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Filipino American Women's Perceptions and Experiences With Breast Cancer Screening

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Purpose/Objectives: To determine information about Filipino American women's perceptions of breast cancer, the most frequently diagnosed cancer and number-one killer of Asian American women, and their experiences with screening.

Design: A qualitative, exploratory approach with focus groups.

Setting: Suburban Filipino American communities in the midwestern United States.

Sample: 11 Filipino American women aged 45–80 years who shared their experiences with breast cancer screening.

Methods: Focus groups were conducted, and the meetings were recorded on audiotape, transcribed, and analyzed using constant comparison techniques.

Main Research Variables: Breast cancer screening, experiences, motivators, and barriers.

Findings: Avoidance was the main theme for Filipino American women in dealing with a cancer diagnosis in the Filipino American culture. Facilitators of Filipino American women's screening practices were support from family members, recommendations from familiar physicians, health insurance reinforcement, and personal attributes of physical symptoms, family history, past diagnosis, and health literacy. Barriers identified were different mind-sets and healthcare systems in the Philippines in regard to early detection, unpleasant experiences with mammography, cultural beliefs, and difficulties accessing services.

Conclusions: Results of the focus group discussions provide useful information about facilitators and barriers that affect Filipino American women's screening practices.

Implications for Nursing: The findings of the study can be used to develop tailored interventions for addressing culturally specific barriers and promoting screening practices in the Filipino American community.

Cultural beliefs and values about cancer and cancer screening shape and inform decisions about whether to engage in screening behaviors. To date, few qualitative studies have examined the cultural beliefs and values of Filipino Americans related to breast cancer screening practices. Previous survey-based studies have reported on use of and attitudes toward breast cancer screening among Filipino American women (Ko, Sadler, Ryujiin, & Dong, 2003; Maxwell, Bastani, & Warda, 1997, 2000). The results of a randomized trial among Filipino American women indicated that screening rates for breast and cervical cancer did not differ between

Key Points . . .

- ▶ Cultural beliefs and attitudes affect women's experiences and decisions regarding cancer screening practices, yet most studies in Asian American populations have used the quantitative approach, and sociocultural aspects of screening behaviors have been examined less frequently.
- ▶ Filipino American women preferred having female and familiar healthcare providers perform cancer screening. They also appreciated support from their significant others, which motivated them to get screened regularly.
- ▶ Promoting awareness of breast cancer screening modalities that are recommended in the United States and low-cost and accessible mammogram services is critical for new Filipino American immigrants.
- ▶ Healthcare providers should understand Filipino American women's experiences and beliefs regarding breast cancer screening to reduce the disparities of breast cancer screening and promote early detection.

experimental and control groups at baseline and follow-up (Maxwell, Bastani, Vida, & Warda, 2003). The authors urged healthcare professionals who attempt to improve adherence to cancer screening in immigrant populations to consider culturally specific outreach methods.

The purpose of the current qualitative study was to explore views about breast cancer and screening practices from the perspective of Filipino American women in the midwestern region of the United States. The findings of the study can

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provide a greater depth of information and potentially add to healthcare providers' knowledge and create a foundation for developing culturally sensitive interventions tailored for Filipino American women.

In the United States, breast cancer is the most frequently diagnosed cancer in women. Although the rates of breast cancer generally are lower in Asian Americans compared to Caucasian and African Americans, breast cancer has been the number-one killer of Asian American women since 1980 (Jemal et al., 2004; National Center for Health Statistics, 1998), and the incidence rate in Asian Americans has increased 14% since 1988 (American Cancer Society, 2005). In addition, a longer period of residency in the United States increases Asian Americans' risk of developing breast cancer, which eventually will approach the risk of the American-born population (Ziegler et al., 1996). More alarmingly, Asian Americans are the only racial group to have exhibited an overall increase in cancer mortality rates for all sites combined from 1990–1999 (Edwards et al., 2002).

The term Asian American represents a diverse population in the United States and often has been under the category Asian American/Pacific Islander in national data on breast cancer incidence and mortality. Miller et al. (1996) showed great variations in cancer incidence rates for specific ethnic groups and cleared away the myth that all Asian Americans have a low incidence of breast cancer. In fact, Surveillance Epidemiology and End Results released an important document on racial and ethnic patterns of cancer in the United States from 1988–1992, which showed that the incidence rates of Asian American subgroups ranged from 28.5 per 100,000 in Korean Americans to 82.3 per 100,000 in Japanese Americans, with 73.1 per 100,000 in Filipino Americans (Miller et al.). Other data from Los Angeles County, CA, showed that Filipino Americans had an age-adjusted incidence rate of 98.1 per 100,000 (Deapen, Liu, Perkins, Bernstein, & Ross, 2002).

In addition, Tu, Taplin, Barlow, and Boyko (1999) found that breast cancer screening programs are less successful and underused by ethnic communities. Therefore, to develop effective interventions to reduce healthcare disparities among various ethnic groups, healthcare professionals must recognize the specific cultural beliefs and values and different health needs of each group. Filipino Americans are the second-largest Asian subgroup in the United States (Grieco & Cassidy, 2001), with higher levels of acculturation compared to other subgroups (Ko et al., 2003). Nevertheless, an integrative literature review on breast cancer screening practices in four ethnic American groups (Chinese, Korean, Filipino, and Asian Indian) indicated that Filipino American women have been less studied and that sociocultural correlates were absent from the reviewed literature (Wu, Guthrie, & Bancroft, 2005). Further understanding of breast cancer screening practices among Filipino American women may provide vital information about how to address their needs sensitively and effectively to promote regular screening.

Methods

Research Design

Focus group methodology was used to explore the shared meaning of breast cancer and experiences of breast cancer screening among 11 Filipino American women. The method

was chosen for data collection because the interaction of a group provides a social context for the development of each participant's ideas so participants will be able to stimulate and refine thoughts and perspectives (Krueger, 1988; Morgan, 1988; Owen, 2001). In addition, researchers are able to obtain data with greater depth than with individual interviews (Morgan & Krueger, 1994).

Groups were kept small, with fewer than five participants in each session (for a total of three sessions), to allow each woman to share her thoughts with an adequate amount of time. Each session, lasting about two hours, was held in a nonthreatening environment in which participants were able to exchange their views without being judged. The methods effectively gathered information about Filipino American women's views about breast cancer and their current and past practices of breast cancer screening.

Participants

Inclusion criteria were that participants self-identify themselves as Filipino American, speak either English or Tagalog, and be aged 40 years or older. Twelve women were recruited from the metropolitan area of southeastern Michigan through the assistance of community informants and word of mouth. One woman was excluded from the data analysis because she did not live in the United States. Efforts were made to ensure that the sample included a diverse representation in terms of age, education, occupation, and length of residency in the United States. The aim of the purposive sampling was to capture the diversity of beliefs and practices of Filipino American women in the community.

Procedures

The primary investigator developed an unstructured interview guide for the study, which was reviewed and validated by two cultural experts and one consultant. The final interview guide was developed with seven questions (see Figure 1) after revisions were made according to the feedback received during the review.

The study was approved by the affiliated university's institutional review board. Each focus group began with the introduction of the roles of the primary investigator and the moderator, the purpose of the study, and a review of the guidelines for participation. Written informed consent was obtained. Each focus group session was recorded on audiotape (with permission obtained at the beginning of the session), and field notes were taken to document additional comments, facial expressions, and interactions among participants. During the

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1. Would you please tell us about your experience (e.g., yourself, family members, friends) with breast cancer?
 2. What does breast cancer screening mean to you?
 3. What are your breast cancer screening practices in your own country?
 4. What are your breast cancer screening practices when you come to the United States?
 5. For women like you, what makes/motivates you to do breast self-examination/clinical examination/mammography?
 6. For women like yourself, what makes it difficult for you to do breast self-examination/clinical examination/mammography?
 7. In your view, what are some suggestions that would make it easier for you to do regular breast self-examination/clinical examination/mammography?
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Figure 1. Questions Used in the Focus Groups

sessions, the participants were encouraged to ask questions and additional questions were posed to clarify responses. Each session lasted 90 minutes to two hours and allowed discussions to be completed. Participants received \$25 gift certificates as incentives, and refreshments were served.

Data Analysis

Audiotapes were transcribed and verified before data analysis. Verbatim transcripts of audiotapes and field notes served as the primary data for analysis. Data were analyzed by identifying and organizing themes in the text, as recommended by Morgan and Kreuger (1998). The two authors independently reviewed each transcript, coded each line of the transcripts, and analyzed for themes based on the questions asked. The moderator's notes were used to gain more understanding and assist in interpreting the women's responses. Next, the two authors met to compare the coding results, discuss emerging themes, clarify differences, and resolve inconsistencies. Consensus was reached about the categories under each theme, and decisions were made about which comments fit into each category. Concepts that were salient and repeated in the text were identified and kept in preliminary data analysis. To validate the findings from the first two focus group meetings, a preliminary summary was prepared and discussed with the participants in the third focus group and with a key community informant who was familiar with the issues of Filipino American women. After the third focus group meeting, major themes discovered in the final data analysis were presented, with quotations from the transcripts supporting the themes.

Results

Sample

The final sample included 11 women with a mean age of 56.9 years (SD = 10.4 years, range = 45–80 years) (see Table 1). Most women (82%) in the sample were married, and two were single. All of the participants were born in the

Table 1. Demographic Characteristics of the Participants

| Characteristic | n | % |
|--|---|----|
| Age (years) | | |
| 41–50 | 4 | 36 |
| 51–60 | 4 | 36 |
| 61–70 | 2 | 18 |
| > 70 | 1 | 9 |
| Marital status | | |
| Married | 9 | 82 |
| Unmarried | 2 | 18 |
| Occupation | | |
| Health-related profession | 4 | 36 |
| Sales and industry | 4 | 36 |
| Housewife | 2 | 18 |
| Education | 1 | 9 |
| Years residing in the United States | | |
| < 10 | 5 | 45 |
| 10–20 | 2 | 18 |
| > 20 | 4 | 36 |

N = 11

Note. Because of rounding, percentages may not total 100.

Philippines, and the average length of residence in the United States was 16.1 years (SD = 12.5 years, range = one month–34 years). The sample included women with a wide range of occupational backgrounds: four in the healthcare field, four in sales and industry, two housewives, and one in education.

Analysis of the three focus group meetings yielded three major themes: perceptions and experiences with breast cancer, motivators to obtain breast cancer screening, and barriers to obtaining breast cancer screening. Under each theme, categories were created to describe the diverse experiences and beliefs that the women discussed.

Perceptions and Experiences With Breast Cancer

Avoidance of discussing the topic: In the stories the women shared, avoidance was one of the major themes in dealing with a cancer diagnosis in the Filipino culture. Six women with different backgrounds spoke about use of the word cancer and how most people did not use it when someone was diagnosed. Often, alternative words such as tumor, lump, “the sickness,” or mass were used to refer to a diagnosis (see Table 2). Fear was another major reason for avoiding the word cancer. The majority of the women talked about the finality of a diagnosis and that a lot of them assumed the worst. The women told dramatic stories about people they knew who were diagnosed with cancer. Examples of the women's explanations as to why the word cancer was not used: “I think it is too final and too brutal to hear the word.” “You know, we avoid the word cancer. I think [be]cause it really scares most people. The word cancer evokes the real scary.”

Information-sharing process: In the sample of Filipino American women, six of 11 women had relatives diagnosed with breast cancer or breast-related benign diseases, and one woman reported having a personal diagnosis of breast cancer and another having a lump in her breast. The Filipino American women described the process of bringing up the diagnoses of breast cancer to their relatives or friends as either delaying or withholding communication to their loved ones. A participant who was a survivor said that her diagnosis was malignant but that her relatives withheld the information from her. Other participants also reported that their relatives or friends with breast cancer were not told about their cancer diagnoses until much later in treatment or until they completed treatment. For example, one woman talked about her cousin, who still resided in the Philippines, being diagnosed with breast cancer. The family decided to withhold the information from the woman. Radiation therapy was prescribed, and the woman complied with the treatment because she thought it was preventive, not curative. During the participant's description, she spoke about a doctor's decision whether to tell the patient about the diagnosis, an action that had a lot to do with how the physician believed the patient would handle it. When the focus group participant went home to visit her family, the word cancer was never mentioned.

Motivators to Obtain Breast Cancer Screening

Subjects expressed different but related perceptions that motivated them to perform breast cancer screening. The perceptions were categorized as family support, recommendations from familiar physicians, health insurance reinforcement, and personal attributes (see Table 3).

Family support: Participants reported that family members served as major sources of information about breast cancer

Table 2. Participants' Perceptions and Experiences Regarding Breast Cancer

| Theme | Examples |
|-----------------------------|---|
| Avoidance | Did not talk about it (cancer) The word cancer was never mentioned. Avoid the word cancer. Refer to cancer as sickness. Refer to cancer as lump or mass. It's OK to use tumor instead of cancer. |
| Fear | Afraid of hearing the word It is too final and too brutal to hear the word. "The word cancer evokes the really scary." |
| Information-sharing process | "The word cancer is really shock on us." "Not feel comfortable and am waiting the appropriate time" "Want to talk to her about it (cancer), but I haven't given an opportunity." Family members or doctors reluctant to share information with patients; make sure patients can handle it. "You don't tell the person." |

and other topics related to health and diseases. Participants often received encouragement from family members to undergo certain medical procedures. They spoke about family and friends having a positive impact on the initiation of breast cancer screening activities by advising them to perform mammography screening or insisting that they go to a doctor when symptoms occurred. One woman talked about her brother who was a physician. She explained that he took it upon himself to educate his family and tell them the importance of screening every year. The encouragement was a major force for her to get her yearly mammogram and clinical breast examination and to perform monthly breast self-examination. Another woman stated that her husband helped to encourage her to see a doctor yearly for a physical so that she could be in the best of health.

Recommendations from familiar physicians: Two common factors identified that facilitated women to participate in screening were working with physicians whom they knew, preferably women, particularly in taking care of their breast health, and physicians who spoke their own language. Women spoke frequently about their healthcare providers in relation to screening and that they were more comfortable with female physicians. One woman explained, "In the breast, I want a female doctor, but in other ways, for example, in some parts or other parts, it may be male, but [with] the breasts, I want a female." Most of the women also preferred a Filipino American doctor, although it did not seem as important as the need for a female physician. One of the stated advantages of cultural similarity is that a woman could speak her native tongue with a physician, which brings a sense of comfort to the meeting. One woman stated, "He knows our practices, and I told him that it's okay. . . . I can talk to him in my own language." Although the physician happened to be male, the statement shows the importance of the provider-patient interaction and sharing the same culture and language.

Health insurance reinforcement: Another woman described how her health maintenance organization (HMO) encouraged

her to get a mammogram, which helped her to make the decision to get the procedure. One of the ways the HMO motivated its customers to get screened was a penalty method.

My first mammogram was when I was 35. And that was just a requirement of the health organization, the HMO that I was with. [The HMO] has such good health maintenance practices with their members that if you didn't go for their screenings, they gonna kick you out of the insurance plan.

Later in the focus group, she admitted that it was the best motivator for her, because she never would have had the mammogram otherwise. Results from the focus groups showed that policy reinforcement from health insurance is one of the economic factors that motivate Filipino American women to participate in mammography screening in the United States.

Personal attributes: Several personal attributes, including physical symptoms, family history, prior diagnosis, and knowledge about breast cancer, emerged as factors that prompted the women to obtain breast cancer screening. In several instances, the same attribute could serve either as a motivator or barrier to breast cancer screening.

In all three focus group meetings, the women talked about the modalities (e.g., mammography, clinical breast examination) that are promoted in the United States for the early detection and control of breast cancer but were used in the Philippines as mostly diagnostic tools. Therefore, the participants frequently relied on pain, lumps, or other appearance changes to initiate screening tests.

What motivates me to do a self-exam [is] if I feel something different. Then I compare both sides. Like by chance, I saw myself in the mirror and see why is that [breast] lower than the other [breast] and then start examining.

In contrast, several participants said that if they did not feel anything different or painful, then they would not get screened.

Family history: Focus group participants reported that they performed breast self-examination or other types of screening procedures if they had a family history of breast cancer or had

Table 3. Participants' Reported Motivators to Obtain Breast Cancer Screening

| Factor | Examples |
|--------------------------------|--|
| Family support | Advice and education from family members Encouragement from husbands |
| Recommendation from physicians | Female physicians Physicians using the women's native language |
| Health insurance reinforcement | Avoiding insurance penalties for not getting examinations |
| Personal attributes | Relying on experiencing symptoms Having a family history Past diagnosis of breast-related disease Health literacy and knowledge about screening |

friends with breast cancer. One woman's experience with her sister's diagnosis helped prompt her to get screened. When asked about the motivation, she said, "Because of our history, family history, I want to be sure that I'm not one of them, and I don't want to be one of them." Though family history was a strong motivator, it also was a barrier. One woman said that she did not get screened because she had no family history, even though she was told that people do not have to have family history to get breast cancer.

Prior diagnosis: A prior diagnosis of cancer or a benign tumor was a major motivator for breast cancer screening for several women. One woman who was a survivor said that she continued to get screened because of her history. "Well, maybe it's because of my past experience, because I don't want it to be, to return."

Health literacy: Knowledge of breast cancer screening played an important part in the women's participation in some or all types of breast cancer screening. In particular, those who worked in health care (i.e., nurses and nurses' aids) were more knowledgeable about the three screening modalities and seemed to possess the skills to perform breast self-examination. Most of the women who were nurses or in medical fields continued to perform breast self-examinations after they learned how. The experiences that they had in the healthcare field and the patients they encountered helped them to stay current with screening guidelines and recommendations. One woman explained it simply: "I know what happens if you don't do it."

Barriers to Obtaining Breast Cancer Screening

Through the focus groups, the barriers to breast cancer screening were categorized as a different mind-set and healthcare systems in the Philippines regarding early detection, unpleasant experiences with mammography, cultural beliefs, and access difficulties (see Table 4). The reported reasons in concert affected why participants did not follow recommended breast screening modalities.

Different mind-set and healthcare systems in the Philippines regarding early detection: Through the focus groups,

the researchers discovered information about a new trend in the Philippines. Women who have immigrated to the United States in the past 10 years have spoken about new advertisements on television or other media in regard to breast cancer screening in the Philippines. Although the ads' messages generally were generic, such as going to see a doctor once a year for a physical, they were a first step in a new direction to educate the public about early detection and prevention in the Philippines.

In all three focus groups, women mentioned that mammograms are a luxury for women in the Philippines because of the expensive out-of-pocket cost and accessibility only in metropolitan cities such as Manila. As a result of the limited availability of mammography, access is a major problem for Filipino women. The circumstances of health education in cancer screening and the unavailability of screening procedures to most of the general public shed a great deal of light on why Filipino women do not seek breast cancer screening such as mammography when they come to the United States. Lack of knowledge about insurance coverage also created a significant barrier for the women in the focus groups. Three of 11 participants did not have medical insurance. The women talked about the financial burden of medical costs and that Filipino American families often choose to not go to physicians, even when they are sick, because they cannot afford it. One woman who did not have health insurance was asked whether she would get a mammogram if she were sponsored financially; she said yes. In addition, lack of knowledge about health insurance was self-evident when one of the women who recently came to the United States did not find out until a year later that she had insurance coverage for a mammogram.

Participants whose occupations were not health related generally lacked comprehensive and accurate knowledge about the purpose of the three screening modalities (i.e., breast self-examination, clinical breast examination, and mammography) used in the United States. For example, with clinical breast examination, the term was not used to describe the screening modality, and most could only explain about a doctor touching them. One woman could describe the clinical breast examination only as a "doctor . . . ummm . . . examined me; it was just sort of touching." One of the women said that the doctors "just touch you in case there is . . . lump." More specifically, the women lacked knowledge about the necessity and definition of clinical breast examination in breast cancer screening.

In terms of breast self-examination, the women were unfamiliar with the term. Six women had heard of the examination but were not fully aware of all of the components (e.g., technique, frequency) to perform breast self-examination properly. The participants with medical backgrounds who had exposure to various degrees of health education had better awareness of the techniques and frequencies, but some discrepancies existed in the actual application of the screening. Lack of education and confidence with breast self-examination was a reason for some women to not perform it on a monthly basis; one woman expressed that she did not feel that she really knew it. Others spoke about the frequency of their breast self-examinations, which ranged from almost every day to once a month. Most of the women commented that they felt more comfortable with letting a physician examine them because doctors know what to look for in breast tissue. They said that they needed more education about how to do it to feel more comfortable.

Table 4. Participants' Reported Barriers to Breast Cancer Screening

| Factor | Examples |
|---|---|
| Different mind-set and healthcare systems | New trend to promote breast cancer screening in the Philippines Mammography is expensive and not affordable. Lack of understanding about the three common screening modalities |
| Unpleasant experiences with mammography | Discomfort, pain, and uneasiness Screening is associated with having a cancer diagnosis; mammography is a diagnostic tool in the Philippines. Not having time for denial if cancer is found |
| Cultural beliefs about breast health | Not comfortable being touched or exposing own body Not wanting to talk about breasts |
| Difficulties in accessing services | Difficult to schedule an examination Forgetfulness Lack of transportation |

Unpleasant experiences with mammography: Focus group participants associated mostly negative feelings with mammography. Five women reported negative reactions related to discomfort, pain, and uneasiness of the examination. One woman said, "To me, I feel that it's demeaning to be pulled and smashed in that part of my body, so I don't like it." Another woman commented, "I think the word cancer and pain are associated with the mammogram." The vivid statement shows the negative aspects of mammography.

The women's fear of cancer and how the fear affected their perceptions about breast cancer screening were reflected in several scenarios. One woman's remarks touched on why she responded to breast cancer screening as she did. She stated, "I don't want to know. I am just afraid. I know so many things that happened in health-care-wise cause I work in the hospital." Often, several women spoke about mammograms being associated with already having cancer. One woman said, "When I hear that word [breast cancer], it makes me afraid. I'm afraid . . . cause once I heard that you go to get a breast cancer screening, it means that I have it." Another woman also made a statement that reinforced a similar mind-set: "People at home also do not go, undergo this test, because sometimes if you are thinking about this test, it usually comes out positive. And they think you get the disease because you have the test done." The statement is a great example of the use of mammography in the Philippines as a diagnostic tool instead of a screening tool. One woman spoke of the negative aspect of finding out right away and not having time for a denial period to cope with a diagnosis.

Cultural beliefs about breast health: Culture's unspoken traditions and beliefs caused some of the women to feel uncomfortable with touching or exposing their bodies or talking about their breasts. The length of time since immigrating to the United States did not change women's cultural views about their bodies and comfort levels while addressing topics in breast health. One participant who had resided in the United States for 20 years said, "It is very uncomfortable to discuss any part of the body that's supposed to be covered in clothes." Several women with various lengths of residence in the United States did not feel comfortable showing their bodies to physicians. An explanation from one woman (who had been residing in the United States for nine years) was, "Sometimes our Filipino women are very conservative. They don't want to touch their body. You think if you touch your body it's a sin."

Difficulties accessing services: The women also shared other issues related to their participation in screening, including scheduling, transportation, and community resources. Finding time to schedule appointments for mammography was reported to be a main barrier for women who worked five to six days a week or had busy family schedules. For example, the opportunity for one woman to get time off work during weekday hours was almost impossible. She said that the only day she could go was on Sundays, when doctors' offices and clinics are not open. Forgetfulness also was associated with scheduling problems and not getting any type of breast cancer screening.

Lack of transportation or limitations on driving made going to a physician difficult. One woman could drive only short distances and was not able to drive herself to visits. This raised another barrier: finding someone to transport her.

Lack of knowledge about agencies in the area to help with medical expenses and resources was a significant barrier

for new immigrants. When asked about certain agencies or federal programs for breast and cervical cancer screening that were available, most of the women were unfamiliar with them.

Discussion

Focus groups were useful for gaining insights into the range of views that Filipino American women held about breast cancer and breast cancer screening. The themes identified in the discussions came from the participants' past experiences in the Philippines and their daily lives in the United States. The themes described in the study have important implications for healthcare professionals to assist and encourage breast cancer screening in their communities. Previous studies in African American and Hispanic American groups also have shown that clinician recommendation and presence of a symptom are facilitators of breast cancer screening and that lack of cancer screening knowledge, patients' perceptions of good health or absence of symptoms attributable to ill health, and fear of pain from a cancer test are barriers (Ogedegbe et al., 2005). Other studies have reported cultural beliefs such as fatalistic ideas and pessimism linked with cancer held by some minority ethnic groups (Ashing-Giwa & Ganz, 1997; Bailey, Erwin, & Belin, 2000; Champion & Menon, 1997; Glanz, Resch, Lerman, & Rimer, 1996; Lackey, Gates, & Brown, 2001; Phillips, Cohen, & Moses, 1999).

The women in the focus groups held specific views from their Filipino culture about breast cancer and ways to deal with a diagnosis of breast cancer; often, their experiences were closely related to family members. Sensitivities about using the words cancer and breast cancer need to be addressed. The finding is in accord with findings of Bottorff et al. (1998) regarding beliefs related to breast health practices among southern Asian women in Canada. When healthcare professionals address the related topic with Filipino American women, they should assess the needs of each individual client and understand the meaning of breast cancer with cultural sensitivity.

Family members who are employed in the medical profession play an important role in helping their families to deal with health issues. The support of significant others such as spouses and healthcare providers was fundamental to women's participation in screening activities.

Study Limitations

The findings of the current study provide important insights regarding the perceptions of Filipino American women about breast cancer and screening. The findings, however, must be viewed in light of potential limitations of the study. The sample size was relatively small, and the convenience sample focused on women who had immigrated to the midwestern United States, which limits the generalizability of the findings to other groups of Filipino American women. Future qualitative research is needed to evaluate the generalizability of study findings in other samples with second-generation Filipino American women who were born in the United States or women who live in other geographic regions of the United States.

In addition, the focus group discussions were conducted on the culturally sensitive topic of breast cancer. Despite the research team's effort to develop a good rapport with the

women, the researchers were concerned about some women providing the “right” answers instead of sharing their true views.

Nursing Implications

Elements that serve as facilitators to screening also can become barriers to screening, not only when they are absent but also depending on the perceptions of individuals. For women who are looking for physical changes or signs that they need to be screened, healthcare professionals must recognize the need to educate them about the purpose and importance of early detection in breast cancer even when symptoms are absent. The messages should be tailored when communicating to Filipino American women that breast cancer screening such as mammography enables women to find cancer at early stages despite the absence of symptoms so they can get early treatment to increase their chances of a longer life expectancy. Culturally appropriate educational interventions need to be developed based on research findings so healthcare providers can communicate with Filipino American audiences with consideration of their cultural views, negative thoughts, and misconceptions.

The findings of the study also suggest that Filipino American women should be better educated about current recommendations for the three modalities for breast cancer screening and about the skills and knowledge to perform breast self-examination properly. As the researchers found in the focus groups, healthcare education in cancer detection and control has been evolving in the Philippines. In the past, the major focus in public health was on communicable diseases and vaccinations because they were the major health concerns. Cancer screening was not on the priority list for the health departments of the Philippines and so was not emphasized to the public until the late 1990s. For women who are new immigrants, information about available financial alternatives and assistance to participate in screening and other pertinent information in relation to breast cancer screening should be provided and made available. Focus group participants offered

several suggestions about how to educate Filipino American women about breast cancer screening. Some of the women believed that flyers would help to promote better health in the Filipino American community. Such flyers could give general information, both in English and Tagalog, about breast cancer, the three types of screening, and the technique of breast self-examination, as well as information about state-assisted breast and cervical cancer programs. The women said that educational sessions for women in their own communities, like those that are provided for blood pressure and diabetes, could help. Radio and television advertisements also were suggested to help reach those in more rural settings.

Cultural beliefs, including barriers to screening, differ among ethnic groups (Miller & Champion, 1997; Wu, Brady, Chen, & Hergert, 2006). Healthcare professionals should be aware of facilitators and barriers to breast cancer screening among Filipino American women to plan effective, tailored interventions. Barriers that are constraints to cancer screening for Filipino American women should be addressed carefully, with consideration for cultural sensitivity. Nurses and other healthcare professionals can provide alternatives to women who have scheduling, transportation, or financial constraints that interfere with their medical care.

Conclusion

The cultural, social, and healthcare-system factors related to breast cancer screening as identified by the Filipino American women who participated need to be addressed. Nurses and healthcare professionals should be cognizant of such factors to improve the quality of service to Filipino American women. Instead of translating health education materials into different languages, key strategies include tailoring health education messages to their specific needs and cultural beliefs to empower the women with necessary resources and information.

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