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Factors Related to Cancer Screening in Hispanics: A Comparison of the Perceptions of Hispanic Community Members, Health Care Providers, and Representatives of Organizations That Serve Hispanics

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Hispanics have lower rates of screening for cervical, breast, and colon cancer than non-Hispanics. Activities to increase cancer screening in this population may not be informed by Hispanics, which may have implications for success rates of interventions. In this study, the perceptions about cancer screening behaviors in Hispanics are compared among three groups: a random sample of respondents (75% Hispanic) to a population-based survey, health care providers (primarily non-Hispanic), and representatives of organizations that serve Hispanics (36% Hispanic). While there was agreement that socioeconomic factors were important for cancer screening, differing views were expressed regarding the importance of cultural factors for cancer screening among Hispanics. Interventions developed by those who serve the Hispanic population may be based on inaccurate perceptions about the beliefs and practices of the population served. For effective interventions, it will be necessary to understand the factors important to Hispanics for cancer screening.

Hispanics are the second fastest growing population in the United States. Currently, they represent 11% of the population and will constitute about 15% by 2010.[1-3] Cancer is an increasing public health problem in this ethnic group,[2-7] and fatality rates for cancer among Hispanics are higher than for non-Hispanics.[8,9] Several studies have found lower screening rates for cervical, breast, and colorectal cancer among Hispanics compared

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with non-Hispanics,[10-15] with low socioeconomic status and lack of access to health care cited as factors contributing to differences in screening rates.[10,12,15] However, studies have shown that even controlling for these factors, Hispanics have lower screening rates for breast, cervical, and colorectal cancers relative to non-Hispanics.[11,13,14]

Many activities directed to increase cancer screening in the Hispanic populations are not developed by Hispanics,[16-18] which may have implications for the success or lack thereof of interventions in this ethnic group. Planners of health interventions must understand the realities experienced by Hispanics if activities are to result in desired changes.[2,19] Disparities between the perceptions of the community served (Hispanics) and those who serve the community (e.g., health care providers, representatives of organizations that serve Hispanics) can lead to poor or minimal effects on screening behavior among Hispanics.

Health care providers play an important role in the information, coordination, and provision of services directed to improve cancer prevention among Hispanics. Actions taken by providers are likely to be shaped by *their own perceptions* of the group they are serving (in this case, Hispanics), which can have an important effect on Hispanics' actual preventive behaviors.[2,19,20] There is, however, a lack of data about health care providers' perceptions of the cultural beliefs, attitudes toward cancer, and cancer prevention practices of the Hispanic population. Because such perceptions may influence how providers treat Hispanics in their practices, data about perceptions are relevant to the potential impact that health care providers can have in changing preventive practices among Hispanic patients.[21-24]

The role of community organizations such as advocacy groups, religious organizations, voluntary agencies, social service organizations, and other agencies that serve Hispanics has also been shown to be of special importance in interventions oriented toward improving cancer prevention among Hispanics.[25-27] Representatives from community organizations that serve Hispanics may be involved in developing and implementing cancer prevention programs.[25-29]

To improve cancer screening behaviors among Hispanics requires that health care providers, representatives of community organizations serving Hispanics, and Hispanics themselves share a common perspective about factors that may influence Hispanics' cancer prevention practices. This study compares the perceptions of three different groups, all living in the Lower Yakima Valley of eastern Washington state, regarding cancer screening behaviors in Hispanics. The groups include a population-based random sample of residents in the largest community of the valley, a sample of health care providers working in the community, and representatives of community agencies that serve Hispanics.

METHOD

Setting

The Lower Yakima Valley of Washington state has a population of about 60,000, of whom about 50% are of Hispanic origin. The majority of residents have low socioeconomic status. Most of the Hispanic population in the valley is Mexican American.[30] Data for this study came from three sources: a population-based sample of community members randomly selected from the largest city of the valley, health care providers, and representatives of community organizations that serve Hispanics.

Data Collection

Sample of community members. In the summer of 1996, a face-to-face household survey was conducted in the largest city of the valley (population ~ 11,000). This survey was part of a larger study conducted by the Fred Hutchinson Cancer Research Center, which sought to identify attitudes, beliefs, and practices about cancer in the Hispanic population in preparation for a large-scale intervention study. Census blocks of the community were randomly selected with oversampling of census blocks containing Hispanics. A total of 351 households were identified for surveying. If present, one adult male and one adult female within each household were identified for interviewing. If more than one male or female lived in the household, month of birth was used as the selection criterion. Eight Spanish/English bilingual interviewers of Mexican American ethnicity were hired from the community. Interviewers underwent 3 days of training in interviewing and tracking procedures; each was required to pass a certification test.

Sample of health care providers. A number of clinics and health care practices that serve Hispanics exist in the valley. Because few, if any, health care providers were represented in the population-based survey, health care providers were selected using a snowball technique, by which key informants are initially contacted and then provide recommendations for additional contacts.[31,32] The importance of the snowball strategy is that it is a good way to reach key informants in a community, that is, those who are most involved in the cancer issue. Health care providers were also identified from local telephone books of the valley and from information provided by the local health department. Two criteria were used to select health care providers for participation in the study: They needed to practice in the valley and work in cancer-related areas. Health care providers included in the study were cancer specialists, primary care physicians, nurses, and affiliated health professionals. Ultimately, all but a handful of health care providers in the valley were interviewed.

The potential participants were mailed a letter describing the study. Two weeks later, they were contacted by telephone and asked to participate in a discussion, either individually or in a focus group format, about their perceptions of and recommendations for cancer prevention in the valley. All health care practices invited sent at least one representative. Prior to the discussion, the facilitator explained that the information would be used for research purposes and that the discussion would be audiorecorded. Because the information being sought was of a nonsensitive nature, verbal consent was requested for participation; all attendees provided verbal consent. Furthermore, after transcription of the interview or focus group, draft transcripts were sent to participants so they could identify any discrepancies, which were then resolved in a conversation with the participant.

At the end of the discussion of their own perceptions, the participants received information about the results of the population-based survey that reported the views of community members. The participants then had an opportunity to discuss how their perceptions related to those of community members. Four individual interviews and five focus groups, with a total of 36 members, were conducted with health care providers. The facilitators were bilingual and of Hispanic ethnicity. In all focus groups except one, which was small ($n = 3$), two researchers were present; the small focus group had only one facilitator. One researcher facilitated the group discussion, while the other kept minutes of the meeting.

Sample of representatives of community organizations serving Hispanics. As with health care providers and for the same reasons, the snowball strategy and the telephone books of the valley were used to identify community organizations included in the study. Beginning with organizations that were known to serve Hispanics (e.g., the Migrant Council; the Farm Workers Clinics), other organizations that provided programs for or served Hispanics were identified. Organizations were included if the organization's mission was related to cancer prevention (e.g., American Cancer Society) or the organization provided programs to or served the Hispanic community in the valley. Individual discussions or focus groups with representatives from organizations were conducted as was done with health care providers.

The number of organizations identified was relatively small ($n = 11$), and staff size was small; thus, 10 individual interviews and only one focus group, with 4 members, were conducted. As with the health care provider interviews, two researchers were present. In addition, 2 of the individual interviews, with representatives of two organizations, were conducted in Spanish.

Instruments

Survey of community members. The instrument used in the community-based, face-to-face survey consisted of a 104-item interview that took about 30 minutes to complete. Interviewers used a standard verbal script to inform potential participants of the study and their rights. Participants provided verbal consent to respond to the interview. Verbal consent was considered appropriate for this population for two reasons: First, the questions in the survey were relatively nonintrusive; second, the overall low educational level of the population led to concerns that potential participants would not be able to read even a very low literacy informed consent.

The questionnaire was prepared in English and translated into Spanish. It was back-translated into English to ensure fidelity of the questions. The questionnaire addressed five major topics: health care access, health beliefs and attitudes about cancer, preventive behaviors (e.g., diet, smoking), screening knowledge and behaviors, and demographics. Health care access was assessed by asking the respondents if they had a regular physician or a regular clinic to go to when they had health problems and what type of insurance they had.

Information about knowledge, beliefs, and attitudes about cancer was collected based on questions developed by Lantz, Dupuis, Rending, Krauska, and Lappe.[33] Response categories were in Likert-type form (*strongly agree*, *agree*, *disagree*, *strongly disagree*). Screening behavior was assessed through questions that asked, "Have you ever had . . ." screening test. The survey included questions related to Pap test, mammograms for age-eligible women (≥ 50 years of age), fecal occult blood test (FOBT), and sigmoidoscopy or colonoscopy for all age-eligible individuals (≥ 50 years of age). For each test, a simple description of the procedure was included, and pictures of the procedures were shown to subjects who needed further explanation.

Interviews with health care providers and representatives of community organizations. A semistructured, open-ended questionnaire was used to guide the interviews. Topics included in the interview schedule were identical to those in the survey of community members; however, response categories were not provided. Although specific topic areas were identified for the interviews and focus groups on the interview schedule, the facilitators had freedom to probe for more information and explore tangential areas if they emerged. The following topics were addressed: (1) perceptions of the main health risk factors and health problems affecting Hispanics and non-Hispanics, (2) perceived barriers and facilitators of disease prevention and health promotion among Hispanics, (3) perceived barriers to lifestyle change and screening behaviors among Hispanics and non-Hispanics, and (4) personal experiences with and suggestions for collaboration among different agencies to improve prevention services and programs among Hispanics in the valley. The institutional review board at the Fred Hutchinson Cancer Research Center approved the interview and focus group content, the survey content, and the methods to conduct the study.

Analysis of the Information

Analysis of quantitative information. Descriptive analysis was conducted for all variables obtained in the population-based sample. Questions with Likert-type scale responses were dichotomized into agree (*strongly agree* and *agree*) and disagree (*disagree* and *strongly disagree*). Logistic regression was the primary method used to study the association between ethnicity and the binary dependent variables.

Analysis of qualitative information. Analysis of the qualitative information was based on audiotaped transcripts and field notes of the researchers. After the interviews, a transcription of their content was sent to the interviewees. All the participants of the interviews and one representative of each focus group were contacted personally or by phone to clarify aspects of the interview and receive their feedback based on the report sent to them previously.

The analysis of the information obtained during the focus groups and interviews was made following principles of qualitative research as suggested by Krueger[31] and Creswell.[32] In each interview, key words and common themes were identified. A matrix of the main topics identified in each interview was created. An ordinal scale was used to measure how often a concept within a particular topic was mentioned; specifically, the concept was mentioned in two-thirds or more of the interviews (+++), one-third but less than two-thirds (++), less than one-third (+), or not mentioned (NM). Aggregated information of the interviews is based on this scale and is presented in the tables.

To maintain the richness of the information obtained during the interviews, relevant quotes are presented in the Results section of this study. In qualitative studies, it is customary to present direct quotes from participants to demonstrate the views of the participants.[31] In this study, quotes that represent prevailing interpretations, views, and themes are given. Although the specific words may not have been repeated by all interviewees, the meaning of the quote was supported. Where divergent opinions were expressed, they are noted in the text and the tables. Participants' words are much richer and more meaningful than words we could ascribe to them.

Qualitative information obtained from focus groups and interviews conducted with representatives of health care providers and community organizations was compared with quantitative data (i.e., the population-based random sample) obtained from community members. Unfortunately, it was not possible to obtain qualitative information from the community members, and the nature of the data was considerably different (i.e., qualitative vs. quantitative). Because the survey of community members asked questions directly of the targeted population, those survey responses are likely to accurately reflect the beliefs, attitudes, and practices of the Hispanic population in the valley. The quotes from the health care and service providers, where few members were of Hispanic origin, illustrate the *beliefs* of those who provide services to the Hispanic population.

RESULTS

Characteristics of the Study Participants

Population-based sample of community members. The overall response rate to the population-based survey was 80.5% for a total of 380 respondents; of those, 54.8% responded to the questionnaire in Spanish. Table 1 summarizes the characteristics of the respondents. More than 75% identified themselves as Mexican Americans. The majority of Mexican American respondents were agricultural workers with few years of education. Almost all respondents were residents of the valley, and the median length of time residing in the area was 13 years.

Health care providers. All health care providers contacted agreed to participate in the discussions about cancer prevention; however, schedule conflicts prevented one interview from being completed. A total of 17 physicians, 1 pharmacist, and 22 nurses, representing seven health institutions, were included in the study. The vast majority of the respondents were primary care physicians ($n = 16$) and nurses. All physicians interviewed were non–Mexican Americans. This is consistent with the ethnicity of providers in the valley, according to the information obtained from the local health departments and the key informants. Two nurses were of Hispanic origin.

Representatives of community organizations serving Hispanics. Representatives of 11 different community organizations were interviewed or participated in focus groups (total $n = 14$ participants). The organizations included were social service groups (e.g., Women, Infant, and Children Program; Catholic Family Services), health institutions with community programs (e.g., local hospitals, Farm Workers Clinics), social justice groups (e.g., Farmworkers Union, Department of Justice of the Catholic Diocese), the local American Cancer Society, and groups working closely with Hispanics (e.g., Migrant Council, Radio KDNA [Spanish radio]). Of the 14 people included, 5 were of Hispanic origin.

Health Care Access Barriers for Cancer Prevention

The survey of community members showed significant differences in health care access between Hispanics and non-Hispanics (see Table 2). Hispanics were less likely than non-Hispanics to have a regular health care provider, more likely to rely on clinics (which are low cost) for health care, and more likely to have lower rates of health care insurance than non-Hispanics. For health providers and representatives of community organizations, economic barriers and lack of health care insurance were mentioned as the most important problems for Hispanics in the lack of access to health care (see Table 2). One nurse stressed the value of having adequate health insurance among Hispanics:

> It really makes a difference when they can pay. It is an issue of pride. Many Hispanic clients don't even go to the clinic to get screening tests if they don't have insurance or have to use their medical coupons.

Table 1. Demographic Characteristics of a Sample of Community Members Responding to the Population-Based Survey

Characteristics	Hispanics ($n = 285$)	Non-Hispanics ($n = 95$)	Total ($N = 380$)
Female (%)	56.0	65.9	57.7
Married (%)	69.1	47.1	64.0
Annual family income (%)			
Less than $10,000	39.0	39.7	39.2
Between $10,000 and $25,000	48.1	33.3	42.6
More than $25,000	12.9	27.0	16.2
Education (%)			
No school to 4th grade	23.7	—	17.9
5th grade to 12th grade	53.4	45.9	51.7
High school or GED	14.1	24.7	16.7
More than high school	8.8	29.4	13.7
Occupation (%)			
Unemployed	19.6	17.6	19.0
Agricultural/warehouse	49.8	8.2	39.7
Service, retail, technical	13.9	23.2	16.4
Administration, management	2.8	4.7	3.4
Professional	6.8	8.2	7.1
Retired, student, other	7.1	37.7	14.3
Live in the valley all year (%)	98.2	100.0	97.9
Low acculturated Hispanics (%)	47.7	NA	
Mean age (years)	39.7	38.4	39.4

NOTE: GED = general equivalency diploma; NA = not applicable.

A representative of a community organization highlighted the importance of economic issues as a barrier for cancer prevention among Hispanics:

> Hispanics have serious economic problems. They are concentrated on their daily living and are not very concerned about health practices that may affect their lives in 40 years.

More than half of the Hispanic community survey respondents mentioned the long waiting time at the clinic as a barrier to health care; this was significantly different from non-Hispanic respondents. None of the health care providers or representatives of community organizations mentioned this factor as an important access barrier for Hispanics. On the other hand, most health care providers and about one-third of community organizations' representatives mentioned inadequate transportation as an important barrier for lack of access to health care among Hispanics. There was not a significant difference between Hispanic and non-Hispanic survey participants in identifying transportation as a barrier.

A number of representatives of community organizations identified language differences as a factor that affects communication with and confidence in health care providers as well as access of Hispanic patients to health information. A representative of a community organization said the following of his experience in trying to promote preventive care with Hispanic families in the valley:

Table 2. Perceptions of Health Care Access Barriers for Cancer Prevention by Health Care Providers, Community Representatives, and Barriers Reported by Hispanics and Non-Hispanics

			Community Members' Perceptions (in percentages)		
	Health Care Providers' Perceptions	Community Organizations' Perceptions		Hispanic ($n = 283$)	Non-Hispanic ($n = 85$)
Presence of a regular provider:			Presence of a regular provider:**		
Lack of a regular doctor among Hispanics	NM	(+)	Lack of regular physician	51.8	89.6
Get health care at clinic:			Get health care at clinic:**		
Clinics are low cost	NM	NM	Clinics are low cost	50.4	34.4
Health care insurance:			Health care insurance**		
Low health insurance exists among Hispanics	+++	+++	Private insurance	27.6	50.6
			Medicare	4.6	23.5
			Medicaid/coupons	22.2	11.8
			No health insurance	45.6	14.1
Transportation to the clinic:			Transportation to the clinic:		
Lack of transportation prevents Hispanics from going to the clinic	++	+	Lack of transportation to get to clinic	25.2	16.7
Waiting time at the clinic:			Waiting time at the clinic:**		
Long waiting time at the clinic is a problem for Hispanics	NM	NM	Long waiting time at the clinic is a problem	58.3	28.9
Language barriers:			Language barriers:		
Language differences are an important barrier for Hispanics at the clinic	+	++	Language differences are important because Spanish is not spoken at the clinic	19.6	9.3

NOTE: +++ = barrier was mentioned in ≥ two-thirds of the interviews; ++ = barrier was mentioned in one-third to two-thirds of the interviews; + = barrier was mentioned in less than one-third of the interviews; NM = barrier not mentioned.
$^{**}p < .01$.

> Language is a big barrier for Hispanics in this community. They cannot communicate well with nurses and doctors and so they lose confidence and do not get the information in a way that encourages them to change their practices. Sometimes they complain about not being heard by health care providers.

Most health care providers, however, stated that the presence of translators at the clinic or the inclusion of family members who speak English could overcome language barriers. Many physicians agreed with one physician, who stated,

> Although I don't speak Spanish, I think I can communicate with my Hispanic patients in a way that they can understand the message.

Among respondents to the survey, there was a significant difference between Hispanics and non-Hispanics as to the language spoken as being a factor that affects health care.

In addition to the health access barriers described, health care providers and community organizations' representatives also mentioned the importance of continuous traveling, migration, and fear of deportation as factors that prevent Mexican Americans from accessing the health care system. One health care provider noted,

> Many Hispanics are afraid to go to the clinic. They think they will ask them for legal papers. We try to inform them that at the clinic they are not interested in their legal status. Problems arise when they have to be referred to the hospital because of an abnormal test.

The latter refers to the likelihood that the hospital will request some type of documentation so it can recoup some of the expenses involved in treating a patient.

Screening Behaviors

The survey of community members showed a statistically significant difference between Hispanics and non-Hispanics for cervical cancer screening (women older than age 18) and colorectal cancer screening (women and men age 50 and older). This difference held when adjusting for income (see Table 3). However, about two-thirds of health care providers interviewed and one-third of the representatives of community organizations thought that differences in cancer prevention between Hispanics and non-Hispanics were determined by socioeconomic status rather than ethnic background. In a focus group of physicians, they agreed that

> the main problem for screening is economic problems. This holds for Hispanics and non-Hispanics in the same way. When patients have some kind of insurance they are more likely to seek care early and get screening procedures independent of their ethnicity.

Another physician stated,

> Poor people tend to have misconceptions about cancer prevention. They think that they need screening only if they are at risk or they have symptoms. In addition, they know they will have problems to afford screening tests or medical procedures. This is not a problem restricted to the Hispanic population but for people of low socioeconomic status in general.

Table 3. Perceptions of Cancer Screening Behavior by Health Care Providers and Community Representatives and Actual Screening Behavior Among Hispanics and Non-Hispanics

	Health Care Providers' Perceptions	Community Organizations' Perceptions	Community Members' Perceptions		
				Hispanic	Non-Hispanic
Cancer screening among women:			Cancer screening among women[a]		
Hispanic women receive less cancer screening than non-Hispanic women	++	+++	Women older than 18 (n)	156	55
			Never had Pap screening* (%)	23.1	7.3
			Women ≥ 50 years old (n)	36	11
Hispanic women receive less cancer screening regardless of socioeconomic status	+	++	Never had a mammogram (%)	52.7	26.4
Colorectal screening:			Colorectal screening[a]		
Older Hispanics receive less cancer screening than non-Hispanics	++	+++	Men and women ≥ 50 years old (n)	71	16
			Never had FOBT or sigmoidoscopy* (%)	76.1	43.6
Older Hispanics receive less cancer screening regardless of socioeconomic status	+	++			

NOTE: +++ = barrier was mentioned in ≥ two-thirds of the interviews; ++ = barrier was mentioned in one-third to two-thirds of the interviews; + = barrier was mentioned in less than one-third of the interviews; NM = barrier not mentioned; FOBT = fecal occult blood test.

a. Adjusted for income.

*$p < .05$.

Beliefs and Attitudes About Cancer Prevention

Survey results showed that Hispanics in the valley had significantly different beliefs about cancer than non-Hispanics (see Table 4). Many more Hispanic respondents thought that screening is only necessary if they have symptoms or if cancer runs in their families than non-Hispanic respondents. More Hispanics thought that "God can punish people by giving them cancer" than non-Hispanics. The differences in beliefs between Hispanics and non-Hispanics remained after adjusting for income.

Some health care providers and representatives of community organizations also expressed the opinion that cultural factors were important in decisions to seek cancer prevention screening. As one health care provider noted,

> The problem of low compliance with medical recommendations and regular screening among Hispanics is mainly due to their attitude towards prevention.

A representative of a community organization emphasized that many Hispanics do not believe in cancer prevention:

> Many Hispanics have learned to respond to health problems only when there is an emergency. They do not believe that having a regular care could prevent them from getting diseases such as cancer in an advanced stage. Even if they have the resources they tend to wait before seeking care.

Some health providers said that they thought cultural factors specific to women and men played important roles in explaining the lower screening rates of cancer screening among Hispanics. For example, one physician stated that

> the idea that the breast is property of their husbands and that an intact uterus is essential for their identity as females is very strong among Hispanic women. They tend to resist the breast examination and cervical cancer screening because it is seen as a procedure that might affect their integrity and therefore their identity as females.

Although not using the same words, one-third to two-thirds of health care providers expressed this same view of Hispanic women's perceptions of their femaleness.

Similarly, both health care providers and male Hispanic and non-Hispanic representatives of community organizations serving Hispanics stated that Hispanic men were influenced by *machismo*:

> The machismo attitude is a strong barrier for Hispanic males to get colorectal cancer screening. Even if they can afford the procedure, it is not seen as a male attitude and many of them will not go to the clinic.

Among community members who responded to the survey, a significant difference between Hispanics and non-Hispanics was seen in attitudes toward cancer. The vast majority of Hispanics agreed that they would "rather not know if they had cancer," and more than half of them said that "once you get cancer you will always die from it." In contrast, less than one-third of non-Hispanics agreed with these statements. These differences remained even after adjusting for income.

Table 4. Health Care Providers and Representatives of Community Organizations' Perceptions of Hispanic and Non-Hispanic Beliefs and Attitudes About Cancer Among Hispanics and Non-Hispanics

			Community Members' Perceptions (in percentages)[a]		
	Health Care Providers' Perceptions	Community Organizations' Perceptions		Hispanic ($n = 285$)	Non-Hispanic ($n = 85$)
Beliefs			Beliefs		
Hispanics think they need screening tests only if they have symptoms	+	++	"I only need cancer screening if I have symptoms"**	42.5	25.0
Hispanics believe that they only need cancer screening if cancer runs in their families	+	NM	"I only need cancer screening if cancer runs in my family"***	41.1	15.9
Hispanics believe that cancer is a punishment from God	+	+	"God can punish people by giving them cancer"***	47.5	10.0
Attitudes			Attitudes		
Hispanics tend to avoid or deny a diagnosis of cancer	+	++	"I would rather not know if I had cancer"***	71.0	26.4
Hispanics tend to have a more fatalistic attitude toward cancer	++	++	"Once you get cancer, you will always die from it"***	54.7	29.6

NOTE: +++ = barrier was mentioned in ≥ two-thirds of the interviews; ++ = barrier was mentioned in one-third to two-thirds of the interviews; + = barrier was mentioned in less than one-third of the interviews; NM = barrier not mentioned.

a. Adjusted for income.

**$p < .01$. ***$p < .001$.

About half of health care providers and half of representatives of community organizations thought differences existed in attitudes toward cancer among Hispanics in comparison to non-Hispanics. Some of them mentioned that Hispanics tend to avoid or deny the diagnosis of cancer or tend to be more “passive” once they are diagnosed with cancer. Representatives of community organizations described the avoidance attitude among Hispanics:

> Many Hispanics don’t want to know if they have cancer. They seem to think that if you don’t pay attention to the disease it will go away.
>
> Cancer is seen as an “evil” word by Hispanics; they don’t want to talk about it.

A physician also shared his experience in treating Hispanic cancer patients:

> Hispanic families tend to hide the diagnosis of cancer from the patient. The doctor is often asked to talk about the diagnosis and prognosis of the disease with the patients’ relatives.

More than half of Hispanic survey respondents stated that “once you get cancer, you will always die from it.” This attitude, called “fatalism” in the literature,[20,21] was mentioned in about half of the interviews conducted with health care providers and representatives of community organizations. Many representatives of community organizations and health care providers, however, also stated that a more fatalistic attitude about cancer among Hispanics might be due to their inability to afford costly medical interventions. Physicians emphasized this idea in one of the focus groups:

> They know that if the disease comes they will not have the resources to afford expensive medical treatments. Therefore, they prefer not to think about it. Their attitude would be different if they had the resources to receive good treatment.

DISCUSSION

This study examined the perspectives of three different groups of community players around cancer screening behaviors: health care providers, representatives of community organizations, and community members themselves. The interaction among these players is a key factor for increasing preventive behaviors among Hispanics. In this study, we used qualitative and quantitative information to compare the perspectives of the three groups. As the data indicate, there were significant discrepancies between the views expressed by those who serve Hispanics and Hispanics themselves. A number of overall differences were found. Community health providers expressed the belief that lack of a regular physician was not a problem among Hispanics; however, almost half of Hispanics reported that they had no regular provider compared with 10% of non-Hispanic whites. Community providers and representatives of community organizations expressed the belief that low-cost health care exists among the Hispanics; however, more than 45% of Hispanics had no kind of health care insurance, including coupons or Medicaid. While all three groups agreed that Hispanic beliefs and attitudes affected screening rates, the specific attitudes given differed, with health care providers and representatives of community agencies citing cultural values of machismo and a passive attitude toward preventive care as barriers to screening. Hispanics themselves, however, emphasized the concept of fatalism in their attitudes toward cancer screening.

As in other studies,[2,4,11,33] health care providers and representatives of community organizations in this study recognized the importance of economics and their relationship to lack of health care insurance among Hispanics as a main barrier for improving cancer screening. The findings of our survey of community members confirmed the existence of this barrier. Language differences were not considered essential barriers for cancer prevention by most health care providers in our study. In contrast, representatives of community organizations stressed the importance of language differences and the limitations of translators at the clinic for building confidence and motivating Hispanic patients to improve preventive behaviors. Several studies have shown the importance of language differences for improving cancer preventive behaviors among Hispanics.[2,22,34]

The lack of a regular provider among Hispanics was not recognized as an important barrier by health care providers and representatives of community organizations in our study; however, there is evidence that physician advice and continuity of care are important predictors for getting cancer screening among Hispanics.[13,22,35,36] Only one representative of a community organization mentioned this factor as a barrier for cancer screening among Hispanics. Among the Hispanic survey respondents, however, less than half had a regular provider. This may have implications for fostering the ongoing physician-patient relationship that is necessary for cancer screening.

Health care providers and community organizations' representatives noted the importance of continuous migration and fear of deportation as important factors for Hispanics in the valley for difficulties in accessing the health care system. Migration in the valley is somewhat contained, with workers following the harvest of various crops as they become ripe. This is demonstrated in our community survey data in which 98% of the Hispanics reported living in the valley all year. Deportation was not addressed with community members in the population-based survey for three reasons: first, the Immigration and Naturalization Service (INS) routinely conducts sweeps of the valley to identify and deport undocumented workers, and we did not want participants to think information would be passed to the INS. Second, asking community members about their documentation status was considered a very sensitive issue that could affect response rates. Finally, we did not wish to put participants in the position of having to misrepresent their documentation status by asking about that issue. Other studies have noted that deportation fears are relevant for this population.[2,37] The fact that health care providers and representatives of community organizations in this study considered it important may mean that Hispanics in the valley also find this a problem.

Several studies have found that lower screening rates for cervical, breast, and colorectal cancer among Hispanics are not totally explained by socioeconomic factors.[10,12-14] These findings were confirmed in this study for screening rates for cervical and colorectal cancer, which were lower for Hispanics, even after adjusting for income, but not for breast cancer.

Several studies suggest that cultural factors play an important role in preventing Hispanics from getting cancer screening.[33,38-40] These factors could affect compliance with preventive practices, even when patients get into the clinic after having overcome access barriers.[20,22,33,40,41] Only a minority of health care providers and about half of representatives of community organizations mentioned different beliefs and attitudes toward cancer as an important factor for improving screening behaviors among Hispanics. In contrast, the population-based survey and other studies[13,33,38-40] suggest that Hispanics have less knowledge about cancer, tend to avoid the disease, and have a more fatalistic attitude toward cancer than non-Hispanics. These differences in beliefs and attitudes appear to be independent of socioeconomic status.[13,38,40]

In summary, this study suggests that interventions devised by health care providers and representatives of community organizations serving Hispanics may be based on perceptions that are inconsistent with the beliefs and practices of Hispanics—the population served. For effective interventions, it will be necessary to understand the factors that keep Hispanics from obtaining cancer screening. In this study, we combined qualitative and quantitative methods to obtain complementary and rich information that may be very useful in developing health interventions that are pertinent for the targeted population.

Limitations

This study has some limitations. There was a gap of about 18 months between the time the population-based survey was conducted (summer 1996) and the qualitative data were gathered (spring 1998). This gap does not appear to be a threat to the validity of the comparisons between the perspectives of the community members, health care providers, and representatives of community organizations because no new health policies, programs, or cancer prevention projects were developed in the valley during that period.

The community-based sample collected information only from one community and did not include other communities of the valley. Representatives of health care providers and community organizations included professionals of other communities in the valley. Given the homogeneous characteristics of the population in the valley, it is likely that the situation in other communities did not differ significantly from the one observed in the largest city of the valley.

Nonrandomized samples of representatives of health care providers and representatives of community organizations were taken for the qualitative data collection; however, this approach is characteristic in qualitative research.[31,32] The main goal of this study was to understand how those who served the Hispanic community perceived the Hispanic population and how their perceptions compared with the practices of Hispanics. The systematic approach used in the identification of interviewees, administration of interviews, later review of each interview by the participants, and follow-up contact with each representative produces confidence in the reliability of the information; however, this method of sampling makes it difficult to make inferences and generalizations of the results beyond the participants of the study.

Another potential limitation lies in the different methods used to gather data from each group of constituents. The characteristics of the two groups of respondents were substantially different in terms of ethnicity, occupation, education, and use of health services. Adding to those differences were the data-gathering methods used: Individual community residents responded to a face-to-face structured interview, and health care providers and representatives of organizations serving Hispanics responded to a fairly unstructured interview or a focus group. Both of these factors may have contributed to some differences in responses. However, the qualitative questions were based on the responses of the community members, providing some confidence that the meaning of the questions was somewhat similar between groups. It may be that groups that serve Hispanics would have similar perspectives as Hispanics if their data had been gathered quantitatively. However, given the similarity of the questions, the differences between Hispanics themselves and those who serve them are quite disparate, giving some credence to the notion that real differences exist between the groups.

Implications

This study has important implications for the development of strategies directed to increase cancer screening behaviors among Hispanics in the Lower Yakima Valley. There is a strong need to improve access to health care among Hispanics. The community has many health care resources for people with low incomes; these include a Breast and Cervical Cancer Early Detection Program, Farm Worker Clinics, hospitals with sliding scale fees, and an inexpensive state health insurance plan (Washington State Basic Health Plan). Representatives of community organizations and health care providers may need to work to publicize such resources.

It is of key importance to address other important access barriers for Hispanics such as lack of a regular provider and long waiting time at the clinic. These factors were mentioned as important obstacles for improving cancer prevention by more than half of the Hispanic population but not recognized as important barriers by the vast majority of health care providers and representatives of community organizations.

It is also important to address cultural factors that may keep Hispanics from receiving cancer screening. Other researchers have noted the importance of *familialism* (importance of family) and *simpatía* (the desire to get along) as central Hispanic values.[2,42] Others have emphasized linking with fictive kin to encourage screening, with the idea that *comadres* and *compadres* would be trained as lay health workers to spread messages about the importance of screening.[15,25,36] Values related specifically to cancer screening include a strong sense of privacy, the belief that enduring sickness is a sign of strength, and a reliance on home remedies rather than Western medicine.[2] Interventions to promote screening can build on cultural values and beliefs by emphasizing that screening will be done in private; projects among other minority groups have done so by making videos that show women having mammograms and cervical cancer screening in a quiet, private setting.[43-45] To combat the belief that the ability to endure sickness is a sign of strength, influential leaders and organizations, such as churches, in the community may be enlisted to help disseminate messages promoting screening.[46] Integration of traditional medicine may help Hispanics feel more comfortable in a Western medical setting.[46] A comprehensive intervention program to increase cancer screening among Hispanics will consider all of the factors identified in this study.

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