

Providing Culturally Tailored Breast and Cervical Cancer Programs for Asian American and Pacific Islander Women: A Case Study of a Filipino Community in Honolulu

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Abstract

Asian American and Pacific Islander (AAPI) women have low breast and cervical cancer (BCC) screening rates compared to other ethnic groups. However, there is a lack of culturally tailored programs designed to promote screening practices within AAPI communities. The CARE Program sought to reduce BCC morbidity and mortality rates among AAPI women by building the capacity of community health centers to deliver effective, culturally and linguistically appropriate screening programs in six different AAPI communities. This paper will (1) provide an overview of the CARE Program, (2) highlight a BCC screening program for a Filipino community in Hawaii, (3) present specific cultural tailoring strategies from the program, and (4) discuss program challenges and propose recommendations for future breast and cervical cancer interventions with Filipino communities in Hawaii.

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Introduction

Asian American and Pacific Islanders (AAPI) are the fastest growing minority group in the United States. Population figures are expected to nearly double to 20 million people by the year 2020. Within AAPI communities, there are over 50 distinct ethnicities, over 100 languages and dialects, and tremendous depth of diversity, culture, and history (Lai & Arguelles, 2003). Given the staggering growth of the AAPI community and the increasing diversity of the general U.S. population, it is critical, as a matter of social justice, to recognize and address the health disparities that exist for all underserved communities (IOM Report on Health Disparities, 2002). This attention is also needed in order to promote linguistically and culturally appropriate health programs for those most in need to increase access to care and ultimately improve health outcomes.

Asian American and Pacific Islander (AAPI) women, in aggregate, are more likely to die from breast cancer than any other type of cancer, and certain AAPI ethnic groups have among the highest rates of cervical cancer in the United States. Between 1990 and 1995, there was a decrease in cancer incidence and mortality for all cancers combined in all racial groups, except for Asian American and Pacific Islander (AAPI) women. For these women, cancer incidence remained level while mortality rates increased for all major cancers (Wingo, Ries, Rosenberg, Miller, & Edwards, 1998). In fact, AAPI women are the only racial group with an overall increase in cancer mortality rates for all sites combined (except lung) between 1990 and 1999 (Edwards et al., 2002).

Aggregation of data for AAPI groups results in lower incidence and mortality rates of breast and cervical cancer and masks those AAPI subgroups that are most at risk. For example, a

local study disaggregated data by ethnicity and generation in the U.S. and found that breast cancer incidence rates among Japanese American women have increased the fastest out of all women in Los Angeles County (Deapen, Liu, Perkins, Bernstein, & Ross, 2002). Aggregate data on AAPIs also hide the fact that Native Hawaiian women have the second highest mortality rates from breast cancer in the nation, largely due to the fact that a greater percentage of these cancers are diagnosed at later stages (Miller et al., 1996). Research has also shown that the rate of cervical cancer for Vietnamese American women ages 55 to 65 is 10 times higher than white women of the same ages (Lam et al., 2003).

When examining breast and cervical cancer incidence and mortality, it is critical to discuss the rates of breast and cervical cancer screening as well, including Pap tests, mammograms, and clinical breast examinations (CBEs). AAPI women have the lowest screening rates among all other racial and ethnic populations in the country (American Cancer Society, 1998; Kagawa-Singer & Pourat, 2000). According to one study, only 25% of Chamorro women in California received yearly mammograms (Tanjasiri & Sablan-Santos, 2001). Other studies have found that only 51% of Hmong women surveyed had ever performed a BSE (Tanjasiri et al., 2001), and only 46% of American Samoan women had had a Pap smear within the past 3 years (Mishra et al., 2001).

Past research studies with AAPI communities have identified several cultural, linguistic, and socioeconomic barriers to receiving appropriate health care (Ro, 2002). Commonly identified cultural barriers that exist for most AAPI women include differing cultural values with respect to modesty and sexuality, being uncomfortable with a male provider, preference for traditional medicine, and fear of cancer. Structural barriers include lack of adequate medical insurance or financial resources, lack of transportation, lack of culturally appropriate services in the community, and lack of bilingual and bicultural providers (Jenkins & Kagawa-Singer, 1994). The CARE Program (A Community Approach to Responding Early to breast and cervical

cancer) was established to address these barriers, especially for those women who were low-income with limited English speaking abilities. CARE is one of the first national program models that provides culturally appropriate intervention strategies to promote breast and cervical cancer early detection and screening in multiple Asian American and Pacific Islander populations.

CARE Program Description

The CARE Program, funded by the Centers for Disease Control and Prevention, was based at the Association of Asian and Pacific Community Health Organizations (AAPCHO) in Oakland, California. AAPCHO is a national association advocating for the health needs of medically underserved Asian Americans and Pacific Islanders. The CARE program goal was to reduce breast and cervical cancer morbidity and mortality rates among AAPI women by improving the capacity of community-based health centers (CHCs) that serve these women to deliver effective, culturally and linguistically appropriate breast and cervical cancer screening programs. It was hypothesized that providing culturally tailored intervention programs would increase the number of women who practice regular breast and cervical cancer screening through breast-self examinations, clinical breast examinations, mammograms, Pap tests, and pelvic examinations.

The CARE Program partnered with six community health centers across diverse geographical regions to pilot the breast and cervical cancer screening program for 16 months from May 2000 through September 2001. Each participating CHC was selected for the CARE program because they already had a strong reputation and experience serving their respective communities and providing linguistically and culturally appropriate care:

- Asian Pacific Health Care Venture, Inc. (Los Angeles, CA) – Thai
- Family Health Center (Worcester, MA) – Cambodian
- Kalihi-Palama Health Center (Honolulu, HI) – Filipina

- Kokua Kalihi Valley Comprehensive Family Services (Honolulu, HI) – Samoan
- South Cove Community Health Center (Quincy, MA) – Chinese
- Waianae Coast Comprehensive Health Center (Waianae, HI) – Native Hawaiian

These sites specialized in providing quality care to low-income, uninsured, or underinsured members of their communities. The CARE Program also took into consideration that each CHC was at a different stage in their organizational capacity and varied in their resources and experiences in providing breast and cervical cancer care. AAPCHO sought to partner with these CHCs to build on their strengths and to document the efforts and strategies required to improve their capacity to address the breast and cervical cancer screening needs of their respective communities.

Theoretical Rationale

The CARE program utilized the Ecological model (Bronfenbrenner, 1979; Richard, Potvin, Kishchuk, & Green, 1996), Transtheoretical model (Prochaska, DiClemente, & Norcross, 1992), and the Form and Function framework to guide the conceptual and theoretical development and evaluation of intervention strategies. Details about the theoretical rationale and organizational capacity building processes for the CARE Program have been discussed in another paper (Rezai, Nguyen, Fu, & Kagawa-Singer, 2003). Given the diversity of each of the six AAPI communities involved in the CARE Program and the different stages of readiness for delivery of health care services, it was critical that each CHC culturally tailor their respective programs to take into consideration the unique needs and strengths of their communities. Cultural tailoring can be defined as the development of interventions with strategies, messages, mediums, and materials that directly address the cultural and environmental needs and resources of a community (Pasick, D'Onofrio, & Otero-Sabogal, 1996).

Each CHC worked in conjunction with their respective communities to develop breast and cervical cancer education programs that were similar in function, but culturally tailored in form. The CARE Program used a framework called “Form and Function” developed by Marjorie Kagawa-Singer, Ph.D., to better understand how the six partnering CHCs culturally tailored their breast and cervical cancer screening programs. *Functions* are common elements present in all cultures to achieve a particular aim (i.e., communicating a message, addressing access barriers, conducting inreach/outreach, etc.). *Forms* are the tailored strategies used to address the unique needs of cultural groups to accomplish the function. Such tailoring of the efforts or the format of the particular intervention makes the design of the program effort more acceptable to the community. The elements of the tailored intervention strategy answers the following questions for each targeted community: what is the purpose of the program? (message), who is the credible spokesperson? (messenger), when (timing) are the most appropriate and opportune times to present the information, and where (location) to conduct outreach for the most effective and efficient means to communicate the message (see Table 1). In other words, breast and cervical cancer programs for AAPI women may implement activities that accomplish the same function (e.g., educate women about cancer or reduce their barriers to getting screened), however the specific forms or ways in which these functions are best achieved will be unique for different communities. For example, to communicate an educational message, some women preferred to be educated one-on-one by medical providers in a clinical setting, while others preferred informal “talking” groups that occurred at familiar community sites. Still others were most receptive to learn about the issue through different forms of media such as radio, television, or newspaper ads.

Table 1
Form and Function Framework (Kagawa-Singer et al., 2002)

<i>FUNCTION</i> (similar across sites)	<i>FORM</i> (tailored to community)
Communicate a Message	Delivery Messenger
Conduct Outreach	Type Location
Use Educational Materials	Language Medium
Address Access Barriers	Primary Barriers

The case study of the of Kalihi-Palama Health Center’s (KPHC) CARE program is presented here to provide specific examples of cultural tailoring strategies developed by one community to more effectively reach an underserved ethnic group.

Kalihi-Palama Health Center: A Case Study of a Filipino Community in Hawaii
Background on KPHC

Kalihi-Palama Health Center (KPHC) is a community health center located in urban Honolulu, Hawaii (see Figure 1). KPHC serves

Kalihi-Palama, a low-income, inner-city community and a designated medical and dental Health Professional Shortage Area (HPSA). Within the densely populated district are seven public housing projects and a blend of apartments, single family/extended family homes, emergency shelters, industrial facilities, and small businesses. Kalihi-Palama is typically the first home for immigrants arriving in Honolulu. Of the more than 47,000 people in the Kalihi-Palama service area, 84% are Asians or Pacific Islanders and 72% are living at or below 200% of the federal poverty level.



Figure 1
Kalihi-Palama Health Center

Founded in 1975, KPHC's mission is to deliver health services to those who face barriers to health care such as having low income, lack of health insurance, unfamiliarity with Western medical practices, and little spoken English. Kalihi-Palama Health Center provides comprehensive primary care services to Kalihi-Palama residents and others in need of low-cost, linguistically accessible health care. Services include adult primary care, pediatrics, perinatal care including midwife-assisted deliveries, WIC (Federally funded Women, Infant and Children Nutrition Program), family planning and gynecological care, dental care, optometry, health education, behavioral health, and the

Health Care for the Homeless Project. Included in the medical care are clinical breast examinations and Papanicolau (Pap) screening tests.

In 2002, KPHC served over 16,000 patients. Eighty-percent of these patients were Asians or Pacific Islanders; 58% had an annual family income at or below 100% of the federal poverty level guidelines, and over half had no medical insurance. Many were immigrants or refugees, and more than one third of adult patients required an interpreter. Filipino patients were the largest single ethnic group served by KPHC (23% of all patients) (see Figure 2).



Figure 2
Filipino Patients at the Kalihi-Palama Health Center

Filipinas and Breast and Cervical Cancer

Since 1998, KPHC has collaborated with the Hawaii Breast and Cervical Cancer Control Project (BCCCP) by recruiting Filipino and Hawaiian patients for free mammograms and follow-up services provided by a local hospital. The Hawaii BCCCP works with Filipino and Hawaiian women because they have the highest breast and cervical cancer mortality ratios in Hawaii (Meng, Maskarinec, & Lee, 1997). In Hawaii, 22% of Filipino women had never had a clinical breast exam compared to the state average of 10.8% and the national average of 11.2%. In addition, 7.5% of Filipino women had never had a Pap smear compared to the 4.8% state average and 5.4% national average

(Hawaii Breast and Cervical Cancer Control Program, 1998).

Despite the availability of free, BCCCP-funded breast and cervical cancer screening exams, these services continue to be underutilized by Filipino and other eligible women over 50. The primary barrier to screening is the lack of bilingual, bicultural staff assigned to recruit women for screening. Other barriers to screening for Filipino women, identified via focus groups, key informant interviews, and by KPHC staff include: language barriers, lack of time due to multiple jobs, lack of family members or friends to accompany individuals to services, anxiety surrounding diagnostic screening results, and lack of transportation to

and from clinic sites. These barriers reflect both limited transportation options and a strong desire to have a family member accompany the patient to appointments for linguistic, cultural and emotional support. In many of Hawaii's Filipino families, especially in those who have recently immigrated, family members work at multiple low-paying service sector jobs and cannot afford to accompany relatives to non-urgent medical visits. In addition, many women are unable to make appointments for screening because they are the primary caretakers for their children or grandchildren and do not have the time to take care of their own health.

CARE Program Implementation

"Filipinas believe that the best person to 'educate' them would be another Filipina. They would have instant credibility and would be best at understanding the concerns of other Filipinas." (Hawaii Breast and Cervical Cancer Control Program, 1997)

In an attempt to reduce the breast and cervical cancer mortality rates of Filipino women, KPHC implemented a unique educational approach that involved hosting monthly Women's Health Education Parties and Group Clinics.

To plan an effective program, it was essential to first become knowledgeable about Filipino culture and values. An in-house Filipino Advisory Committee was convened that consisted of medical assistants, health educators, a nutritionist, and a nurse. The Advisory Committee recommended incorporating key cultural values and customs into recruitment methods, the curriculum, and the style of

interaction with participants. For example, the presentation style of the education sessions was organized in a group format to foster a social, party-like atmosphere and to create a familiar environment which would allow participants to get to know the project staff and each other in a non-threatening, non-medical setting. To establish rapport and trust, staff interacted with participants in a *karinosa* way. For Filipinos, being *karinosa* refers to the warm, caring, and affectionate manner that people connect with each other. This involves addressing Filipinas in a way that would make them feel comfortable, addressing them as *Nana* (Ilocano word to address an older woman) or *Ate* or *Manang* (Tagalog and Ilocano words which translates to older sister) or by Mrs. or Ms. Nonverbal communication in a *karinosa* way can include a touch on the shoulder or arm, or a hug at the end of a session. This conveys a message of support and comfort.

The Health Education Party participants were recruited via a number of different strategies, including: 1) Filipina bilingual recruiters (KPHC Medical Assistants) inviting women from the KPHC clinic waiting room; 2) referrals from KPHC and community medical providers; 3) using social networks to spread the word about the program; and 4) personalized invitations sent out to Filipino women over age 40 listed in the KPHC patient database (and followed by a call from KPHC staff). These personalized invitations were linguistically tailored for Filipinos by developing and translating a CARE program slogan into Tagalog, the national language of the Philippines (see Figure 3a and 3b).



Figure 3a
Personalized Invitation: Cover

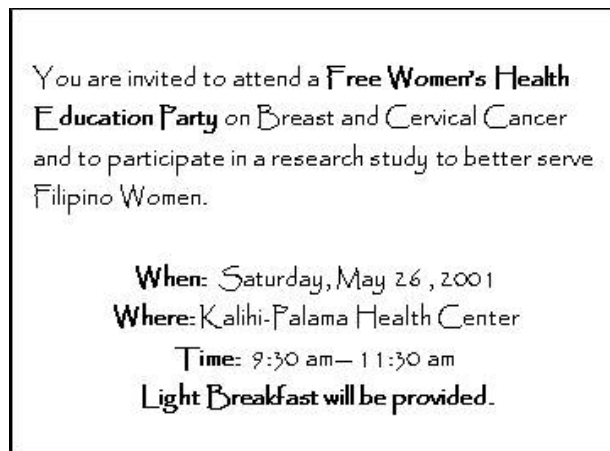


Figure 3b
Personalized Invitation: Inside

The Women's Health Education Parties and Group Clinics

"You may feel you are wasting time talking about other people and sundry matters, but to a Filipino, cultivating a friend, establishing a valuable contact, and developing personal rapport are what make business wheels run." (Roces & Roces, 1992)

The Women's Health Education Parties, consisting of between 10-15 participants, were approximately two to two and a half hours long and held at various venues in the community including KPHC, local churches, and local social service agencies. At the beginning of the Party, an icebreaker was used to get to know the participants. Three questions were asked: 1) What part of the Philippines are you from?; 2) How long have you lived in the U.S.?; and 3) How many children and grandchildren do you have? These questions allowed KPHC staff to get to know the participants and to establish rapport with them. Following this introduction, participants were asked to complete a breast and

cervical cancer knowledge, attitudes, and behavior survey, which was offered in three different languages, Tagalog, English, and a Philippine dialect, Ilocano. Bilingual and bicultural Filipina staff provided assistance for women who had difficulty in completing the CARE survey. For instance, more personalized one-on-one attention was devoted for women who did not understand the questions or were not literate. The second hour of the Party was dedicated to providing participants with information regarding the "Truth about Breast and Cervical Cancer." This session was conducted in *Itaglish*, a term coined by KPHC staff to describe a conversation conducted in a combination of English, Tagalog, and Ilocano. Women were taught about early detection, including clinical breast exams, mammograms, Pap tests, and breast self-exams (see Figure 4 and Figure 5). In order to encourage attendance of women who normally took care of their children or grandchildren, on-site childcare was offered free of charge (see Figure 6).



Figure 4
Women Receiving Instruction on Breast Self-Exams at
Kalihi-Palama Health Center



Figure 5
Women Practicing Breast Self-Exams at
Kalihi-Palama Health Center



Figure 6
Onsite Child Care Facility at Kalihi-Palama Health Center

This education was conducted in a culturally appropriate *talk story* (sharing of stories) manner to create a more comfortable and supportive environment. And of course, as in all Filipino gatherings, a *merienda* (light meal) was

provided at the end. The *merienda* included Filipino foods such as pancit, nice cakes, lumpia, and fresh fruit. As a gift of appreciation for their time and efforts, all participants who

attended the Health Education Parties also received a ten-dollar drugstore gift certificate.

To ensure that all women, despite financial barriers, had access to screening, KPHC partnered with local hospitals and the Hawaii BCCCP to provide free screening exams to eligible women (ages 50-64, uninsured or underinsured) in a Group Clinic format whereby a group of women would attend a clinic together to get their screening tests. Clinical breast exams, mammograms, and Pap tests were provided to all eligible participants from the Women's Health Education Parties via the BCCCP program. In addition, transportation to and from KPHC was also provided by the hospital's BCCCP Program.

During the Group Clinics, KPHC staff provided technical assistance in filling out forms, translating information, and providing moral support to participants. In addition, to ease patients' anxiety and long waiting periods, refreshments and a Filipino entertainment video (i.e. drama or popular movie) were provided. All participants received a free tote bag that contained the CARE Program slogan in Tagalog: "Kalihi-Palama Health Center: *Pangalagaan ang kalusugan ng mga kababaihan*" which in English means, "Kalihi-Palama Health Center: Taking Care of Women's Health" (see Figure 7).



Figure 7
Free Tote Bag Distributed by Kalihi-Palama Health Center

Program Results

In the nine months from December 2000 – August 2001, KPHC convened 11 Women's Health Education Parties and reached a total of 118 women. Over 500 personalized invitations were sent out to KPHC patients (approximately 40-50 invitations per party) to promote the Women's Health Education Parties. In addition, seven Group Clinics were held with a total of 34 women receiving at least one or all of the following services: mammograms, Pap smears, and clinical breast exams. Many of the

participants who attended the Group Clinics had not responded to standard care, as evidenced by the fact that they had not accessed cancer screening exams for over 3 years, and in some cases, had never had these exams. Currently, the Women's Health Education Parties and Group Clinics continue to be provided with funding coming from federal and local sources.

One example of the positive effects of the program is shown by the case of a woman we call Ms. A. Ms. A was an elderly Filipino

woman who visited her doctor at Kalihi-Palama Health Center for a routine health check-up. After reviewing her chart, the doctor realized Ms. A had never had a mammogram. The doctor educated Ms. A about the importance of an annual mammogram and referred her to a local hospital. Unfortunately, Ms. A insisted that she did not need a mammogram. She said with conviction to her doctor, "I feel fine. I do not want a mammogram!" The next day, the doctor's medical assistant called Ms. A and invited her to a special "Health Party" for Filipino women. She decided, hesitantly, to attend the party and bring along a friend.

Upon arrival to the party, Ms. A walked into the room full of participants and stated adamantly to the health educators that she was only there to see "what this party is all about" and that she was not there to get a mammogram. The health educators encouraged her to stay and told her that the final decision whether to get a

mammogram was ultimately hers to make. Through the course of the party, Ms. A asked several questions regarding the importance of receiving mammograms and Pap smears. She even challenged the health educators, testing their knowledge on the subject matter. Fortunately, Ms. A liked the young health educators, who reminded her of her daughters. At the end of the "party," Ms. A, along with her friend, decided to attend the Group Clinic with other Filipino women. Although they were both nervous, they both attended the Group Clinic and Ms. A received a mammogram for the first time in her life. In the end, Ms. A told the health educators, "That was not so bad. *Anak* (Daughter), please call me the next time you go again."

The tailoring of the efforts of the KPHC staff are summarized in Table 2 of the Form and Function Framework.

Table 2
KPHC Implementation of Form and Function Framework

Function	Form
Communicate a Message	Bilingual/Bicultural Community Health Outreach Workers
Conduct Outreach	Group Health Education "Parties" at Community Health Center
Use Educational Materials	"Itaglish" verbal communication and Tagalog written materials with culturally meaningful symbols and colors
Address Access Barriers	Bilingual and Bicultural Navigators/Community Health Outreach Workers; Provide child care & transportation services for Group Health Education Parties & Group Clinics

Program Limitations and Challenges

Although the strategies of Health Education Parties and Group Clinics were successful in reaching Filipinas in the Kalihi-Palama area, several challenges were faced by KPHC staff in implementing the CARE program. Challenges included devoting significant time and effort for inreach and recruitment efforts, handling clinic no-shows, and providing case management services to ensure that women receiving abnormal screening results returned for

diagnostic or treatment services. All of these challenges increased the amount of staff labor and implementation time needed to ensure the program's success. Despite the challenges, the results were worth the effort because KPHC staff were able to reach a group of women who were not responding to standard care, as illustrated by the example of Ms. A above.

In response to some of the program limitations and challenges, the following recommendations

were developed for future programs with Filipino communities in Hawaii.

Recommendations for Community and Patient Recruitment

Ms. Minerva Falcon, Former Philippine Consulate General of Hawaii, was interviewed as a key community leader. She noted: "Look through the local Philippine Newspapers and look at the calendar of events. Take some money out of your budget and attend these events so that you can be visible within the community. That is the best way to reach them (Filipino women)."

1. **Be visible:** Take the time to network within the Filipino American community. Program staff should introduce themselves and the program to community leaders and health care providers. Consider attending community events and social gatherings in order to heighten awareness of the program and establish program staff as the "people" behind the project.
2. **Access community resources and social networks:** Identify, involve and motivate possible groups associated with the target population (e.g., Philippine Medical Association, Philippine Nurses Association). Utilize health care providers, community contacts, front line staff workers with access to ethnic community contacts and social networks, and past program participants to recruit new clients.
3. **Offer incentives for recruiters:** Recruiters are likely to be busy health workers or community residents who are volunteering their time because they believe in the goals of the program and/or have a past working relationship with the program staff. Possible "appreciation" incentives such as lunches, gift certificates, recognition, social support, etc should be offered as small compensations for the recruiters' time and efforts.

Recommendations for Educational Sessions

"Filipinos have a tendency to relate to persons rather than to agencies or institutions. For example, Filipino clients prefer to go to a clinic or hospital where they know at least some staff

members." (Tompar-Tiu & Sustento-Seneriches, 1995).

1. **Provide refreshments:** Traditionally, when visiting Filipinos in their homes, guests are always served something to eat and drink. In order to create a comfortable and culturally acceptable environment, serving refreshments at educational sessions is a must.
2. **Conduct sessions in a group setting:** Learning in a group setting gives women an opportunity to share their experiences and support one another through "talk story" approaches.
3. **Create a warm and friendly environment:** Creating a safe and warm environment (as one would do for honored guests in one's own home) will make it easier for women to share their experiences and provides opportunities for establishing rapport with clients.
4. **Establish rapport and trust:** As mentioned in the quote above, Filipinos tend to relate to persons rather than to agencies or institutions. Employing and training staff who have the skills to establish rapport and trust in culturally credible, respectful, and responsible ways with the community and clients will make participants more receptive to the program.

Discussion and Conclusions

As demonstrated by this case study of a Filipino community in Hawaii, implementation of a culturally tailored breast and cervical cancer screening program had many positive effects. Using their community strengths and resources, KPHC was able to overcome program limitations and challenges to deliver culturally appropriate health care services to an underserved community that had been unresponsive to "standard" outreach and education efforts in the past.

Findings from the CARE program demonstrated that in working with six diverse community health centers with varying barriers and strengths for cancer screening services, it was critical to recognize and account for these cultural differences by tailoring programs

according to the organizational capacities and unique needs and resources present in the different communities. No one model would adequately address the varying needs and resources in the heterogeneous AAPI communities, and so programs and services needed to be tailored to be consonant with the multiple ecological factors affecting cancer screening in the target communities. One key finding that was universal across the six sites was the importance of developing trust and interpersonal relationships and partnerships between community members and their providers of care to increase cancer screening. Using Kagawa-Singer's Form and Function Framework, results showed that the supportive "function" of trust was the same across all six sites. However, the specific "form" or strategies used to build trust varied from community to community (Rezai, Nguyen, Fu, & Kagawa-Singer, 2003).

This paper detailed the work of one of the sites involved in the CARE program: Kalihi-Palama Health Center. By presenting this case study,

we described the specific "forms" used by this site to establish trust in a Filipino community in Hawaii and the strategies used to tailor their breast and cervical screening services to the needs and resources of the target community.

This paper is the first of many additional articles on case studies of the other health centers and communities involved in the CARE program (in fact, this paper is directly adapted from a case study monograph which was written by staff from each of the six CARE program sites) (AAPCHO, 2002). By learning about the diverse, culturally tailored forms and strategies used by these communities, we can better understand the differences and similarities across different AAPI cultures and develop recommendations for future work with these communities. Thus, additional studies on culturally and linguistically appropriate breast and cervical cancer programs are needed to more effectively design and evaluate successful health care programs for diverse and multicultural Asian American and Pacific Islander communities.

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