



Vietnamese American Women's Beliefs and Perceptions About Breast Cancer and Breast Cancer Screening: A Community-Based Participatory Study

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Abstract

Introduction: Although breast cancer (BC) rates are declining in White non-Hispanic American women, they are increasing among Vietnamese American women (VAW) at 1.2% (95% confidence interval [0.1, 2.2]) per year. BC screening rates (64%) are below the national rates (81.1%). This article explores VAW's beliefs about BC and screening. **Method:** Using community-based participatory qualitative descriptive methods, 40 VAW were recruited from Oregon, and four focus groups were conducted. A directed content analysis was used. **Results:** Main themes were as follows: deferred to a health care provider or relying on self-detection and symptoms; fear of BC versus fear of procedural pain; limited knowledge; motivation by observing others' journey in BC death or survivorship; body image concern; "living carefree," "good fortune—having good health"; and coverage for a mammogram expense means health care access. **Discussion:** Tailored interventions should address mammogram knowledge, fear, erroneous information, body image, fate and luck, and promoting access.

Keywords

Vietnamese, breast cancer, screening, beliefs, qualitative, focus groups, community-based participatory research

The Asian American population originates from over 50 different countries (Gomez et al., 2013). However, current literature tends to aggregate findings across subgroups. Vietnamese American women (VAW) may have different cultural health beliefs and practices than other racial ethnic groups, potentially affecting the risks for cancer and outcomes (Solanki, Ko, Qato, & Calip, 2016). Breast cancer (BC) rates are declining in White non-Hispanic American women, but increasing among Asian American women, with the incidence rates particularly high among VAW at 1.2% (95% confidence interval [0.1, 2.2]) per year (Gomez et al., 2013). BC screening rates in VAW (64%, Pourat, Kagawa-Singer, Breen, & Sripipatana, 2010) are below the national goal of 81.1% (HealthyPeople.gov, 2016).

VAW experience several barriers such as language, economic, health care access, and cultural barriers to preventive health care. VAW, who did not speak English or had limited English proficiency and/or reported income lower than 200% below the federal poverty level, were less likely to obtain regular mammograms (MMG) to screen for BC (i.e., an x-ray of the breast and surrounding tissues) than Japanese American women (Chawla, Breen, Liu, Lee, & Kagawa-Singer, 2015). In addition, those VAW who only had access

to public health insurance and no regular source of care were less likely to obtain regular MMGs than Japanese and Filipino American women (Chawla et al., 2015). VAW with infrequent medical visits within the past 12 months were also less likely to obtain regular MMGs than Japanese, Filipino, Chinese, and Korean American women (Chawla et al., 2015), underscoring the importance of understanding VAW's beliefs about BC screening separately. Vietnamese American (VA) immigrants are less likely than White and African populations to seek information about cancer (Nguyen et al., 2010). Thus, VAW may not actively seek information about BC

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screening from health care providers (HCPs). Thereby, HCPs may have missed opportunities to provide VAW culturally and linguistically appropriate counseling about BC screening. Researchers have suggested that VA immigrants need a compelling reason to seek care from a HCP and that BC is only a concern when symptoms arise (Nguyen, Barg, Armstrong, Holmes, & Hornik, 2007). VA immigrants believed that *looking for problems* would invite new troubles into their lives (Nguyen et al., 2007).

Overall, the literature indicates a need for a deeper understanding of BC beliefs by VAW including facilitators, as well as common and cultural barriers to BC screening. VAW's cultural beliefs and practices need to be addressed when designing interventions. The purpose of this community-based participatory research (CBPR) qualitative descriptive investigation is to explore VAW's beliefs about BC and BC screening.

The health belief model (HBM) frames the current study emphasizing individual health beliefs, which includes the concepts of perceived susceptibility, benefits, and barriers (Champion & Skinner, 2008). This model has been used in a few studies of Asians and Asian Americans (Lee-Lin, Menon, Nail, & Lutz, 2012; Lee-Lin, Nguyen, Pedhiwala, Dieckmann, & Menon, 2015). Perceived susceptibility is the "belief about the chances of experiencing a risk or getting a condition or disease" (Champion & Skinner, 2008, p. 48). Perceived benefits are the "belief in efficacy of the advised action to reduce risk or seriousness of impact" (Champion & Skinner, 2008, p. 48). Perceived barriers are the "belief about the tangible and psychological costs of the advised action" (Champion & Skinner, 2008, p. 48). For example, a VA woman is more likely to participate in BC screening if she believes she is susceptible to developing BC, sees benefits and few barriers in BC screening, and has adequate knowledge of BC screening, which may influence BC screening beliefs and practices (Champion & Skinner, 2008). The interview guide included questions related to these HBM concepts, and details are provided in the method section.

Method

Design

A local institutional review board determined the study to be exempt. The Immigrant & Refugee Community Organization and their Asian Family Center, a community-based organization, and the principal investigator (PI, first author), an academic investigator, have a partnership since 2008. A CBPR design was used to conduct the study involving collaboration with community members to address an identified public health priority (Israel, Eng, Schulz, & Parker, 2012). Community members worked with the PI and assisted in defining the study's purpose; modified the interview guide; recruited or referred participants; coconducted focus groups; transcribed, translated, and analyzed data; and disseminated

their findings to the VA community. The community members ensured cultural and linguistic appropriateness. Details of involvement are described in the method.

Sample and Setting

The study sample were VAW in the Portland, Oregon, metropolitan area in the United States. The participants were recruited from the Immigrant & Refugee Community Organization (2001-2017) and their Asian Family Center, a local community-based organization, with 40 years of history and experience working with immigrants, refugees, and communities-at-large including the VA community. A flyer was created in Vietnamese and English and used in outreach. The flyers were distributed at Asian grocery stores, providers' offices, and community outreach events. The final sample size of 40 participants was determined by reaching meaning saturation of the data (Hennink, Kaiser, & Marconi, 2017). Hennink et al. (2017) found that meaning saturation was reached between 16 and 24 interviews to develop a richly textured understanding of the main themes. Of the 45 VAW enrolled in the study, 5 did not want to participate due to schedule conflicts. Participants were included if women self-identified as Vietnamese or VA, immigrated to the United States or were U.S.-born, with no personal history of BC, age 21 years or older, and able to understand or read Vietnamese or English. Although the U.S. Preventive Services Task Force (2016) BC screening guidelines include screening as early as age 40 years, but there are no known guidelines in Vietnam. Thereby, being inclusive of age may contribute to the rich understanding of the main themes.

Procedures

All study materials were translated into Vietnamese using a VA bilingual team approach to translation. The health educator/research assistant translated the study materials into Vietnamese. Next the PI, the assistant project coordinator with a graduate degree in counseling and a prior background as a Vietnamese language teacher, and a VA community consultant with a graduate degree in public and health administration reviewed the translated materials and identified grammar, clarity, and logical flow issues. Then the team had discussions, resolved ambiguities, and arrived at a consensus for a meaningful translation. This process improved the quality of translation above that of a literal translation (Nguyen-Truong et al., 2015).

Informed consent and sociodemographic information were obtained from the participants in either Vietnamese or English. As part of the informed consent process, a VA bicultural and bilingual health educator/research assistant provided a study information sheet and explained the study's purpose, procedures, the lack of any known risks, discomforts or personal benefits to the participants, and emphasized that participation was voluntary and confidential. This did

Table 1. Semistructured, Open-Ended Interview Guide.

Knowledge
 What do you know about breast cancer (BC)?
 What do you think causes BC?
 What are the risk factors for BC?
 What do you think is the frequency of mammography screening?

Perceived Susceptibility
 Who do you think is at risk for BC?
 What do you think is your chance of getting BC compared to other people of your age and race?

BC Screening Practice
 Have you ever had a mammography screening (mammogram)?

Perceived Benefits
 What are reasons that you would decide to do a mammogram?

Perceived Barriers
 What are reasons that you would not want to do a mammogram?
 What are conditions that would affect your ability to do a mammogram?

not require the participants to sign their names to indicate consent for study enrollment.

Focus groups were used for data collection about perceptions and beliefs related to BC, BC screening, and experiences (Morgan & Bottorff, 2015). Forty women attended one of four focus groups, and each group consisted of 7 to 15 participants. All participants chose the Vietnamese language. The focus groups were conducted at the Immigrant & Refugee Community Organization Asian Family Center, which is conveniently located near public transportation. Prior to conducting the focus groups, the PI led a *dinámica*, which is a social learning game to help the participants feel at ease by engaging in song and choreographed movements (Nguyen-Truong, Tang, & Hsiao, 2017; Wiggins, 2011). A semistructured, open-ended interview guide following the HBM described earlier was used to conduct the focus groups (Table 1). Each focus group was conducted by the PI and the health educator/research assistant. The PI has extensive experience in clinical nursing, conducting focus groups, community leadership, community assessments, and translating with VAs. Another focus group facilitator had experience in clinical nursing and was trained in co-conducting focus groups. The focus groups were audio recorded and were 90 to 120 minutes long. Refreshments were provided, and each participant was presented with a \$20 grocery gift card as a token of appreciation.

Data Analysis

A team approach was used for transcription and translation of the focus group data. One team member transcribed each focus group verbatim in Vietnamese, and next reviewed each focus group transcript a second time to verify accuracy. Next, the PI reviewed the transcriptions for accuracy. After that, two team members translated the transcripts into English. Finally, the team members compared the English and Vietnamese versions. Team meetings were then held to

review the translations where ambiguities were discussed and resolved in consensus.

ATLAS.ti (version 7.5.18) qualitative software was used to manage the data. A theory-directed approach to content analysis was used, which is a more deductive, structured approach than conventional content analysis (Hsieh & Shannon, 2005). A coding scheme was developed based on the interview guide. Prior to the study, a qualitative consultant with a research background in Asian American research reviewed the definitions, ensuring the accuracy of predetermined categories that included the focus areas of the HBM described earlier (Hsieh & Shannon, 2005). Throughout the data analysis, a team approach was used. Two VA bicultural and bilingual team members independently coded the first English translation of the focus group transcript. After that, the team met to discuss discrepancies and agreed on the best codes to improve consistency. Next, three team members independently coded the remaining English translations of the focus group transcripts. Coding was then reviewed by and discussed with the PI. The codes for each focus group were compared across transcripts, and the main themes were identified. Next, the team discussed the data findings with VA community advisors having various backgrounds in medicine, public and health administration, and biology as well as with VAW community members. Thus, they served as external auditors, enhancing rigor.

Rigor was ensured as cultural and language insights were taken into consideration throughout the team’s review. Trustworthiness of the data analysis was assured by checking the English translations against the Vietnamese transcriptions, and credibility was ensured via the team’s review of the transcripts and through peer debriefing (Lincoln & Guba, 1985). The authors’ team approach to data analysis allowed for in-depth discussions about shared and differing understandings about the data, while addressing reflexivity. Reflexivity denotes as having an awareness of personal biases and an examination of their potential influence throughout the research process (Rae & Green, 2016).

Results

Sociodemographics and Background Characteristics of the Participants

The mean age of the participants was 46.45 years. Nearly all participants reported being born in Vietnam ($n = 39, 97.5\%$), and the mean years lived in the United States was 11.65. Thirty-five percent ($n = 14$) of participants reported average English-speaking ability. Nearly all participants reported having health insurance ($n = 39, 97.5\%$). The full results are displayed in Table 2.

Main Themes

Seven main themes were identified: (1) deferred to a HCP or relying on self-detection and symptoms, (2) fear of BC

Table 2. Sociodemographics and Background Characteristics of the Participants ($n = 40$).

Characteristic	n (%)
Age, years, M (SD)	46.45 (12.93)
Age at immigration, years, M (SD)	35.18 (14.36)
Years lived in the United States, M (SD)	11.65 (10.98)
Birth place	
South Vietnam	35 (87.5)
Central Vietnam	4 (10.0)
United States of America	1 (2.5)
Marital status	
Married	32 (80)
Separated	3 (7.5)
Single and never married	2 (5.0)
Widowed	2 (5.0)
Divorced	1 (2.5)
Education	
Some high school	13 (32.5)
Graduated from college	13 (32.5)
Some middle school	6 (15.0)
Some college	6 (15.0)
Elementary	2 (5.0)
Employment	
Not employed	18 (45.0)
Full-time	13 (32.5)
Part-time	9 (22.5)
Household income before taxes	
\$15,000-\$30,000	12 (30.0)
<\$15,000	10 (25.0)
\$30,001-\$50,000	10 (25.0)
Not sure	5 (12.5)
\$50,001-\$75,000	4 (10.0)
\$75,001-\$100,000	2 (5.0)
How well do you speak English?	
Average	14 (35.0)
Fluently like a Native English speaker	12 (12.5)
Poorly	9 (22.5)
Well	6 (15.0)
Not at all	6 (15.0)
Do you have any kind of health care coverage?	
Yes ^a	39 (97.5)
No	1 (2.5)

^aThree (7.6%) participants had health insurance coverage for emergency room visits only.

versus fear of procedural pain, (3) limited knowledge on BC causes and risks, (4) motivation by observing the journey of others with BC death or survivorship, (5) body image concern, (6) “living carefree” and “good fortune—having good health,” and (7) coverage for a MMG expense means health care access.

Theme 1: Deferred to a HCP or Relying on Self-Detection and Symptoms. Some participants deferred initiating BC screening communication with a HCP. Some VAW reported having

a HCP make a recommendation for a MMG and then taking the time to explain the purpose of MMGs. Some VAW’s decision to have a MMG was deferred to their HCP. For some VAW, deferring their decision was a facilitator or a barrier in having a regular MMG. One VA woman said, she “had a MMG one time, doctor [in Vietnam] said it was good, then I don’t have it anymore. Don’t need to have MMG anymore. In the United States, I have not done [one] yet.” Another woman shared,

I usually have an annual exam [clinical breast exam] when I was under 40 years old and doctor used hands to check. When I turned 40, doctor asked me to have a MMG yearly . . . I visit doctor every year because doctor say so.

Many participants relied on the breast self-examination (BSE) to detect changes in their breasts. They also believed the main indicators for seeking an exam from a HCP was having breast pain or feeling a hard lump, not for having a MMG. As described by a VA woman,

Must go to have [general] exam, finding out early and not waiting until late . . . if I see symptoms in my body . . . no matter it is small or big, but I feel [BSE] it is unusual, I must see doctor immediately. I need to let doctor know that I suddenly feel pain in my breast [I need an] exam . . . to ensure that it is safe rather than ignorance, keep ignoring, [then] I [can] die someday.

Another VA woman stated,

No MMG, went to see doctor . . . I touched it [breast] and felt something being puffed up. . . . Doctor [in Vietnam] said that it was no problem. But that time, I didn’t have husband, doctor said I was still a girl [not sexually active] . . . it is still puffed up, but I don’t know if it is cancer or not. . . . I thought that is *trái chàm* [a tenderness or hard lump behind the nipple that commonly found in young girls at puberty/teenage when their breasts are growing]. It has the size of *trái chàm*, a dish shaped herbal seed, one inch in radius . . . *Trái chàm* is considered harmless. Now having husband, I feel that lump, but I don’t know that I need to have an exam [MMG] or not.

Theme 2: Fear of BC Versus Fear of Procedural Pain. A common barrier to BC screening was that most of the participants stated being fearful about having a painful MMG. These concerns included having encountered a past painful procedural experience or women who have never had a MMG. Some VAW described their fear of having BC outweighed their experience of a *very* painful MMG, thus influencing them to complete BC screening. A woman shared, “I’m afraid of having the disease [BC] so I have to do the MMGs. When I go there, I have to do it and have no fear of pain at all.” Another woman shared, “I have to have an exam [MMG] annually . . . people use a machine that causes pain, but I must tolerate the pain. If there is nothing [not abnormal], it [MMG] is done for that year.” A VA woman described,

I went because . . . an American girl friend explained to me. After the first one [MMG], I don't want to come back for another one. They pressed hard . . . I feel pain and uncomfortable . . . I am afraid of pain.

Another VA woman described her observations,

I have not had a MMG. . . . I work at a doctor's office. . . . Most of them are Vietnamese, asking them to take picture [having a MMG], they said no, very painful, so they don't want to have it. . . . I will never go [to have a MMG].

Theme 3: Limited Knowledge on BC Causes and Risks. Some VAW knew the current national BC screening recommendations, and believed that they needed an annual MMG. VAW expressed many beliefs about causes and the risks of BC, which included the following: BC occurs at any age, hereditary, diet, environmental, breast feeding, not having children, not being married, sleeping with a bra, and having large breasts. Although some beliefs were accurate, many erroneous opinions were expressed. Breastfeeding and not having milk was believed to cause BC. One woman shared, "But there is no more milk . . . it draws together [to] become a small bump . . . evolution of an illness [BC]." Some women thought that not having children and not being married increases the risks for BC. One woman described sleeping with a bra as a risk factor for BC. "I think that many people wear a bra to sleep during night time, it is not good and easy to have [breast] cancer." Although women may develop BC whether they have small or large breasts, some believed that people who are obese and have big breasts often have tumors.

People who have big breasts must pay more attention. . . . My company in Vietnam had hundreds of people and we had an exam [MMG] yearly. . . . I noticed people had big breasts, having tumors in breasts, their breasts were always full and firm . . . during [menstrual] period . . . it is normal for having full and firm breast, but when getting old, it should be limp.

Theme 4: Motivation by Observing the Journey of Others in BC Death or Survivorship. Some VAW shared compelling stories of being influenced by knowing a family member, friend, or knew of someone who died from BC or has BC and is a survivor. One woman shared,

First, my aunt had a lump, but it doesn't ache, then she ignored it. Then couple years later, it started aching, she found out that it was [breast] cancer when she had an exam [MMG]. From the time that the [breast] cancer was found out to the time that my aunt died is about 2 years. Doctor said that it was Stage 4 . . . had chemotherapy . . . it seemed to be metastasized and extended to other organs. Then my aunt died . . . my cousin who also had it [BC] . . . very fast . . . inside her breast had one seed that she felt like a lump as small as a mung bean. . . . It didn't hurt; so, she didn't consider to have exam [MMG] immediately. Then, 2 to 3 months later, she had an exam and was diagnosed for breast cancer. Doctor has treated . . . now, it metastasizes and they

remove the breast which has cancer . . . and cut off another breast . . . she has survived for 5 years . . . if found out early . . . need to follow doctor's guidance.

Another participant shared,

My friend [and] I . . . was very close, [she] had BC . . . but not feeling pain. One day . . . suddenly, she touched and felt one lump, [then] another friend said that she had a lump, then I was scared. So, I had ultrasound and doctor said there was no problem. [Two additional women] said, I have a lump. I said, oh my God, [I am] going to have an exam [MMG]. A [close friend] having [MMG] exam, found a lump . . . referred to doctor to get . . . sample by needle . . . [finding she had] cancer. She was not feeling pain . . . I was sad . . . 9 years later she died. . . . You need to be careful.

Theme 5: Body Image Concern. A few women expressed their concerns about body image in connection with surgical treatment of BC. A VA woman explained that she discovered a lump and received a recommendation from a doctor in Vietnam not to have surgery because of her age, marital status, and body appearance. Another VA woman, who has not seen a HCP since she immigrated to the United States, shared, "[A] doctor [in Vietnam] who I had [a physical] exam said that . . . not have husband yet, having surgery makes your breasts ugly . . . I was only twenty something."

Theme 6: "Living Carefree" and "Good Fortune—Having Good Health." Some VAW discussed that living carefree, fate, and luck were preventive factors for cancer including BC. A VA woman described not being sick and not having seen a HCP since she immigrated to the United States long ago, "I'm telling the truth that I'm living carefree with no worries." Another VA woman commented,

I think it's the fate . . . good fortune—having good health. It's rare . . . life is lucky. Unlucky people fall ill and die. . . . It's God's kindness for our good health. People . . . lead a religious life now or in their past life, so they are lucky to have such a good health. . . . People who are carefree and have a good heart live well.

Theme 7: Coverage for a Mammogram Expense Means Health Care Access. Having health insurance is a facilitator for BC screening, while not having health insurance is a barrier to screening. A VA woman described, "People here [in the U.S.] are encouraged to have it [MMG] if they have insurance. . . . My doctor explained so I agreed to do that [MMG]." Another VA woman described not scheduling an MMG due to not having health insurance despite having been reminded by an imaging center. "This year, they [Imaging Center] sent paper that reminded me having another MMG, but I have not contacted them yet because I don't have health insurance with [that] hospital anymore."

Discussion

The authors' findings suggest that some VAW's decision making to have a MMG was deferred to their HCP rather than it being a shared decision. In shared decision making, the client and HCP would engage in a discussion of preferences by both parties and arrive at a mutual decision about BC screening needs (Mead et al., 2013). Some VAW expressed not having medical knowledge, suggesting that women deferred decision making to their HCP as the person who would know what they needed in terms of BC screening. These findings are similar to qualitative studies where clients across racial-ethnic groups perceived the importance of demonstrating respect for the position of HCPs as an authority figure by deferring decision making to them (Mead et al., 2013). Deferring decision making was a facilitator or a barrier for some VAW to have regular MMGs. Some VAW did not have a HCP to talk to about BC screening and thought it could be due to not being of age to have a MMG. These findings suggest that VAW are waiting to be asked or talked to about BC instead of being encouraged to bring the topic up to the HCP. HCPs need to take a more active role in anticipating, initiating, and facilitating the discussion on BC screening. This study's findings also suggest that most VAW's decisional autonomy was guided by their heavy reliance on being capable to perform a BSE correctly to detect lumps or changes in their breasts, as indicators for seeking a HCP for a check-up but not necessarily for a MMG. Relying on a BSE to determine whether to have a MMG is concerning, since MMGs are the most effective method for early BC detection.

A limitation to the HBM is its sole emphasis on cognition without attending to the influence of emotions on screening behavior (Champion & Skinner, 2008). This study's findings suggest that VAW were weighing their fear of BC with fear of anticipated or actual pain from a MMG, adding to the HBM. VAW who believed that they were at risk of dying from BC were willing to endure the procedural pain. In women who believed their risk of dying from BC was low, their intense fear about having a painful MMG dissuaded them not to have a MMG or avoid regular screening altogether. These results underscore the importance for nurses and other HCPs to consider how VAW evaluate their fears about some diseases and certain procedures while considering their perception of risk for developing BC.

Cultural beliefs influenced VAW's beliefs about BC risk factors. This study's findings suggest that VAW are aware that BC is influenced by hereditary, environmental, and lifestyle factors. Many of them had varying levels of awareness regarding screening guidelines, which is consistent with findings among other ethnically diverse women (Allen et al., 2013). Their views on their marital status, ability to breastfeed, and wearing a bra as risk factors for BC underline the cultural beliefs that may influence screening behaviors among VAW. This adds to the literature that VAW

share similar concerns as do many other women about how wearing a bra increases their risk of BC despite a lack of evidence addressing this issue (Chen, Malone, & Li, 2014). Culturally sensitive counseling and education should be tailored to address these concerns and clarify confusions about BC and screening recommendations among VAW.

Some VAW were motivated to have BC screening, due to their awareness that BC can present as painless, as they had profound past experiences about knowing someone who died from BC or is a BC survivor. In a past study, researchers found that VA immigrants believed that BC is only of concern when symptoms arise (Nguyen et al., 2007). However, seeking care when symptomatic, may delay BC detection, possibly leading to more advanced BC with a worse prognosis. The current study findings contrast with Lee-Lin et al.'s (2012) Chinese American immigrant women study finding that women who had past negative experiences in connection with knowing someone with BC, believed BC was a terminal disease and that nothing could be done to prevent it. Thus, the authors' work underscores the importance of investigating subgroups within the Asian American population to determine culturally specific differences. Nurses and other HCPs should promote culturally tailored messaging about early detection of BC and BC survivorship instead of using generic messages with VAW.

Cultural contexts need to be explored about cultural-social acceptability regarding body image and beliefs including living carefree, fate, and luck as preventive factors for cancer including BC. A health care divide occurs if beliefs are discounted and respectful and sensitive communication is not provided. Donnelly (2006) conducted a study with Vietnamese-Canadian immigrant women and found that women live and practice health care *in-between spaces*. Vietnamese immigrant women were found to compare and negotiate differences between the Western and Vietnamese cultures and would retain their values and beliefs while also incorporating some of the Western values as they see as being congruent in their lives (Donnelly, 2006).

The current authors found that most VAW did not discuss alternative resources for an MMG if uninsured or having lower income despite the availability of state programs such as the Oregon ScreenWise Breast and Cervical Screening Services (Oregon.gov., n.d.). Chawla et al. (2015) did not find insurance or income levels to be a significant predictor of having a MMG. They asserted that California State policies and programs in California (e.g., The Every Woman Counts program) may explain the increase in access to BC screening independent of health insurance coverage (Chawla et al., 2015). California state-level programs provide in-language services for people who are uninsured and lower income and offers more liberal eligibility criteria than do other states (Chawla et al., 2015). This underscores the critical role of nurses and other HCPs in community and public health settings for promoting available resources. More support is needed for statewide and community outreach

campaigns to increase awareness and provide access to resources. Advances in population health are dependent on essential health care delivery organization–community/public health partnerships and should consider the time and financial resources available for their implementation (Goldberg, Feng, & Kuzel, 2016).

Conclusions

This study provides valuable insights for practice. HCPs have a crucial role in promoting positive health behaviors and providing culturally sensitive interventions to increase BC screening. Intervention efforts that consider the creation of a safe space where power is given to the VAW to say when they feel safe in their interactions with HCPs may promote open discussions to clarify misconceptions and myths (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012). The current authors recommend that HCPs initiate the discussion about BC screening, provide clarification on BC screening recommendations, and address concerns regarding pain from a MMG, as VAW may not be willing to initiate such discussions.

The importance of culturally tailored health messages cannot be underestimated for proceeding to the next step in research. To bridge the health care divide, culturally tailored multicomponent interventions need to be designed to increase BC knowledge, improve access to MMGs, and help VAW overcome barriers, which may promote positive health outcomes among this population. Nurse investigators should consider using a CBPR approach to conduct studies through an academic and community partnership as an empowerment process that builds team capacity for sustainability. CBPR is an effective method to obtain the perspectives of subpopulations regarding sensitive topics such as BC and BC screening. Working with communities provides trust. Collaborating with Asian American community leaders and members affected by cancer screening health disparities as equitable partners on the research team may help ensure cultural and linguistic appropriateness throughout the research process.

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