. In one study, some Arab and Muslim American women identified potential financial issues as a barrier to breast cancer screening [208]. In a study with 897 white, African American, and Native American women, perceived cost of a mammogram, whether accurate or not, was a major barrier to screening; more than half of the women cited costs as a reason they had not sought screening [107]. About 52% overestimated the costs associated with the test, and these women had a greater likelihood of not having a mammogram compared with those with an accurate perception of the costs [107]. For Native American/Alaska Native women, reliance on Indian Health Services has been correlated with lack of mammogram [169]. It is possible that underfunding and understaffing of Indian Health Services may contribute to this gap.

CULTURALLY SENSITIVE CANCER PREVENTION AND HEALTH PROMOTION MESSAGES

Racial and ethnic minorities are often considered hard-to-reach, but experts have asserted that they are instead hardly reached [83]. The one-size-fits-all model of healthcare provision is not culturally sensitive or relevant and therefore does not reach this group. When working with racial and ethnic minority groups or those who are new immigrants, it is important for practitioners to remain flexible and open to negotiation. Serving these patients involves practicing in what Donnelly calls an “in-between space—a space where the practice of Western biomedicine model, Western knowledge, and values intersect with Eastern medicine, knowledge, and values” [97]. Some experts recommend mailing self-screening kits for HPV/cervical cancer screening to immigrant women who may be concerned with modesty [209]. Simply impressing Western values regarding health and illness on minority women does not empower them to change their behaviors; instead, it reinforces their preconceived notions about the healthcare system being marginalizing [98].

Developing culturally sensitive and relevant health prevention education for breast and cervical cancer screenings requires active listening. Recommendations for improving cancer knowledge among racial/ethnic minority women include [83]:

- More information in the relevant language(s) should be offered and disseminated through mass media (e.g., radio, television, newspapers) that target the various racial and ethnic minority groups.
- Cancer community workshops can be offered in local communities.

- Educational materials about cancer prevention should be available in a variety of non-English languages.
- Health fairs can be offered in the community and can include free medical services.
- Health information and announcements in the relevant languages can be posted in public areas (e.g., ethnic grocery stores) and also on public transportation.

In a 2015 study, the Internet was one of the most common sources of breast cancer information for college-age women, regardless of race [141]. Researchers and practitioners should consider how to implement digital technology, such as smartphones, to disseminate breast cancer prevention content [141; 170]. For certain groups, social media apps may be more amenable [209]. For example, WeChat is a popular social media app in China, and Chinese immigrants in the United States use this app to connect with family and friends in China. Some researchers and practitioners have begun exploring the use of WeChat for providing health education to this patient population [209].

IMPORTANCE OF LANGUAGE

When trying to reach racial/ethnic minority women, it is important to consider how mammogram and Pap test screening messages are framed [89]. For example, the word “cancer” can evoke dread and fear for many women, with several cultures attributing the power to cause illness to the word. Similarly, some women may believe that the only “real” cancers are those in the late stages. However, if cancer screening is couched within a discussion about benign tumors, emphasizing the importance of early detection, then the message will be better received [89]. Instead of employing the word “cancer,” the terms “tumors” or “lumps” could be employed as a way to start a dialogue.

UNDERSTANDING SPECIFIC TRENDS AMONG DIFFERENT GROUPS

Variations in screening guidelines have caused confusion among the general public. For example, the American Cancer Society recommends starting mammography at 40 years of age; however, the U.S. Preventive Services Task Force has recommended initiation at 50 years of age (unless risk factors are present) [142]. It is also important to recognize that screening guidelines should be individualized based on the specific patient’s risk factors and healthcare goals. For example, estrogen-positive breast cancer tends to progress more quickly and is much more prevalent among younger African American women [142]. Knowing this, healthcare professionals may decide to recommend earlier screening in this population.



The U.S. Preventive Services Task Force asserts that cervical cancer screening may be clinically indicated in older women for whom the adequacy of prior screening cannot be accurately accessed or documented. Women with limited access to care, minority women, and women from countries where screening is not available may be less likely to meet the criteria for adequate prior screening.

(<https://jamanetwork.com/journals/jama/fullarticle/2697704>. Last accessed December 12, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

CANCER SCREENING AS HOLISTIC HEALTH

Cancer screening promotion messages should be framed within the context of holistic health maintenance. Many cultures believe that good health is the result of harmony of the mind, body, and environment, and preventive medicine can be a part of this [98]. Mammograms and Pap tests can be discussed within the overall context of physical, spiritual, and emotional health.

RELIGIOUS AND SPIRITUAL SENSITIVITY

When caring for minority and immigrant women, practitioners must be willing to discuss religion and spirituality and to acknowledge the connection of the mind, body, and spirit for many racial and ethnic minority groups [106]. In focus groups, African American women were receptive to receiving text messages about cervical cancer and screenings that had underlying religious and spiritual content if they were aligned with their belief systems [170]. Some experts have developed workshops that educate Somali American women about breast and cervical cancer screening, with trainings specifically tailored to their cultural and religious beliefs [210]. The beliefs of Islam were woven into themes of modesty, faith practice, and preventive health care. Educating women about cancer prevention screening was promoted as being consistent with predestination and self-care was a form of respecting the will of Allah. Imams led the workshops in mosques. Ultimately, their messages were more readily accepted by the Somali American women [210]. This may be a foreign concept for many providers practicing within the Western biomedical model which adheres to an empirically based disease model with an emphasis on diagnosing and treating disease [108]. Practitioners should strive to become comfortable talking about prayer and taking care of one's spiritual health, which is viewed as a pathway to physical health for many racial/ethnic minority groups [74; 109].

USING PEERS AND FAMILY MEMBERS

Peers and family members are often the most effective communicators of both accurate and erroneous health messages. On the one hand, they may disseminate medical information that is inaccurate or relate sensationalized anecdotes about health and remedies [84]. Alternatively, the family and peer network is frequently the most relied upon source of health information. In one survey, Filipino American family members frequently encouraged their female relatives to seek breast cancer screenings [100]. In many cases, a best friend, daughter, or other important person may have more power to influence a

woman to obtain mammograms than a physician or husband [110]. However, some women reported that their mothers never talked about breast and cervical cancer screening, likely due to embarrassment [196; 199]. Family members, friends, and peers can be important partners, because observing trusted individuals can prompt patients to engage in healthier lifestyle behaviors, such as cancer screenings [167].

For Native Americans, a tribal leader or provider may be identified to deliver health information with sensitivity to the group's communication patterns [143]. Instead, lectures with the facilitator at a podium, having participants sit in a circle, providing food and crafts, and encouraging extended family members to attend can be beneficial for this group.

LINGUISTICALLY APPROPRIATE SERVICES

Language barriers are one of the major predictors of health disparities in breast and cervical cancer screenings. In an analysis of a large study of multiethnic women undergoing menopause, the researchers found that women who indicated not being able to read or speak English at all or who were less proficient were less likely to have had breast and cervical cancer screening compared with those who could read and/or speak English. These differences could not be accounted for by other variables such as number of years residing in the United States or contact with a physician or hospital [111].

Obtaining cancer educational materials translated to the appropriate language can be difficult. The National Cancer Institute has a Spanish-language website with information about screening recommendations and patient education handouts. The American Indian/Alaska Native Cancer Information Resource Center and Learning Exchange (Native C.I.R.C.L.E.) focuses on developing culturally relevant cancer and health resources and training [171]. The Susan Komen Foundation has a wide array of translated educational cancer materials available on their website.

Multimedia educational information can help convey health information ranging from basic (e.g., anatomy) to advanced (e.g., specifics of screening). Providing educational materials in a patient's native language can be helpful [172]. It is important to provide information in a way that takes into account cultural norms and avoids technical medical jargon [173].

In some instances, interpreters may be needed. Practitioners often consider interpreters neutral parties who communicate information back and forth, but in reality, their role can be much more complex. The role of the interpreter can be conceptualized along a continuum, with "neutral" at one end and "active" at the other [112]. On the neutral end of the continuum are interpreters who essentially act as conduits; at the other end are interpreters who are active cultural brokers and participants in the healthcare process. Most commonly, interpreters in healthcare settings are viewed as conduits of information, which can be dehumanizing [113]. It is implicit in the assumptions of this model that interpreters should/can all be the same, with no individuality, and that the interpretation process and experience is universal [114; 211]. This perspective has been criticized, and interpreters find this perspective challenging. Interpreters may struggle with the tension between an ethical responsibility for speaking out and advocating for clients and being silent because clinicians and providers expect a conduit model [144]. Clinicians tend to want an interpreter who can act as a cultural broker but are simultaneously concerned with power shifts if the interpreter has too much voice.

Another perspective is that the interpreter is an active agent, negotiating between two cultures and assisting in promoting culturally competent communication and practice and in determining a diagnosis [112; 211]. As co-diagnosticians, interpreters determine which medical information is valuable, seek illness-related information outside of the provider's questions, and participate in the diagnostic process by identifying symptoms the provider may not have directly asked about [114].

In this more active role, the interpreter's behavior is also influenced by cultural variables, such as gender, class, religion, educational differences, and power/authority perceptions of the patient [112]. Consequently, an intricate, triangular relationship develops between all three parties.

Specific qualities are necessary for interpreters to help negotiate communication between healthcare professionals, patients, and family members, including [115]:

- Ability to negotiate tension between strictly interpreting word-for-word versus being an advocate, cultural broker, and/or educator
- Awareness that language and culture are two different dimensions (i.e., the interpreter and the patient/family may speak the same language but be from two different cultures)
- Ability to negotiate time spent with family members and the patient
- Willingness to address religious or spiritual issues that arise in the clinical encounter
- Awareness of personal discomforts that may arise given the sensitive and stressful nature of the encounter

Experts have also suggested using third person when interpreting information about cancer [173]. This approach may provoke less fear and anxiety, especially for some cultural groups that believe language can dictate the course of events. Cancer is associated with death, and therefore, many cultural groups prefer to use this term as little as possible [212]. This can be taken into consideration when creating patient education and screening materials. In collaboration with the American Cancer Society and the Susan G. Komen Foundation, researchers developed a glossary of cancer terms specifically tailored for Navajo Indian patients [213]. Instead of using the term "cancer," experts used the descriptive phrase "when one's source of life (i.e., cells) begin to grow out of control."

GENERAL BEST PRACTICE GUIDELINES WHEN WORKING WITH RACIAL AND ETHNIC MINORITY WOMEN

MEANINGS OF HEALTH ARE INFLUENCED BY CULTURE

For many racial and ethnic minority women, health is holistic and multidimensional, consisting of not only the physical body but the emotional, social, spiritual, and cultural health as well [116]. Social health refers to one being comfortable, living stress-free, and being in control of one's living environment. This may be a significant issue for immigrant women, as they live in a country in which they are constantly negotiating new systems and usually learning a new language. Impaired social health then affects their overall health [116]. Messages about the importance of cancer screenings often focus only on physical health, which may be a small part of the holistic health perspective. The goal is not to discard the preventive methods, but rather to reframe the messages so they are relevant to the lives of racial and ethnic minority women and therefore more effective.

RELATIONAL PROCESSES

In collectivist cultures, individuals' roles as part of a larger group are paramount, with an emphasis placed on interdependence [117]. There are three major elements of collectivist orientation: interdependence; familiarity, caring, and trust; and sense of obligation [117]. The family and the church are concrete representations of this cultural norm, and they influence many behaviors, including health decisions. This translates into cancer prevention and education in that the relationship, connection, and trust between the messenger and the recipient have more importance than the message [117]. Therefore, when practitioners deliver a health message in a personal manner that communicates that they can be trusted and that they care, the message will be viewed as more credible and is more likely to be acted

on. If a patient sees the same practitioner at every (or most) visit, there are more opportunities to establish a therapeutic alliance, ensuring that health behaviors are maintained.

Family and collectivism can play facilitator and barrier roles in cancer screening [199]. Practitioners should remember that in collectivistic cultures, the family will play a larger role on stage in decision-making. Furthermore, because cancer is serious and can be frightening, this may also lead to family tension, conflicts, and collusion (i.e., a secret agreement between two or more individuals not to share information) [145]. Cancer screening messages can also be framed within the context of family commitment and well-being to facilitate engagement [102; 174; 199]. For example, women may be told that mammograms and Pap tests promote family well-being and obtaining these screenings is a symbol of their pledge to the overall functioning of the family.

COMMUNICATION STYLES

Styles of communication can be classified from high- to low-context [118]. High-context cultures are those that disseminate information relying on shared experience, implicit messages, nonverbal cues, and the relationship between the two parties [119]. Love and care may not always be verbally expressed but rather demonstrated through concrete actions [175]. Members of these cultural groups tend to listen with their eyes and focus on how something was said or conveyed [118]. On the other hand, low-context cultures rely on verbal communication or what is explicitly stated in a conversation [119]. Consequently, low-context communicators listen with their ears and focus on what is being said [118]. Because of this, the use of narratives or stories in breast and cervical cancer education may be effective for these groups [129]. Stories of cancer survivors' personal experiences bring more credibility and can reinforce adherence to mammogram screening and breast self-examination recommendations [129]. Navajo Indian women test to prefer to hear personal accounts from community and family members about how they dealt with cancer, fatalism, and stigma [213].

Hmong patients, particularly older ones, tend to prefer responding in narratives to health providers' questions, which is consistent with their oral story telling traditions [214]. Western culture, including the United States, can be classified as a low-context culture. On the other hand, groups from collectivistic cultures, such as Asian/Pacific Islanders, Hispanics, Native Americans, and African Americans, are from high-context cultures [118].

Understanding the distinctions between individuals who come from high- and low-context cultures can promote cultural sensitivity. However, it is vital that practitioners take heed of several words of caution. First, it is important not to assume that two individuals sharing the same culture (e.g., low-context culture) will automatically have a shared script for communicating. Second, it is important to not immediately classify an individual into a low- or high-context culture because of their ethnicity. A Chinese American male social worker may not necessarily be a high-context communicator because he is Asian. A host of factors, such as gender, level of acculturation, upbringing and socialization, education, and family immigration history, will all play a role in how one learns to communicate.

Most practitioners have been taught and socialized in a Western biomedical environment in which communication styles are direct (i.e., low-context). This is evidenced by the following common behaviors [120]:

- Asking questions to obtain more information about the medical condition
- Checking for information (e.g., side-effects, symptoms)
- Directing and advising (e.g., telling a patient the necessary treatment)
- Summarizing (e.g., recounts of the patients' accounts of feelings)

The literature has shown that because many racial and ethnic minority patients view healthcare professionals as authority figures, they expect a direct communication style on the receiving end [121].

However, as communicators, they do not necessarily utilize the same direct communication style and expect the professional to infer the underlying meanings of what they express.

COLLABORATION WITH INTERPROFESSIONAL TEAMS, THE COMMUNITY, AND CULTURAL EXPERTS

Interprofessional collaboration is defined as a partnership or network of providers who work in a concerted and coordinated effort on a common goal for patients and their families to improve health, mental health, social, and/or family outcomes [215]. Interprofessional collaboration traverses professional boundaries and allows providers to harness the skills and knowledge of their colleagues in order to achieve a common goal [216]. Aside from improving patient care and outcomes, collaborating practitioners experience improved job satisfaction, retention, and working relationships and report higher levels of creativity [217; 218; 219].

Some experts suggest a community capacity enhancement approach to cancer prevention when working with racial and ethnic minority communities [122]. This involves using existing community resources and ties and determining mechanisms to strengthen these links. The community capacity enhancement model can help reduce any perceived differentials in authority when "outsiders" enter into communities and begin implementing health services. For example, doulas have been deployed to educate foreign-born women regarding cervical cancer screening. Doulas are socially accepted by the women and their families because of their role in childbirth [220]. Partnering with cultural experts and those entrenched in the community can provide insight on how to use specific practices to educate racial/ethnic minority women about cancer screenings. For example, community health workers who work with Vietnamese immigrant reported using the cultural practice of coin rubbing to build trust with their physicians. The practice in itself was innocuous but built rapport and improved patient comfort before Pap tests [221].

In many communities, this will mean involving churches and other religious and spiritual institutions. Ministers, pastors, imams, and church board members, such as female deaconesses, are often viewed as credible and trustworthy and can be effective communicators of breast and cervical cancer screening messages [102; 122; 174; 222]. In one study, churches were determined to be a useful venue for disseminating cancer education and preventive services information for Latinas [72]. The “witnessing” of a survivor of breast cancer about her experiences may also touch segments of the population that are considered “hard to reach” [123; 159].

CONCLUSION

Despite the specific guidelines for mammograms and Pap tests and the increased education about adhering to these guidelines, racial and ethnic minority women continue to have lower rates of cancer screenings compared with their white counterparts. Cultural factors play a role in health beliefs, which then impacts health prevention behaviors, including cancer screenings. Cultural health beliefs should be honored and incorporated into the provision of services to patients either individually, within the family system, or in the community. Frequently, racial and ethnic minority communities are labeled as “hard-to-reach,” but in reality, they are hardly ever reached. When developing culturally sensitive intervention, prevention, and educational strategies to promote positive cancer screening behaviors, practitioners should work with the existing resources in the community in order to promote the cultural practices and beliefs and more effectively convey the importance of cancer screenings.

RESOURCES

African American Breast Cancer Alliance

<https://aabcainc.org>

Indian Health Service

<https://www.ihs.gov>

The American Indian/Alaska Native Cancer Information Resource Center and Learning Exchange (Native C.I.R.C.L.E.)

<http://www.nativeamericanprograms.net>

Center for Disease Control and Prevention Office of Minority Health and Health Equity

<https://www.cdc.gov/minorityhealth>

Intercultural Cancer Council and Caucus

<http://www.interculturalcancerCouncil.org>

National Alliance for Hispanic Health

<https://www.healthyamericas.org>

Native American Cancer Research Corporation

<https://natamcancer.org>

Instituto Nacional del Cáncer

<https://www.cancer.gov/espanol>

The Office of Minority Health

<https://minorityhealth.hhs.gov>

Redes En Acción: The National Latino Cancer Research Network

<https://redesenaccion.com>

Sisters Network, Inc.: A National African American Breast Cancer Survivorship Organization

<http://www.sistersnetworkinc.org>

University of Arizona Cancer Center: The Partnership for Native American Cancer Prevention

<https://cancercenter.arizona.edu/researchers/collaborative-research/nacp>

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

FACULTY BIOGRAPHY

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

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