On the whole, rates of breast cancer screening by mammography have increased steadily in women ages 40 and older, Pap smear use for cervical cancer screening is increasing slightly among women ages 18 and older, and colorectal cancer screening rates have recently increased but remain low among people ages 50 and older. But those rates vary among people of different ethnic backgrounds, and understanding how cultural beliefs and other factors play into those disparities can help researchers develop better cancer screening programs.

One of the fundamental issues underlying how cultural beliefs influence behavior is understanding that social norms for discussing various topics differ among groups. “There are whole different ways of communicating and relating to others that go beyond a belief in fatalism or [a sense of] embarrassment about cancer screening—that is the most superficial sort of level looking at culture,” said Rena Pasick, Dr.P.H., associate director for education and outreach at the University of California at San Francisco Comprehensive Cancer Center. “One of the big cultural differences is the difference between collectivist cultures versus individualist cultures.”

Whether people function more fundamentally as autonomous individuals (individualist) or as part of a group (collectivist), this difference has a specific impact on communication. “In collectivist cultures, such as Latino and many Asian cultures, communication is much more indirect,” said Pasick. This is one reason researchers find that approaching people from collectivist cultures with specific, direct information about cancer usually does not work.

“Having control over one’s health may just not be a familiar concept for people from other cultures,” said Helen Meissner, Ph.D., chief of the National Cancer Institute’s Applied Cancer Screening Research Branch. “And it’s important for us to recognize that in how we communicate, because in fact it may be that what we think we are communicating is just alien or unfamiliar to people.”

One such example is research by Hee-Soon Juon, Ph.D., assistant research professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health, who recently examined the adoption of Pap screening by Korean-American women. Juon found three beliefs common in the Korean culture that made Korean-American women less likely to report having had a recent Pap smear: Women who reach menopause do not need Pap tests very often, after women stop having children they do not need Pap tests, and it is embarrassing to have a Pap test.

In the study, Juon found that “about 40% of Korean-American women said that they did not have regular screening because [they had] no gynecological problems. Many elderly women think that a Pap test once in a lifetime will take care of the rest of their life problems.” Korean-American women who have lived in the United States longer tend to become more acculturated and to use gynecological preventive care, said Juon.

Another research issue for gathering information about different cultures is how various questions are interpreted by the audience. “We did survey work in three or four different languages in one study where you want your data to be comparable across cultures and languages and they’re not,” said Pasick, who has worked in African-American, Latino, Chinese, Vietnamese, and Filipino communities. “You can translate your questions and go out and ask them and you will get data back, but it does not mean that you’ve really asked the same question with the same meaning to these different cultures,” she said.

To avoid problems with these and other types of interpretation bias, researchers at Bradley University in Illinois are seeking funding for a proposal that uses a tool most common
in the social sciences, the ethnographic approach. Kerry Ferris, Ph.D., associate professor of sociology at Bradley, said the approach is “not novel in sociology—but in applied health research it is.” The study, being designed to learn more about the subtle social and cultural factors that influence screening rates among poor African Americans within a single community, would avoid the participant bias Ferris’ colleague, Marjorie Getz, instructor in Bradley’s department of psychology, said is inherent in many studies.

“[Participants] know they are being interviewed and there’s always the bias of the individuals wanting to present themselves in a socially desirable framework,” said Getz. “We want to get at the meaning structures—learn how to approach, to appeal, and to understand people’s perspective,” said Ferris.

Another factor inextricably linked to how cultural beliefs play a role in the likelihood that a person will be screened for cancer is socioeconomic status. “If you look at the use of pretty much all cancer screening tests, you see that having health insurance and having a usual source of health care are two of the strongest predictors of whether someone’s going to have a recent screening test or not,” said Meissner. “Most people don’t pay for screening or preventive services out of pocket. It’s something that we pay for with health insurance. So if you don’t have health insurance or a usual source of health care then you’ll be less likely to get screened.”

This applies particularly to immigrants. “Recent immigrants, for instance,” said Meissner, “usually are more socioeconomically disadvantaged when they first come to the U.S., so they may not have jobs that provide health insurance or the resources to have access to preventive services.” Meissner believes it is difficult to know what effects are from cultural beliefs versus the result of low socioeconomic status. “It’s not to say that culture isn’t important—because it most certainly is—but often many of the disparities that we see in screening are related to socioeconomics. Sometimes it’s hard to disentangle that from culture.”

To address these types of issues that apply across a broad range of populations in the United States, the Centers for Disease Control and Prevention, in partnership with the NCI, sponsor the Cancer Prevention and Control Network through CDC’s Prevention Research Centers. Five of the centers make up the network, which was funded “to create an infrastructure to conduct community-based participatory research and to increase use of cancer screening and use of an informed decision-making process,” said Katherine Wilson, Ph.D., behavioral scientist and public health educator at CDC’s Division of Cancer Prevention and Control.

Now in an infrastructure-building phase, the network’s members are beginning to design protocols around evidence-based strategies. A center in South Carolina is doing a study to increase the use of mammography by rural African-American women and a center in Texas is designing an intervention to increase colorectal cancer screening among Latinos. “One of the benefits of the network is that it’s geographically dispersed and topic-interest dispersed,” said Wilson. “The purpose of funding infrastructure development was to allow time for the centers to strengthen their community networks so they could apply [for funding] wherever they want. We don’t want them tethered to us.”

Pasick has stepped back from researching cancer-screening interventions in favor of learning more about culture in general. “Intervention research led me to realize that there are issues about culture that we didn’t understand,” said Pasick. “Just as you have basic research in the laboratory to look at how different drug components interact with different things..."
before you actually go out and create a drug and use it, I want to try to better understand culture and behavior and communication before I will go back again and work on intervention,” said Pasick. In one study, she is now examining the different styles of communication that go on between providers and patients in African American, Latino, and Chinese cultures, with a focus on colorectal cancer screening.

Although cultural barriers are often mentioned as one reason for the disparities in cancer screening among different ethnic and cultural groups, Meissner looks at culture in another way. “I hate to say ‘cultural barriers’ because I don’t like to think of culture as a barrier,” said Meissner. “A culture is what it is and that’s not the barrier. The barrier is that if we don’t understand the culture then we can’t be very effective in communicating what we think may be beneficial for health—like getting cancer screening tests.”

—Christine Theisen

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