

“We don’t talk about it” and other interpersonal influences on Hmong women’s breast and cervical cancer screening decisions

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Abstract

Hmong women in the U.S. have low rates of breast and cervical cancer screening, and the factors that influence screening in this population are not well-understood. This qualitative study explored family and clan influences on Hmong women's breast and cervical cancer screening attitudes and behavior. We conducted in-depth interviews with Hmong women and men living in Oregon. Interviews were audio-recorded and transcribed. Transcripts of 83 interviews were analyzed using content analysis. We identified four key themes. First, Hmong women make decisions about breast and cervical cancer screening independently. Second, Hmong families do not discuss breast and cervical cancer screening. For some, not talking about breast and cervical cancer screening was seen as a way that family and clan influence attitudes. Third, Hmong families can provide encouragement and support for screening. Although women make their own decisions, about half of participants reported that family encouraged or supported them or women in their family to get screened. Fourth, some family members, especially elders, may actively discourage screening. This study contributes to knowledge about potential barriers and facilitators to breast and cervical cancer screening for Hmong women. Findings expand our understanding of clan and male family member's influence over Hmong women's screening behavior.

Introduction

As with other racial and ethnic minority groups, Asian Americans in the United States (U.S.) bear an unequal cancer burden. Mortality rates for Asian Americans are significantly higher than for non-Hispanic whites [1]. More specifically, breast carcinoma is the leading cause of cancer-related mortality among Asian American women [2], and for specific Asian subgroups cervical carcinoma is among the top three causes of death [3]. Despite these high rates, Asian American women have low breast and cervical cancer screening rates [4, 5].

For Hmong women, cancer is the leading cause of death, and cervical cancer mortality rates are higher than for all Asian American women (2.8 times higher) and for non-Hispanic whites (4.2 times higher) [6, 7]. The Hmong are also diagnosed with later cancer disease stages than are all other Asian American subgroups [8]. Finally, in areas where Hmong screening rates have been measured, the use of mammography and Pap tests were exceedingly low [6]. In separate small area studies, reported rates of mammography for Hmong women over the age of 40 who had ever had a mammogram ranged from 16% to 30%, and 27% to 74% reported ever having a Pap test [6, 9, 10].

Reasons for low screening rates among the Hmong are not well understood [11]. The decision to seek preventive screening may be facilitated or hindered by numerous factors including socioeconomic status, health access barriers, cultural and religious practices, language, length of time in the U.S., and mistrust or lack of experiences with Western medicine [11]. To date only a handful of studies have sought to understand cultural influences on cancer screening behavior among the Hmong [12, 13]. Despite the importance of the clan structure and significance of patriarchy and patrilineality in Hmong culture, no studies that we know of have explored the role of family influences on screening behavior. One study included Hmong men as

part of their intervention, but it did not report data on men's role in women's cancer screening decisions [14].

The Hmong Breast & Cervical Cancer Project is an exploratory study that examines social, cultural, and health care system factors that may influence breast and cervical cancer screening for Hmong women living in Oregon. Using a community-based research approach, our study team sought to understand factors that influence breast and cervical cancer screening behavior from Hmong women and men's perspectives. In the present analyses, we explored how family and clan influence women's attitudes and behavior related to breast and cervical cancer screening.

Hmong in the United States

The Hmong first came to the U.S. in the 1970s as refugees from Southeast Asia. The U.S. Congress authorized the relocation of Hmong from Laos in recognition of the role they played supporting Central Intelligence Agency employees during the Vietnam conflict and the "Secret War" in Laos [15]. Facing political persecution after the U.S. withdrawal from the region, over 200,000 Hmong fled to refugee camps in Thailand. The majority have immigrated to the U.S. with the relocation occurring in waves between 1975 and 2006 [16, 17]. The majority of Hmong in the U.S. live in California, Minnesota, and Wisconsin, but smaller populations reside in a number of other states [18].

Research indicates that the Hmong's unique sociopolitical history, migration experience and cultural traditions have a strong influence on women's health beliefs and practices, creating unique barriers to their use of Western medicine and medical systems [19-21]. The Hmong received some exposure to Western medicine in refugee camps, but arrived in the U.S. with

limited knowledge of Western medical practices, which strongly contrast to their own [22]. Hmong health beliefs center on natural and spiritual causes of illness, and bad health is believed to be the result of a disharmony in the body or spirit and soul loss [23]. The Hmong's belief in the spiritual etiology of cancer and their fatalistic attitudes toward cancer have been identified as potential barriers to cancer screening [11, 12]. In addition, due to their high mobility and constant state of migration, the Hmong were a preliterate society. Their language was only oral until missionaries in the 1950s developed a Romanized writing system. To this day, the Hmong language lacks words for many medical terms, including cancer.

As younger generations of Hmong men and women have grown up in the U.S., understanding and perspectives on Western medicine and traditional beliefs have evolved. However, younger and older Hmong women in the U.S. still face challenges and issues associated with their culture and with navigating a health care system that is based on the biomedical model, consists of medical providers largely unfamiliar with Hmong culture, and in which they represent a very small minority ethnic group.

Clan structure and health decision-making

As noted above, Hmong culture is patriarchal and patrilineal. Traditional Hmong society is organized into large closely knit communities known as clans. Each clan includes multiple extended families with a common surname and is headed by an elder male leader [21]. Strong kinship ties characterize families, and two to three families often live in one household or near each other [20]. In Hmong culture, the well-being of the clan and the family take priority over the individual [13].

Patriarchal practices are thought to be a potential barrier to breast cancer screening utilization among traditional Asian American women [11]. In traditional Hmong culture, the male head of household has a large degree of influence over family members' health decisions [11, 13, 22]. Decisions about a person's medical care are not individually based; rather, a clan elder or other male head of household (e.g., father, older brother, uncle) is involved [13-24]. These roles have been documented in the cases of critical medical conditions [22, 24]. Less clear is the role that men and clan elders play in women's decision to seek preventive screening, a health practice that was new to Hmong upon resettling in the U.S.

With acculturation, Hmong traditional gender and decisions-making roles have evolved. Research suggests that Hmong women, like other immigrants, adopt different gender roles as acculturation and assimilation occur. For example, a qualitative study with Hmong women found that young women remarked on their frustrations with needing to seek permission for treatment from older, male family members [12]. In the same study, women reported that men make health decisions, specifically older men who hold more authority in Hmong culture. In contrast, Culhane-Pera and Xiong [22] note that the decision-making process in Hmong society is rapidly evolving. Hmong women are more educated, acculturated, and independent and consequently take greater control of their health and their own medical decisions.

Limitations of existing literature

Few studies have examined factors that influence breast and cervical cancer screening behavior among Hmong women, and those that have focused on sociodemographic and health care characteristics [6, 9, 10]. No studies have examined Hmong patriarchal and family influences on Hmong women's breast and cervical cancer screening. In addition, we were

unable to locate any current studies that report women or men's perspectives regarding medical decision-making or cancer screening. Previous qualitative research with Hmong women addressing screening did not include male viewpoints [12]. Finally, none of the studies on breast and cervical cancer screening among Hmong have been conducted in locations with small to moderate-sized Hmong populations where few, if any, resources and culturally specific programs for Hmong are available. In this study, our objectives were to (1) explore how family and clan influence Hmong women and men's attitudes toward breast and cervical cancer screening, (2) examine the role of family and clan in decisions about breast and cervical cancer screening, and (3) explore how family and clan encourage or discourage screening.

Methods

Context

This study was conducted in Oregon, which has a small Hmong community. Census figures for the Hmong population have been considered to be a significant undercount, disproportionately representing more acculturated members of the Hmong population [25]. At the time this study was designed and with the input of community members, we estimated that approximately 3,600 Hmong live in Oregon. Most Hmong in Oregon reside in the Portland metropolitan area, with a smaller number (about 300) living in Marion County (Salem, OR) but having familial ties to Hmong in the Portland area. More recent Census data indicate that 2,920 Hmong live in Oregon [18]. Oregon is one of 16 states with Hmong populations between 1,000 and 11,000 [18]. In contrast, California (91,224), Minnesota (66,181), and Wisconsin (49,240) have the largest Hmong populations in the U.S. [18]. Unlike California and Minnesota, Oregon

lacks Hmong health care professionals and culturally specific and appropriate health programs for Hmong.

Research team

The research team included two investigators, one of whom is Hmong and a long-time member of Oregon's Hmong community. The Hmong investigator has served on the board of a local Hmong organization, has well-established relationships with community leaders and organizations, and has worked with various projects with the Hmong and Asian American and Pacific Islander communities in the state. The investigators collaborated on all phases of this project, from conception and design through analysis and interpretation. Other research team members included, but were not limited to, bilingual and bicultural Hmong interviewers; these individuals were recruited from the community, were trained by the investigators in project-specific procedures, and assisted with recruitment and data collection for the in-depth interviews (described below).

Community Advisory Committee

In the early phases of the project's design and development, we approached key leaders of the Hmong community to gain their support for the project. These community leaders provided input into the study's design, indicated their willingness to assist with recruitment, and agreed to serve on a community advisory committee if the project were funded. Once the project was funded, we formally established the project's Community Advisory Committee. With the Hmong investigator's knowledge of the local community, we recruited additional community members to serve on the committee. In total, the committee consisted of six Hmong community

leaders and three additional Hmong community members who were interested in the project. The members represented five clans and had one or more of the following positions or roles: clan leaders, the director of a community-based center that is well-known and highly regarded by the Hmong community, managers at state or regional health and human service agencies, members of the two local Hmong community organizations, a church leader, one physician and one medical student, a shaman, and persons with strong interest in cancer. Throughout the study, the committee and research team met every 1-3 months. In addition, committee members were sometimes consulted between meetings to provide input and help problem-solve. The committee provided support for the project and helped ensure that the research was conducted in a way that met the needs and preferences of the Hmong community. They also represented the project in the community. Once preliminary results were available, we shared them with the committee to obtain their thoughts and reactions to what we learned and to assist with interpretation. The committee also helped develop plans to disseminate findings to the community.

Study design and consent procedures

We selected qualitative methods for this exploratory study because little research on breast or cervical cancer had been conducted with the Hmong, and no studies had focused on the specific topics of interest. In an initial phase, the investigators interviewed 17 key informants who were members of the advisory committee or other knowledgeable persons from the local Hmong community. The purpose of the key informant interviews was to inform the development of the interview guide and the recruitment and data collection plans for the primary data collection effort. Building on those findings, we conducted in-depth interviews with Hmong women and men living in Oregon. Data from the in-depth interviews are the focus of this article.

The study was approved by the Oregon State University Institutional Review Board. The investigators obtained written informed consent from all key informants immediately before conducting each interview. For the in-depth interviews, interviewers used an informed consent document to explain the study to participants, and participants gave oral consent to participate. The methods and procedures for the in-depth interviews are described separately below.

Participants

The target population included women and men, as well as younger (aged 18-39 yrs) and older (aged 40+ yrs) community members. As described above, we included men because of their major role in medical decision-making. We selected a broad age range because women are recommended to begin clinical breast exams and Pap tests by their early 20s [26]. In addition, men of all ages could potentially influence screening through their roles as husbands, sons, and fathers, etc.

Our goal was to interview 20 participants per sex/age group, with a target sample size of 80. Eligibility criteria were (1) self-identify as Hmong, (2) aged 18 yrs or older, and (3) live in Oregon. We wanted to recruit a diverse sample with respect to clan, socioeconomic status, and acculturation. As a result, we used multiple recruitment strategies including placing printed materials (in English and Hmong) at popular community locations, making announcements at events and church meetings, talking with community members at informal gatherings, word-of-mouth, and receiving referrals from participants. All recruitment materials (i.e., posters, postcards, brochures, announcements) indicated that the project was a study to learn what Hmong in Oregon think about breast and cervical cancer screening; some conveyed that other health topics would also be covered. Recruitment materials varied in the level of detail provided

about the project and background information, but all noted the method of data collection (i.e., interview), at least the first two eligibility criteria, and information about compensation. Once someone indicated interest in participating, the interviewer screened the person for eligibility using a recruitment script. The recruitment script provided information about the study, including questions to determine both interest in participating and eligibility to participate, as well as details on scheduling the interview. In total, 84 interviews were conducted. One interview was not useable, resulting in a final sample of 83 participants (44 women, 39 men). The participants represented 12 of the 17 Hmong clans in Oregon, with the number of participants per clan ranging from one to 11.

Data collection

Between December 2009 and May 2010, one of the investigators (a Hmong woman) and trained bilingual, bicultural Hmong staff (two women and one man) conducted the interviews. All interviews with women were conducted by female interviewers. Initially, male participants were interviewed by a male interviewer; however, due to a staffing issue partway through data collection, we revised the protocol with input from a member of the advisory committee such that subsequent interviews with men were conducted by a female interviewer. Interviews were conducted in participants' homes or offices, or in private rooms at a community-based center or other community location. Based on participant preferences, interviews were conducted in Hmong, English, or both. Interviews were audio-recorded and lasted 45-120 minutes. Participants were offered cash compensation for participation (\$25), childcare (up to \$10), and transportation (up to \$10).

We created two versions of a semi-structured interview guide: one to be used in interviews with women, and one to be used with men. The interview guide included questions about a range of topics including perceptions of and experiences with the health care system, medical mistrust and discrimination in health care, health literacy, barriers to breast and cervical cancer screening, health care utilization, and sociodemographic characteristics, among others. For some questions about breast and cervical cancer screening, women were asked about their personal experiences, and men were asked about the experiences of women in their family. Of relevance to the present analyses, the guide included the following questions: In what ways does your family or clan influence your attitudes about breast cancer screening? How does your clan or family influence your attitudes about cervical cancer screening? What's the role of the clan and family in your decisions about screening for breast or cervical cancer? In what ways has your family or other people important to you encouraged or supported you [the women in your family] to get screened for breast or cervical cancer? Are there times when your family or other people important to you have discouraged you [the women in your family] from getting screened for breast or cervical cancer?

Data analysis

Interviews were transcribed and, if conducted partially or entirely in Hmong, were translated into English. We used a systematic process of comparing segments of audio-recordings to transcriptions for a subset of interviews to check the quality and accuracy of transcripts and, if needed, make revisions and provide feedback to transcriptionists. Final versions of the transcripts were uploaded into NVivo 8 (QSR International, Cambridge, MA), a qualitative management and analysis software package, for the purpose of content analysis. For

the first step in the coding process, the two investigators (one of whom is Hmong) and two other research team members (one of whom is Hmong) independently reviewed a subset of transcripts to generate preliminary codes. Then, through a process of discussion, coding of additional transcripts in NVivo, and refinement of codes, we finalized the list of codes. These same members of the research team, along with one additional coder, were then assigned specific interviews to code in their entirety. Each transcript was independently coded in NVivo by at least two coders, including one of the investigators. For the analysis of interpersonal influences, in a subsequent step, one investigator (who is Hmong) and another member of the research team (who is not Hmong) jointly reviewed the text in each transcript that had been coded for content related to interpersonal processes, discussed any differences in how text had been coded, assessed their agreement with the assigned codes, and revised coding where appropriate. During that process, they identified and discussed the major themes and selected illustrative quotations.

Using a function of NVivo that produces a matrix and count of codes by selected characteristics, we examined differences in themes by age and sex. Because younger (aged 18-39 years) participants were more likely to have been born in the U.S.; understand, read, and write English; and have completed four years of college or higher (data not shown), we used age as a proxy for acculturation. As noted earlier, we consulted with the Community Advisory Committee on the interpretation of our findings. We have summarized the major themes below and included quotations to exemplify the content of participants' comments that form the basis of the theme. For each quotation, we noted the participant's sex and age (by decade).

Results

As shown in Table I, most women had completed high school or its equivalent, and most men had completed at least some college. The vast majority preferred to speak Hmong or a combination of Hmong and English. Most participants considered their health to be good, and many had experience with preventative health care. The majority of women had experience with breast and cervical cancer screening. Related to interpersonal influences, most participants were married, living with a spouse, and had children in the home.

Four key themes emerged from the data regarding interpersonal influences on attitudes and decisions related to breast and cervical cancer screening: Hmong women make their own decisions, Hmong families do not discuss breast and cervical cancer screening, family can provide encouragement and support for screening, and some family members actively discourage screening. Each of these themes is described in greater depth below.

Women make their own decisions

The majority of women and men reported that neither family nor clan have a role in determining their attitudes toward or their decisions about breast and cervical cancer screening. Rather, the predominant theme, generated from interviews with women and men, was that women make their own decisions about breast and cervical cancer screening. Most younger and older women discussed making screening decisions independently without consulting family members, clan, or anyone else. Some participants, however, did note that screening was discussed between husbands and wives. Furthermore, women reported that they do not receive support from family because they do not tell anyone that they are getting screened. Some

women seemed to make their own decisions out of a sense of independence, as indicated in the following quotes:

No, it is up to me. They don't control me. I control myself only. I make the decision on my own. (woman in her 50s)

I make the decision, and then, umm, I, I make the decision as, it comes back abnormal, then it's something that maybe I'll just alert my husband about it, um, and I think that's where it ends. (woman in her 30s)

No, for me it's up to myself. Yeah, no one has the right to make a decision for me [laugh]. No, they don't have a right to know about it. [Laugh] they don't have a right to know that about you. It's up to you [laugh]. (woman in her 50s)

In contrast, other women conveyed that they make these decisions, at least partially, as a result of shyness or a sense of shame. For example,

I think for my entire life, just getting the breast screening is up to me....[Regarding cervical cancer screening...] Since I have been in this country, I just make my own decisions....That is something that I am shy about, so I don't want to anyone to know about it. (woman in her 60s)

Similarly, when asked about breast cancer screening, one woman in her 50s, said “It is up to you to decide, if you want to do it.” When she was asked how family or clan influences her decision to get screened for cervical cancer, she said, “They don’t have a say because the Pap smear for us Hmong is shameful, right? You don’t tell anyone. If you want to go, you just go.” This sentiment also reflects the next theme.

“We don’t talk about it”

Another central theme was that Hmong people generally do not talk about breast or cervical cancer screening. This point was made when responding to questions about how family or clan influence attitudes toward screening and/or the ways family or others might encourage screening. More specifically, some participants, especially younger ones (women and men), said that neither family nor clan influenced their attitudes about screening because these topics are not discussed. For example,

I guess it’s hard to talk about if they have an *influence* because we don’t really talk about health....I don’t have conversations with my family members about health and so I don’t ... I think if we *did* and they expressed some strong views, I might, I might say something different but because we never talk about it...what they think doesn’t have an influence on me currently. (woman in her 30s)

I don't, I don't bring stuff like that to them. [Laughter] No. I feel that that's very personal. And I, you know, unless there's symptom, I would never bring that up to them, or let them know I'm go-- I'm doing it. (woman in her 30s)

Mostly for your family or other Hmong families you don't really talk about these things because everyone doesn't see that they will get these diseases, so they don't really talk about it, but when everyone sees that one or two people have had the disease then that is when everyone may be a little worried. (man in his 40s)

Similarly, some participants said that family and others neither encourage nor discourage breast and cervical cancer screening; rather, the topic just does not come up. They indicated that they do not have conversations about screening with family members or friends. Such comments were more prevalent in interviews with women, but both men and women, younger and older participants, made this point. Participants felt that if support were needed, it would be given, but that in general screening is not talked about.

Like I say, I mean, we don't talk about it, so we don't know when they, they get the test and when they get screened. You know.... if it something happened, you know, then, you know, we'd all know and everyone would support each other. But other -- but for just, uh, screening and testing, you know, we don't really, uh, talk about that. (man in his 30s)

When you are going, you don't tell anyone.... You just go on your own, no one knows.
(woman in her 40s)

Participants gave a variety of reasons for why people do not talk about breast or cervical cancer screening including lack of knowledge, especially among elders, and because screening is

personal or shameful. It is also important to note, however, that some participants thought that one way family or clan influenced attitudes was by creating a culture in which breast and cervical cancer are not discussed. Thus, not talking about breast and cervical cancer screening was also seen as a way that family and clan *did* influence attitudes about screening.

Family and/or friends provide encouragement and support

Even though many participants indicated that women make their own decisions when it comes to breast and cervical cancer screening, about half of the participants – women and men, younger and older – reported that family encouraged or supported them or the women in their family to get screened. Both women and men said that women supported each other and indicated that friends, sisters and mothers are important sources of support. Some participants shared that women in the younger generation encouraged screening, and others shared that mothers encouraged their daughters to get screened. The role of women in encouraging screening is illustrated in the following quotes:

Um, they [clan and family] really don't have one [a role in decisions about screening for breast or cervical cancer]....Well, my mom – I would say my mom has encouraged me actually. My mom has actually encouraged me to go get, to get exams. *[Laughter]*
'Cause she's at that age where she's been told to do it. So she's suggested it. Which is kind of weird. *[Laughter]* (woman in her 30s)

...amongst us girls, we do talk about getting it done, and doing it yearly, and trying to keep up with it, like I haven't done mine in two years and then, so they'll tell um, "hey, you need to go, you should go do your annual" or whatever. (woman in her 30s)

What I see are, usually, if it's, uh, female issues or, or the woman's, related to the women, they, they encourage each other. (man in his 40s)

Husbands were noted by some participants as being a source of support for women. Some men shared that they are supportive and would give support if asked, but they did not always know if or when women are getting screened.

Some family members actively discourage screening

Some participants indicated that family members and others discouraged them from screening. Reasons for discouraging women from getting screened included having no family history of breast or cervical cancer, not knowing much about breast or cervical cancer screening or screening procedures, fatalism, modesty, mistrust, and not believing in Western medicine. Participants felt that elders were more likely to discourage screening than were younger family members. One participant described it this way:

....my mother-in-law, are, probably, the one who would, just because it's, I think it's, uh, it has to be with the culture....And so, they're the first generation, the older generation. And so, they're, they don't feel that you should be showing your intimate parts to, uh, others.... let us know that that's, that's embarrassing, don't do that. (woman in her 30s)

Another participant shared:

I think that your um family that doesn't believe in the Western health system, they have [discouraged her from breast and/or cervical cancer screening]. However, ...those people are uh about 20 to 30%, right? They don't know about the system, right? So they will say, don't go because in the future you will be even more sick. [laughs] It's because you went, that is why you got sick, [laughs] but really it is just what they think. So, you don't agree with what they think. So it is better that you go. (woman in her 50s)

As suggested by the quote above, women also talked about not wanting to go in for screening, or being discouraged from screening, because it might invite more trouble. That is, a woman might feel fine, but providers might either find a problem or something wrong with her, cause something to be wrong with her, or make her feel worried (i.e., give cause for alarm).

Screening versus treatment

Some participants indicated that family and clan have a greater role in decisions about surgery or treatment, as compared with screening. One participant said,

If it [is] just a simple exam, I would say no. Because it is a decision my wife and I make on our own, but if it is a surgery then yeah, we would get family opinion....Um probably immediate, mom and dad, brothers and sisters, their husbands and wives. (man in his 30s)

For some, it seemed there were pressures against screening unless symptoms were present. For example,

I think that you know that you are starting to get that [symptoms or cancer], then they will let you go, but if you don't have it and you just want to get screened then you don't go. (woman in her 40s)

Discussion

In this qualitative study, we explored the influence of family and clan on women's attitudes and decisions about screening for breast and cervical cancer. Traditional Hmong beliefs suggest that Hmong men play an important role in health-related decision-making [11, 13, 21, 22, 24]. In contrast, we found that many women in our study did not appear to rely on men for decisions about breast and cervical cancer screening; rather, they talked about independently making these decisions. This finding was surprising, and more studies are needed to explore and confirm our results. Furthermore, according to our study participants, breast and cervical cancer screening are generally not discussed in Hmong families. More research is required to better understand screening decisions and the reasons why these topics are not discussed.

Our findings may indicate that Hmong decision-making dynamics shifted with immigration, acculturation, and increases in education and women's independence [22]. It is important to note that Hmong women and men in our study did not always distinguish between family and clan when discussing the influence of these two groups on screening decisions. There was a general sense that the clan remained a critical part of Hmong's social organization, but that their role in group decision-making around cancer screening issues may be less than that of the

immediate family. Additional studies are needed to better understand the health care decisions in which Hmong families play a role and those in which they do not, as well as the reasons for these differences.

This study's findings have implications for interventions and programs directed at improving breast and cervical cancer screening rates among Hmong women. First, even if Hmong women are making decisions about breast and cervical cancer screening without the influence of family members, study participants shared that family members can provide encouragement and support for screening. Social support seems to be important and valued. Future research should examine ways to enhance family support for screening. Our findings suggest that women can be a primary source of encouragement and support for other women; building on that source of support could be an important component of programs and interventions designed to increase screening among Hmong women. In addition, our results suggest that Hmong men could also provide support, even if they may not actively participate in or influence screening decisions and attitudes. Increasing knowledge and communication skills around screening may also be beneficial. Given that family and clan are important in Hmong culture, encouraging screening as a way to protect family health may be an effective health message. Further research is needed to determine the most effective strategies for improving screening rates for Hmong women.

This qualitative study's strengths are noteworthy. First, interviewing both women and men provided a richer, more robust and comprehensive account of the role of family and clan in Hmong women's breast and cervical cancer screening decisions. Furthermore, community engagement in the project (i.e., members of the community participated in the research team and the advisory committee) enhanced the project's credibility in the community and cultural

sensitivity, our ability to recruit a large and diverse study sample, and the interpretation of findings. With the knowledge and insights of Hmong research team and advisory committee members, throughout the study we were able to evaluate study methods and procedures and interpret the data with a broader understanding of Hmong culture and the local community.

Although we sought and recruited diverse participants, the sample has potential limitations. For example, the women who participated may have been more independent and less likely to adhere to traditional Hmong gender roles than were non-participants, and most had been screened for breast and cervical cancer. The responses of the women in our sample may indicate a higher level of independent decision-making than would be the case for other Hmong women, and our findings may not adequately capture the attitudes or experiences of women whose screening behavior has been heavily influenced by family or clan. . Additional research is needed to examine the extent to which the study participants' opinions and experiences are shared by other Hmong living in the U.S.

In conclusion, this study contributes to knowledge about potential barriers and facilitators to breast cancer screening for Hmong women. Our findings expand our understanding of clan and male family member's influence over Hmong women's screening behavior.

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Table I. Participant characteristics (N=83)

	Mean (SD) or %	
	Women (n=44) n (%)	Men (n=39) n (%)
Age, years M (SD)	38.2 (12.9)	39.5 (13.7)
18-39	25 (57%)	20 (51%)
40+	19 (43%)	19 (49%)
Born in U.S.	18 (43%)	13 (33%)
Married	37 (84%)	31 (80%)
If married, lives with spouse	35 (95%)	30 (97%)
Has children <18 yrs living in household ^a	26 (59%)	25 (64%)
Has children ≥18 yrs living in household ^{a,b}	18 (45%)	15 (45%)
Education		
No school or only kindergarten	10 (23%)	1 (2%)
Grades 1-11	6 (14%)	4 (10%)
Grade 12 or GED	10 (23%)	10 (26%)
Some college	8 (18%)	17 (44%)
College degree or higher	10 (23%)	7 (18%)
Language preferences		
Hmong only	13 (31%)	5 (15%)
English only	2 (5%)	2 (6%)
Both	27 (64%)	27 (79%)
Health status		
Excellent	3 (7%)	3 (8%)
Very good	8 (18%)	4 (10%)
Good	23 (52%)	24 (62%)
Fair	10 (23%)	6 (15%)
Poor	0 (0%)	2 (5%)
Ever seeks preventative care	27 (61%)	17 (44%)
Has personal doctor or health care provider	29 (66%)	22 (56%)
Had routine check-up within past 2 yrs	25 (57%)	21 (54%)
Health Insurance	38 (86%)	31 (80%)
Ever had clinical breast exam		
Age 18-39	17 (68%)	
Age 40 and older	16 (84%)	
Ever had mammogram		
Age 18-39	1 (4%)	
Age 40 and older	15 (79%)	
Ever had Pap test		
Age 18-39	20 (80%)	
Age 40 and older	17 (78%)	

^a Refers to *any* children living in the household .

^b Asked only of those who reported being married, divorced, widowed, or separated.