Cervical Cancer, A Major Killer of Hispanic Women: Implications for Health Education

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Incidence and Etiology of Cervical Carcinoma

Latin America countries have reported the highest incidence of cervical cancer in the world (Reeves et al., 1984; Waterhouse et al., 1982; Austin, 1981). The number of deaths from invasive carcinoma of the cervix is disproportionately large among minority populations in the United States (USDHHS, 1985), and particularly among women of Hispanic descent (Peters et al., 1986; Savitz, 1986; Zunzunegui et al., 1986). Peters et al. (1986) noted that the incidence of invasive carcinoma of the cervix was 7.3 times greater for women with Hispanic surnames than for women with non-Hispanic surnames. Page and Asire (1985) reported that cervical cancer is the third most common cancer among Hispanics in the United States, in comparison with a rank of sixth among non-Hispanic anglos. Mexican American females in Texas experience greater than twice the risk of dying from cancer of the cervix than anglo females, with a rate of 4.8 per 100,000 as compared to 2.3 per 100,000 for anglos (Martin & Suarez, 1987; Suarez, Weiss & Martin, 1988; Alexander, 1987).

Although the cause of cervical dysplasia or carcinoma is not known, several factors have been associated consistently with an increased incidence of cervical cancer: early age at first intercourse, multiple sex partners, cigarette smoking, and lower socioeconomic status (Rotkin, 1973; Harris et al., 1980; Hulka, 1982; Singer, 1983; Clarke et al., 1985). More recently, the male partner has been identified as a potential agent of transmission (Nelson et al., 1984; Skegg et al., 1982; Zunzunegui et al., 1986). An increasing body of evidence has suggested that the human papilloma virus is the causative agent of cervical cancer (ZurHausen, 1969; Morin & Meisels, 1980), and that the male may serve as a reservoir for transmission of the virus (Rotkin, 1973; Zunzunegui et al., 1986).

Zunzunegui et al. (1986) report a higher risk of cervical cancer among Hispanic women whose husbands have had 20 or more sexual partners, whose husbands have a history of syphilis or gonorrhea, and whose husbands smoke. It is paradoxical that Hispanic women have a high incidence of cervical cancer since they tend to have few sexual partners and do not smoke (Zunzunegui et al., 1986; Peters et al., 1986). The authors conclude that the role of the Hispanic male may be even more significant in the incidence of cervical cancer among Hispanic women than previously suspected.

Screening and Treatment for Cervical Cancer

The control of carcinoma of the cervix has served as a model cancer control program. Not only can this lesion be predictably diagnosed during a preinvasive phase, but also because highly efficacious treatment modalities are currently available to eradicate the disease in this stage (Goodman et al., 1986; Lunt, 1984; Roush et al., 1987). The natural course of squamous cell carcinoma of the cervix is a slowly progressive process that may begin 10 or 15 years prior to the development of invasive malignancy, thus providing a lengthy period of time in which there are opportunities for detection and curative therapeutic intervention. In addition, screening of patients for cervical dysplasia is accomplished easily and commonly practiced. Because of the anatomic availability, the cervix can be visualized, photographed, biopsied, and observed over time. The average age of diagnosis of invasive carcinoma of the cervix is 45 years (Goodman et al.,

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1976). Family characteristics (i.e., the degree of support, presence or lack of family or marital problems, and the interdependence of family members) also have been reported as important predictors of an individual's response to cancer (Thomas, 1978; Weisman, 1976; Bloom, 1982).

Very little has been documented about the Mexican American woman's response to cervical dysplasia or the possibility of cervical cancer. Because of the higher incidence and the increased likelihood of hysterectomy or death from cervical cancer among Hispanic women, the Mexican American woman is more likely to have known someone with cervical cancer. The Hispanic woman's response may be similar to that of any woman when faced with the threat of possible loss of a reproductive organ, disability, or death. However, the literature suggests that her interpretation of this condition, or even of illness in general, will be influenced by her cultural values and beliefs.

Cultural Factors Influencing Intervention

Hispanics of various national origins share both similarities and differences in their values, norms, and cultural orientations. This discussion may have broader implications for Hispanics in general and possibly for other low socioeconomic status U.S. minorities. However, this article focuses more specifically on the culture of the Mexican American and implications for designing health education interventions for detection and treatment of cervical cancer.

Familismo. The family has been referred to as the most important institution in the Hispanic culture (Marin & Triandis, 1985) and includes the immediate as well as the extended family. The family is the primary source of emotional and financial support, of advice and counsel, and of health-related information (Ramirez et al., 1988; Garcia Manzanedo et al., 1980; Azziz, 1981; Sanchez, 1983). Consequently, involvement of family members in aspects of treatment or health education would reinforce the importance of the information. It is at this stage that peer or natural support groups may also play an important role (Valle & Vega, 1982).

Role Expectations. As part of the emphasis placed on the family, individuals share a set of expectations for their roles within the family and their obligations to the family. The male head-of-household is responsible for providing for and protecting his family. He is consulted about decisions, especially in relation to financial matters (Garcia Manzanedo et al., 1980). The Hispanic culture traditionally expects the woman to be sexually naive and monogamous. Yet, the male is condoned in seeking sexual relationships outside marriage, frequently with prostitutes (Marin, 1988). The male's role is often referred to as *machismo.* Health education should consider the importance of the husband as a decision maker, his potential influence on his wife in seeking or avoiding treatment, and his potential role in transmission of sexually transmitted diseases or of the agent(s) which causes cervical carcinoma. An effective approach to increasing the detection and treatment of cervical cancer might be to focus on the man's role in protecting Hispanic women from cervical cancer.

The role of the wife, on the other hand, is tied to the physical and emotional care and nurturing of family members. Her reproductive role is of great importance in establishing the family unit. She also may be viewed as the "healer." When ill, she is most likely to consult with other women in the family. An elaborate system for verifying that an individual is ill and can legitimately adopt the "sick role" may exist (Garcia Manzanedo et al., 1980). Acknowledgement of an illness, particularly when it is the mother in the family, assumes that all other family members will have to modify their roles to facilitate family functioning. This may involve the assumption of "mothering" functions by another female member of the family, typically the woman's mother or mother-in-law. The woman may have concerns about the care of her family and fear the imposition which would be placed on her extended family. Her concerns about her family, along with additional fears about the unknown or proposed treatment, might lead her to deny an illness or avoid seeking treatment.

Definition of the woman's role is further confounded when she is the head-of-the-household. An increasing number of Hispanic women, 16 percent of Mexican Americans and 40 percent of Puerto Rican women, are heads-of-households (Cutright, 1974; Ross & Sawhill, 1975; Sweet, 1972; Trevino, 1988). It is unclear exactly how this influences her decision making role. However, her altered role must be recognized and considered in planning for health education or other interventions.

Factors centering around role expectations may have a significant influence on when and whether a woman seeks treatment for cervical cancer. Coupled with the fact that cervical cancer may be in an advanced stage prior to the onset of symptoms, it becomes even more important that women receive and understand information about timely screening and treatment.

Attitude Toward Sexuality

Sexual attitudes may play an important role in detection and treatment of cervical cancer. Sexuality is generally considered to be an extremely personal and private matter among Hispanics. Sexual issues may not be discussed even between sexual partners (Marin, 1988). In the traditional culture, the "good" woman is supposed to be somewhat naive about sex (Marin, 1988). Yet, the role of sexuality and the woman's ability to bear children is of vital importance in the creation of the family unit. Given this context, it is also not unexpected that the Hispanic woman may feel very modest, and her husband very reluctant to have her examined by a male physician (Lawrence & Lurie, 1972). Perhaps the fear of loss of her reproductive capacity, along with a history of uncomfortable or demeaning health encounters and general lack of information and distrust about the health care system, discourage the Hispanic woman from seeking health care.

within the culture of partners discussing sexual issues, individual counseling of husband and wife may be preferable. His encouragement for her following through with treatment is vital.

Learning Resources and Approaches

Ramirez et al. (1987) found that Mexican Americans in South Texas accessed a variety of media forms (i.e., television, radio, newspapers). Preference was voiced for television and printed materials. Subsequently, the A Su Salud/To Your Health Program (McAllister & Ramirez, under review) utilized residents in target communities to identify terminology and visual representations of the "main killers" (cancer, hypertension, poor diet, lack of seat belt use, and alcohol abuse). Media found to be successful in significantly reducing the incidence of smoking included: *fotonovelas,* television, newspapers, and radio discussions. Fliers with a calendar of health related events and messages also were distributed by community volunteers. Role models from the community, people who were virtually identical to the target population and who had similar health problems, shared their experiences with treatment. In some instances, a Hispanic community leader was used as a role model for greater impact.

Media Development

Educational material should be developed in both English and Spanish. Terminology should be clear, concise, simple, and culturally sensitive. Technical language should be avoided. Illustrations for clarification should be used when possible. Expected behaviors should be specific (Marin, 1988; Azziz, 1983). Materials should be developed with community representatives and pretested to assure cultural and language appropriateness (Marin, 1988; McAllister & Ramirez et al., under review). Reading level should be assessed, remembering the reading level of the targeted population.

Feedback from women in the community indicated that health education should focus on providing accurate information which would dispel fears about screening and treatment for cervical cancer. For example, the importance of Pap screening for all women should be stressed since women may have cervical cancer and not experience any symptoms. The message should state also that treatment begun in an early stage is not painful and may not require surgery or loss of childbearing capability. Examples of statements which could be used in media might include: "To go for screening and treatment for cervical cancer is to protect your children. If you do not take care of yourself, you will not be able to care for your family." "To be macho is to protect your wife's health. Encourage her to go for cervical cancer screening."

Personal Approaches

Once the woman seeks care, communication becomes crucial to facilitating continued health care. The health care professional should establish rapport with the woman prior to the history or physical examination. Expressions of interest in her and in her family will be helpful. Privacy should be provided during any interviews, examinations, and teaching. Lack of questions from the woman may be out of respect for the health care professional. Therefore, it is imperative that health care providers and educators validate that she has understood information provided. That is, it is critical to ask her to repeat what she has understood.

Access to a Spanish translator is crucial if the health care professional does not speak Spanish. It still is important to use even limited Spanish and to maintain eye contact with the woman during conversations being translated (Poma, 1983). If she looks away, it is also important to respect that. It is likely an issue of modesty. The manner in which a women is addressed is also critical. To use the informal form of conversation (*tu*) would be considered rude. Thus, the formal mode (*usted*) should always be used. In addition, to be called by her first name would likely be interpreted as a lack of respect to her.

Mexican American women reportedly hesitate to ask questions about recommended treatment. Therefore, it is important to plan follow-up for further clarification and reinforcement so that they will indeed follow recommendations made for follow-up and treatment (Marin, 1988; Azziz, 1981; Poma, 1983). One approach, proven effective in encouraging Hispanic women to keep their appointments at a dysplasia clinic in South Texas, has been to mail reminders in Spanish and English one to two weeks prior to their appointments. The clinic has also found that personal contact, either by phone or home visit after a missed appointment, is helpful in encouraging women to return to the clinic for treatment (Ramos, 1988).

Conclusions

Health educators can play an important role in designing and implementing culturally-specific health education messages. They also can assist in modifying the traditional health care system to be more culturally acceptable to Hispanic women. Recognition and incorporation of Hispanic cultural values in media and through personal contacts may contribute to earlier detection and treatment of cervical cancer among Mexican American women, a high risk population.

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