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TO CERVICAL CANCER
SCREENING IN LATINA
AND VIETNAMESE WOMEN
OUTCOME ANALYSIS

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Perez, Robin Z., A Faith Based Approach to Cervical Cancer Screening in Latina and Vietnamese Women: Outcome Analysis. Master of Public Health (Health Management and Policy), May 2005, 34pp., 4 tables, 3 illustrations, bibliography, 26 titles.

A secondary data analysis study of the cervical cancer screening collaboration hosted by the St. Joseph Health Care Trust through six area Catholic churches was conducted to describe a program that has been recognized as a “best practice” for serving minority communities in Texas. The objectives of the study were to list demographic characteristics associated with the screening participants; to review culturally sensitive programming and approaches to serving both Latina and Vietnamese women.

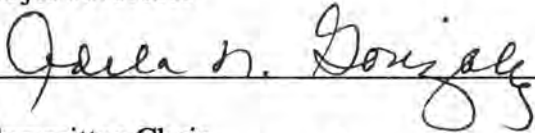
The results of the study will assist in implementation of similar interventions. The conclusions demonstrate that interventions that are tailored to specific communities may influence program participants and increase screening turnout.

A FAITH BASED APPROACH TO CERVICAL CANCER SCREENING IN LATINA
AND VIETNAMESE WOMEN
OUTCOME ANALYSIS

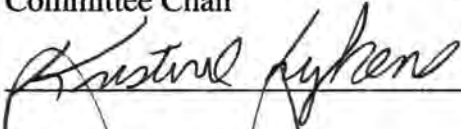
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Major Professor



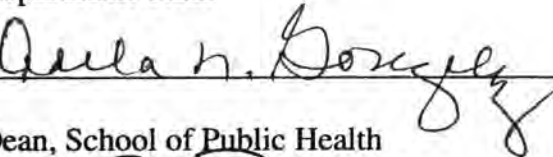
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Department Chair



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A FAITH BASED APPROACH TO CERVICAL CANCER SCREENING IN
LATINA AND VIETNAMESE WOMEN
OUTCOME ANALYSIS

THESIS

Presented to the School of Public Health
University of North Texas
Health Science Center at Fort Worth
in Partial Fulfillment of the Requirements

For the Degree of
Master of Public Health
By
Robin Zamora Perez, B.S.
Fort Worth, Texas
May 2005

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CHAPTER I

INTRODUCTION

Cervical cancer is the third most common gynecological cancer among women in the United States. For the year 2005, the American Cancer Society has predicted that 10,370 new cases of invasive cervical cancer will develop and that 3,710 women will die as a result of cervical cancer. In the past 50 years, cervical cancer mortality has declined almost 70 percent due to the development of the Pap smear technique, which made its debut into western medicine protocol in 1943 (Saslow et al., 2002).

While advancements have been made to prevent and detect cervical cancer in its earliest stages, there is still a disproportionate rate that persists in minority women. Cervical cancer incidence rates in Vietnamese women are five times higher than the rates among American white women (ACS, 2004). In addition Hispanic women had the highest invasive cervical cancer incidence rates of any other group other than Vietnamese, and twice the incidence of non-Hispanic white women (ACS, 2004).

Significance of the problem

Cervical cancer is an excellent example of a disease for which disparities could be overcome, because it is easily detected, the means for detection are inexpensive, and treatment is effective if the disease is detected in early stages (Bradley, Given, & Roberts,

2004). Low income, ethnic minority women are less likely not only to receive routine screening but also to optimally adhere to follow-up visits after abnormal test results. (Coughlin & Uhler, 2002). The importance of culturally competent health programming targeted to underserved communities, specifically the Latina and Vietnamese communities in Tarrant and surrounding counties is an underlying issue in this research. By combining a familiar setting and appropriate cancer information, the researcher is hopeful that this faith-based approach will prove to be worthy of the recognition it has recently received as the recipient of the 2004 Harold P. Freeman Award. An analysis will be used to determine the effect of this community collaborative project. The results of this study will measure whether the program is reaching under-served women.

The St. Joseph Health Care trust was founded after the sale of the St. Joseph Hospital in Fort Worth. The trust fund is available to low-income Catholic churches within the Fort Worth Diocese. The trust fund offers a variety of health services which include flu shots, prescription drug, financial assistance, and various health screenings provided free of charge to the church community. For the purposes of this study, the research will focus on the area of early detection of cervical cancer within the Hispanic and Vietnamese church community.

Statement of the Problem

The purpose of this study is to examine secondary data from six cancer screening clinics coordinated by the St. Joseph Health Care Trust for women to receive cancer-screening services. Therefore, the problem to which this proposal is directed will describe demographic data and types of exams given to the target population to highlight

a program that has been recognized as a “best practice” for serving minority communities in Texas.

While a large part of this research will expand on the importance of culturally appropriate interventions, other factors such as the accessibility and availability of the screening mechanisms for diagnosing cervical cancer will also be discussed. The underlying cost of providing cervical cancer screening will be also be included since it is common knowledge that the Pap smear is a relatively low cost to incur as opposed to treating cervical cancer. The core concern of this research is the lack of health education that has led to the current statistics regarding both Vietnamese and Latina women as they relate to cervical cancer incidence and mortality. New studies conclude that cervical cancer continues to be a more serious threat to women with low income and education levels (Singh, Miller, Hankey, & Edwards, 2004). In addition, data from the Tarrant county community health report will be included in comparison.

Research Question

Is the St. Joseph Health Care Trust program successful in bringing information and education to under-served women in Tarrant County, particularly Vietnamese and Latina women. What details are attributed to the implementation of culturally appropriate programs?

Definition of Terms

Cervical cancer refers to the growth of abnormal cells within the epithelium of the cervix, often times referred to as dysplasia. There are two types of cervical cancer cells

which include: squamous cells and adenocarcinomas. Although many women do not experience symptoms in the early stages of cervical cancer, unexpected bleeding, increased vaginal discharge and pelvic pain are symptoms that may occur. Important to note is that these symptoms are not exclusive to cervical cancer. While sexually transmitted diseases (STD) can exhibit similar symptoms, one STD in particular has been closely linked to cervical cancer. Human Papilloma virus (HPV) is a sexual transmitted and has been identified in 90% - 100% of cervical cancer lesions (Reynolds, 2004).

Pap smear: The collection of living cells from the surface of the cervix, which are examined for abnormalities.

Culture: refers to the values, ideals and belief systems that emerge overtime among a group of individuals

Ethnicity: refers to the commonality among a group stemming from a shared history

Acculturation: refers to the process by which one culture adopts the characteristics of another as a result of continuous contact.

Cultural Competency: defined by the National Alliance for Hispanic Health as, acknowledging and incorporating the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics that can result from cultural differences and ethnocentric approaches, the expansion of cultural knowledge, and the adaptation of services that meet culturally-unique needs

Assumptions and Limitations

All subjects screened through the St. Joseph Health Care Trust collaboration during the six-month period from January 1, 2004 through November 30, 2004 will be included in the study. The anticipated number of subjects is approximately 1,000. Subjects will include patients 18 years of age and older. Children will be excluded because they cannot participate in cervical cancer screening.

CHAPTER II

REVIEW OF LITERATURE

Cancer is a major public health problem in the United States affecting all segments of the population. In 1971, President Nixon declared the “War on Cancer” and numerous strides have been accomplished in the areas of prevention, early detection, treatment and quality of life. However, if the tools that we have to detect cancer early are not being utilized, and knowledge of cancer screening guidelines are not reaching all segments of the population, the results are later stage diagnosis and minimal treatment options. While disparities in cancer incidence, mortality, treatment and prevention continue to persist; ethnic minorities continue to face unique barriers. “The barriers to cancer screening are multifactorial, but much of the responsibility for change must lie with healthcare providers and the health delivery industry” (Womedu & Bailey, 1996, p. 120). This literature review provides an evaluation of several journal entries that substantiate the underutilization of cancer screening among ethnic minorities. In addition, the review also expounds on the needs of culturally appropriate programming, current interventions and behavioral theories as well as their impact on the respective communities.

Compliance & Access to Screenings

Inequalities in income and education underlie many health disparities in the United States. Income and education are intrinsically related and often serve as proxy measures for each other (Healthy People 2010). Several studies have been completed that have established the relationship between racial differences and cancer incidence and mortality. Compared with Anglo counterparts, Latinos more frequently are poor, lack health insurance, have fewer years of formal education, and have higher unemployment rates, all of which contribute in inadequate medical care for this population (Aguirre-Molina, Molina, Zambrana, 2001). The lack of health insurance is clearly an important factor in access and compliance to cancer screening services. An analysis of data collected from the 1998 National Health Interview Survey (NHIS) combined with detailed in-person interviews substantiated that having a usual source of care was the most important predictor of cancer screening use for all racial/ ethnicity groups included in the study (Selvin & Brett, 2003). Important to note is that while it is evident that a source of care is imperative as it correlates to cancer screening, an underlying factor is that having a culturally sensitive provider would be even more beneficial. Traditionally, many ethnic minorities have experienced inferior care due to language barriers and culturally incompetent care. Therefore, mistrust exists and health interventions should work to address and overcome this issue.

In a another report, researchers at the Department of Epidemiology, Public Health and Florida Cancer Data System at the University of Miami School of Medicine, presented cancer incidence and mortality data for South Florida's Hispanic women. The

Faith Based Approach

In accordance with the Healthy People 2010 guidelines, as well as suggestions from the National Cancer Institute's Center for Population Health and Health Disparities, health care educators should continue to find new and innovative ways to educate their respective communities through interventions that are culturally appropriate.

Traditionally, churches are at the center of a community. They offer fellowship and support for spiritual growth among other things. Several studies have shown a positive link between the religion and health initiatives. Historically, churches are associated with healing and the notion of uniting the two in the modern era seems to be a returning to the root. Among minority underserved women, strong social networks (i.e., church groups) can have positive effects on cancer screening rates (Suarez, et al. 2000).

Culturally Sensitive Interventions

In conducting this literature review, the researcher found several studies that maintained the discrepancy between ethnic minority women and their Anglo counterparts. While there is a gradual increase in studies focused on Hispanic/Latina women and the subgroups within this population, there are a limited number of studies that have focused on Vietnamese women in the United States. In 2000, large population based epidemiological studies with sample sizes of more than 1,000 participants did not exist for even the larger Asian groups (Eisler & Hersen, 2000). The Asian American population is expected to increase to 20 million by 2020 and has become increasingly foreign born in character (Eisler & Hersen, 2000). In 1996, the Association of Asian Pacific Community Health Organizations maintained that the lack of linguistically and

cultural competent health services was the most common reason as to why communities did not seek additional health information and services. In 1995 the Commonwealth Fund conducted a national survey that reported 47% of the Vietnamese group who had visited the doctor in the last year did not receive preventive care services such as a pap test compared to Anglo adults. "Despite their growing risk, Asian-American and Pacific Islander women have the lowest screening rates of all ethnic groups in the U.S., and the population has gotten the least attention of all ethnic populations in cancer control research studies and targeted intervention programs by the U.S. government, according to some researchers" (Kagawa-Singer & Pourat, 2000, p. 2). This section of the review highlights issues that pertain to culturally sensitive interventions and the lack thereof. Researchers at the Fred Hutchinson Cancer Research Center and Departments of Epidemiology and Health Services at the University of Washington in Seattle have analyzed the accuracy of methods to ascertain Hispanic ethnicity, focusing on possible misclassification of patients within cancer registries. To assign ethnic identity, the North American Association of Central Cancer Registries standards use stated ethnicity in medical records, stated ethnicity on death certificates, birthplace, information on life history, language spoken and last name or maiden name appearing on a list of Spanish surnames (Coronado et. al., 2002, pp. 979). If this information is not available, codes are provided to record computed ethnicity. Methods for determining registry protocols were conducted via telephone inquiries to representatives from cancer registries in six states that have a high proportion of Hispanics (Texas, California, New York, Florida, Illinois, and New Mexico). In conclusion, recommendations are to require self reported ethnicity

information on medical records, standardizing methods for obtaining ethnic identity and providing extensive training for registrars (Coronado et. al., 2002).

Although this study is not specific to screening practices, it is an important piece to include because of the relevance of collecting accurate data exclusive to the target population. The usage of Spanish/Vietnamese surnames as an ethnic identifier is one example of overlooking a significant concern. Just as Spanish/Vietnamese language literacy levels are often times excused, this is another area that is in the same category providing a case that additional research needs to be considered.

In 2000, researchers in Texas analyzed the association between social networks and cancer screening practices. The Department of Disease Control and Prevention, Texas Department of Health, The Baylor College of Medicine, The University of Texas Health Science Center in San Antonio, and the University of Texas Houston Health Science Center are just a few of the institutions represented in this investigation. Researchers used telephone surveys to collect data in eight U.S. regions and used logistic regression to estimate the effects of social integration on screening, adjusting for sociodemographic factors. Instruments used to conduct the survey were translated and back translated using well-established methods to ensure accuracy and wording that was appropriate. Language acculturation was measured with a modified Cuellar scale. In addition, a social network index was formulated. Results concluded that social integration had a strong significant effect (Odds Ratio of 1.44) of Mexican American Women, but was also evident in Central American and Cuban women (OR 1.22, 1.25 respectively) (Suarez et al., 2000). There was no significance among Puerto Rican

women for Pap smears or mammograms. "To women who are undereducated and without ready access to health care services or health information, informal support networks may be particularly crucial, providing the only means for receiving information about cancer screening" (Suarez et al., 2000).

Again, the issue of subgroups within a population is addressed with an emphasis on acculturation issues. Independent of socioeconomic factors, social integration appears to influence cancer-screening participation in Hispanics (Suarez et al. 2000).

Perhaps one of the most significant cultural factors affecting access to health care is communication, or language. Several studies focusing on minority communities clearly demonstrate the effect language had on access to health care as well as inequality in health care delivery.

One example of an intervention that is specific to the Spanish speaking community is the Cuidando su Salud program. Authors Huerta and Weed, researchers at Washington Cancer Institute and the National Cancer Institute, comment on the usefulness of a Spanish-language radio show as an avenue for both preventive and public health messaging. Goals of this program are to reach the estimated 2.6 million undocumented Hispanics living and working in the United States (Edward Fernandez, Office of Demographic Analysis, U.S. Bureau of the Census) and the 49% of Spanish speaking people in the U.S. who do not speak English well or at all (U.S. Bureau of the Census). Research takes into account Hispanics above 65 years of age that may be isolated linguistically. Cuidando su Salud has been broadcasted since December 1989 on one of two Washington DC area Spanish radio stations. Programs last for 2 minutes and

air three times a day inserted into the news segments, which feature stories from several Latin countries. Material from recent medical literature is summarized and translated into broadcast Spanish before it is adapted to a sixth-grade literacy level. Regionalisms and slang are avoided in order to clearly communicate to the broad Spanish speaking population. Individual show topics were categorized into Healthy People 2000 priorities to demonstrate the spectrum of health messaging. Every year in October the show focused on Breast Cancer Month airing 22 different breast cancer programs. In efforts to increase screening participation at a Maryland Breast and Cervical Cancer Program, 44% of the 655 women screened were Hispanic and a third of the women claimed they heard about the screening via *Cuidando su Salud* (Huerta & Weed, 1998). Other campaigns have included recruitment for the Breast Cancer Prevention Trial. Prior to radio promotion, no Hispanic women had been recruited at the Washington Cancer Institute clinical trial site. In a 3-week period, 300 Hispanic women were recruited for the trial.

While a systematic evaluation of the impact of the show has not been attempted, the authors demonstrated an example of how to provide daily health promotion messages to this growing population. If anything, this article proves that an ethnic-oriented media market does exist and can provide an avenue for needed health information.

Behavior Theories

In researching cervical cancer screening rates among minority women, the constructs of the Health Belief Model are helpful in forming attributes as to the perceived barriers (Austin, McNally & Stewart, 2002). The Health Belief Model attempts to predict preventive health actions based on health belief patterns. Cultural differences in

knowledge and beliefs about cancer can play a role in determining whether individuals avoid exposure to cancer risk factors and whether they seek cancer screening (Eisler & Hersen, 2000). Fatalistic attitudes, fear of cancer, embarrassment, and limited English ability seem to account for underutilization of cancer screening within certain Latina groups. Many studies have identified positive cues to action, which include: physician recommendation, lay health workers, and written materials and media campaigns. However, even with knowledge of health concerns, individuals must believe in the medical system in order to adhere to recommendations. This can often be difficult when minority communities experience negative interactions and mistrust the medical system.

Researchers at the University of Houston, School of Public Health, The University of Texas M.D. Anderson Cancer Center, and the Cesar Chavez Institute for Public Policy at San Francisco State University, examined the beliefs, attitudes, and personal characteristics that correlated with self-reported cervical cancer screening. Researchers conducted a cross-sectional; face-to-face survey of Hispanic women aged 18-25 living in El Paso, TX. Scales were developed based on Health Belief Model constructs and acculturation was measured using the Balcazar General Acculturation Index. Most of the women in the study were Spanish speaking or spoke both English and Spanish, and the majority of the women were high school graduates. In general, respondents seemed to understand their susceptibility to cervical cancer. Barriers identified indicated embarrassment (39%), pain (32%), and other, thinking a young woman might be engaging in sexual activity (32%). The most highly acculturated

women are almost 5 times as likely to have a Pap test compared to those in the lowest acculturation group (Byrd, Peterson, Chavez & Heckert, 2003).

In a similar study, researchers at the Baylor College of Medicine in Houston, conducted a randomized controlled trial to examine whether a personalized form letter or a personalized tailored letter would better prompt women to schedule a screening appointment for either a mammogram or a Pap smear. Specific to this study, the personalized form letter consisted of general cancer information. The personalized tailored letter contained individual risk factor information based on the patient's medical record. Subjects for this research project included patients from two urban health centers in Houston, TX. In addition, six focus groups were created for three ethnic groups (African American, Mexican-American, and non-Hispanic white) to discern cancer knowledge, attitudes and practices among their respective community. Letters were available in both English and Spanish and produced a sixth grade literacy level. Findings suggested that using personalized tailored letters that contain specific cancer risk factors may actually decrease the likelihood of obtaining a cancer screening among disadvantaged women (Jibaja-Weiss, Volk, Kingery, Smith, & Holcomb, 2003). A possible explanation may lie in the perceptions that the letter was too alarming. Another possibility is that the women may have received screening from another health facility. Further research is recommended to determine if additional cancer risk information may be beneficial.

This study proves to be a diligent effort in reaching low-income and minority women; however there were limitations to the research. The article may actually prompt other researchers to develop a tool that may produce a stronger positive association. The methodology component of this study is of particular interest because it is inclusive of participant ideals and it analyzes the need for appropriate literacy guidelines. Overall, although the study did not generate significant differences in screening practices among the sample, it did review the necessary steps for additional research. It also addressed the trust factor and the value of face-to-face interaction in specific communities.

CHAPTER III

METHODOLOGY

Program Description

The vision of the St. Joseph Health Care Trust is to continue the ministry of the St. Joseph Hospital in providing health care for those who cannot afford services. To address the need of the under-served church community, the American Cancer Society (ACS) has partnered with the St. Joseph Health Care Trust and Harris Methodist Hospitals to conduct ongoing breast and cervical cancer screening projects in the Hispanic/Latina and Vietnamese communities through their respective church. At each event, women are educated by ACS trained volunteers on breast and cervical cancer and the importance of early detection and screening guidelines. After the initial education session, women are taken to the mobile unit to receive either a mammogram or Pap test, or both. In the event that additional screening is necessary, volunteers counsel the women on the next appropriate action to be taken, refer them to a treatment facility, and assist in navigating the system to ensure they receive the help they need.

The Harris Methodist mobile unit has visited churches in the past, however not to the capacity that the collaboration with the St. Joseph Health Care Trust has provided. According to program coordinators of both Harris Hospital and St. Joseph Health Care Trust the collaboration between the two entities is unique in that the trust factor is present

with the community, the need is being met and finally the vehicle to reach the underserved community is present through the program.

Every year more and more screenings and services are provided with the influx of participants and the St. Joseph Health Care Trust continues to work for additional funding specific to cancer screenings through the Susan G. Komen Foundation and the Harris Methodist Foundation. There is no fee to patrons who receive the screening and education. A variety of screenings were offered, which included cervical cancer screening, mammography, colon cancer screening, prostate cancer screening, and skin cancer screening.

Through collaborative efforts the St. Joseph Health care Trust, an effective outreach initiative has been implemented. During the months of February through June 2004, screening events took place at St. Matthew's Catholic Church in Arlington, Holy Name Catholic Church in Fort Worth, Our Lady of Guadalupe Catholic Church in Fort Worth, San Mateo Catholic Church in Fort Worth, Vietnamese Martyrs Catholic Church in Arlington, and Christ the King Catholic Church in Fort Worth. Combined, these churches hosted 522 cervical cancer screenings provided to high-risk women.

Protection of Human Subjects

The approval to conduct this study was granted from the Institutional Review Board of the University of North Texas Health Science Center. Because this study used data from a secondary source, it did not require a consensus form, and was therefore classified as exempt.

Measurement

The instruments used in this study include: Records obtained through the St. Joseph Health Care Trust – Program Coordinator and a facilitator evaluation. None of the data obtained had identifiers.

The data for this study was collected through the St. Joseph Health Care Trust health coordinator at programs conducted at participating churches during the year 2004 in Tarrant County.

Our Lady of Guadalupe	Fort Worth, TX
Christ the King	Fort Worth, TX
Holy Name	Fort Worth, TX
San Matthew	Fort Worth, TX
Vietnamese Martyrs	Arlington, TX
San Mateo	Arlington, TX

This research project is a process evaluation of the of the St. Joseph Health Care Trust program as it relates to cultural factors and success of the program. Qualitative information was obtained for a descriptive study through face-to-face interviews with St. Joseph Health Care Trust facilitators. Through the evaluation, the researcher was able to account for results of the cancer-screening program using methods that are useful,

feasible, and accurate. Process evaluation data can be used to monitor and document an initiative, identify needs, and generally contribute to program improvement over time.

Facilitator Evaluation

February 10, 2005

How do you feel this program has impacted the community?

Underserved, undocumented and uninsured women would not otherwise receive the care needed if not for this program. Even at a reduced rate from other community resources, most clients cannot pay for the service.

In every consecutive year, does turnout to screening increase?

Definitely. Word of mouth is very powerful and care and education provided at each site encourages women to return and refer friends and family members.

Do you feel that participants encourage other friends and family members to be screened through this project? Yes. Because of the awareness and education provided for each client, they tend to share the information and awareness with others.

How is this program marketed through the church locations? Weekly announcements are placed in the bulletins. Verbal announcements are made from the pulpit at each mass and posters are placed in bathrooms and hallways to remind women to sign up.

Has it appeared in bulletins? Yes weekly.

Do you feel this program is evidence of trusting relationship with the church? If we did not have a good relationship with our churches, collaboration would not be possible.

Have people viewed persons related to screenings as point persons for other health issues? Because of the bond they establish with us, they tend to feel comfortable in asking questions about other health related issues.

What are the results of this project in your own words? Women who had abnormal results receive the help needed to resolve the issue. Education is the key element in keeping women healthy.

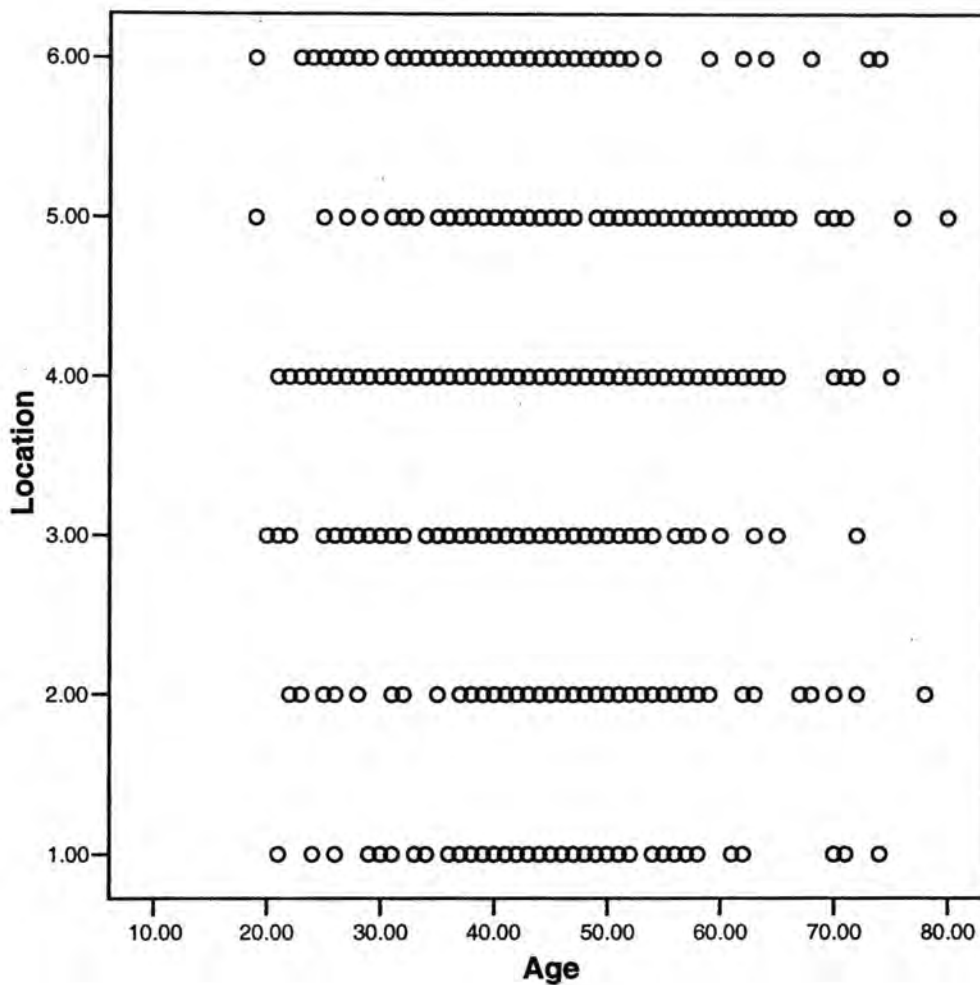
What follow-up is done? Referral to the proper medical doctor for further evaluation and medication are done for each participant.

Describe the process of a participant. Participant makes a call for sign up. Screening takes place to see if that person is a good candidate and the appointment is done. After the screening; if the results are okay, client receives a copy of results. If abnormal results are determined, referrals are made.

Anything else you would like to add? This program has helped so many women that did not believe that screenings were important. We have made a difference in many lives and have caught infections early enough to treat them without further complications.

Illustration 1

Age Range for all cancer screenings through St. Joseph Healthcare Trust collaboration



Statistical Analysis

A database was created to in Statistical Packages for Social Sciences (SPSS). The database contained variables based on age of participant, zip code of participant, ethnicity, screening obtained, and location of screening. The statistical analysis will be a chi-square test on data collected through the screening process. Chi square test can be

used when the data are nominal or categorical. In addition, descriptive statistics will also be presented in the results of study.

CHAPTER IV

RESULTS

This study was designed based on a secondary data analysis that included a process evaluation. The data was analyzed through descriptive and inferential statistical procedures. The hypothesis and the respective findings will be discussed in this chapter.

Description of Sample

A sample of 1091 participants from six church programs, were examined. Participants' age ranged from 19 to 78 years of age with a mean age of 45 and a standard deviation of 10 (see Table 1). St. Matthew had the highest percentage of participants (27.2%) followed by Holy Name (19.4%), Vietnamese Martyrs (16.7%), Christ the King (13.7%) Our Lady of Guadalupe (11.7%) and San Mateo (11%) as can be viewed in Table 2.

All participants were qualified as low income, meaning that they are classified as having a household income 2% below poverty level. A weighted average poverty threshold in 2003 for a family size of four was \$18,810.00 as calculated by the U.S Census Bureau. The ethnicity of screening participants for cervical cancer screening was 370 Hispanic/Latina women and 155 Asian/Vietnamese women (Table 3).

TABLE 1

Statistics

Age		
N	Valid	1089
	Missing	2
Mean		45.0799
Std. Deviation		10.19939

Illustration 2

Number of participants by church location

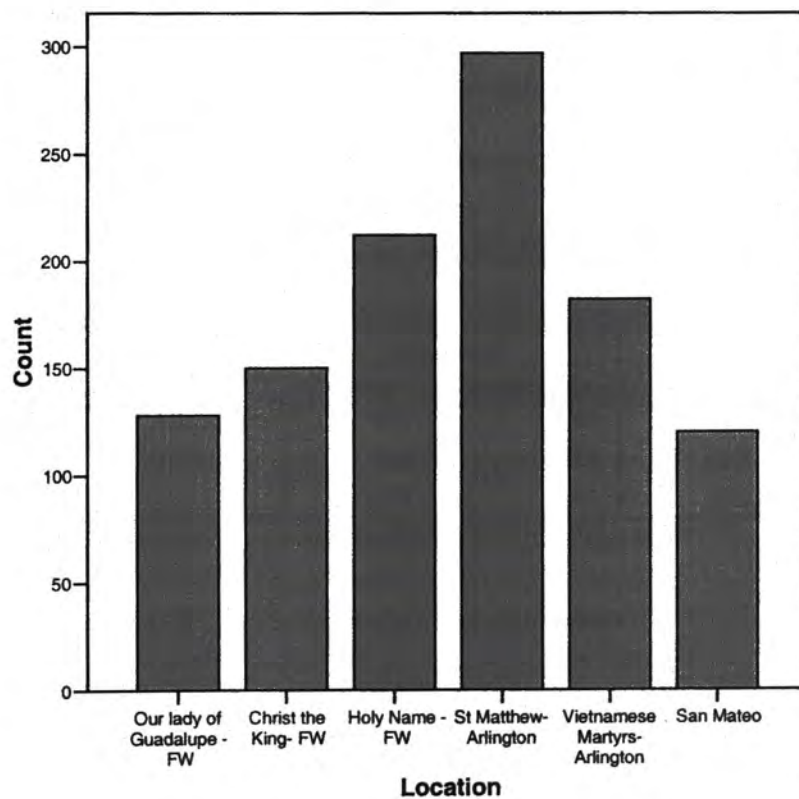


TABLE 2

		Location			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Our lady of Guadalupe - FW	128	11.7	11.8	11.8
	Christ the King- FW	150	13.7	13.8	25.5
	Holy Name - FW	212	19.4	19.5	45.0
	St Matthew-Arlington	297	27.2	27.3	72.3
	Vietnamese Martyrs-Arlington	182	16.7	16.7	89.0
	San Mateo	120	11.0	11.0	100.0
	Total	1089	99.8	100.0	
Missing	System	2	.2		
Total		1091	100.0		

TABLE 3

Ethnicity * Screening Crosstabulation

Count		Screening		Total
		Cervical	Mammogram	
Ethnicity	Hispanic	370	341	711
	Asian	152	121	273
Total		522	462	984

Findings

In conducting the process evaluation, the researcher was able to analyze the facilitator's remarks on the program and its development. The responses given by the facilitator were very positive and assist in establishing a constructive outlook of the cervical cancer-screening project. Throughout the evaluation, the facilitator reiterates the uniqueness of the program in that it is serving a segment of the population that would otherwise be excluded. It is evident that social networks play a significant role in increasing screening turnout. In addition, the location of the screening aids in bringing attention to health issues and behaviors. The St. Joseph Health Care Trust collaboration seems to be a program that creates a rapport with participants taking in to account the sensitivity of the issue. Based on the findings, both groups (Hispanic/Latina & Vietnamese) seem to benefit from this intervention.

Results from the chi square test do not demonstrate a significant difference. In comparing the data from this study with data from the Tarrant County Community Health Report (Appendix A), the program is consistent for meeting needs in zip codes which have been classified as linguistically isolated. In addition, based on statistics from the National Cancer Institute SEER (Appendix B), for the period 1997-2010 the highest incidence for cervical cancer lies within the 60-64 age range(15.4), followed by 40-44 (14.6) and 65-69 (14.6).

Table 4

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.048 ^b	1	.306	.319	.170
Continuity Correction ^a	.907	1	.341		
Likelihood Ratio	1.050	1	.305		
Fisher's Exact Test					
Linear-by-Linear Association	1.047	1	.306		
N of Valid Cases	984				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 128.18.

CHAPTER V

DISCUSSION

The results of this study provide conclusions that the St. Joseph Healthcare collaboration exceeded its goal in serving the underserved. This information will assist in future community health interventions involving health education to the respective communities. The conclusions demonstrate that cancer-screening programs must take into account a myriad of issues prior to planning effective programs directed towards minority and traditionally underserved communities. Perhaps one of the most significant cultural factors affecting access to health care is effective communication and a genuine respect of cultural practices and beliefs. Sensitivity and understanding need to play a pivotal role for developing service delivery models.

Healthy People 2010 recognizes that communities, States, and national organizations will need to take a multidisciplinary approach to achieving health equity (Healthy People 2010). Dedicated to the principle that every person in every community in the United States deserves equal access to comprehensive, culturally competent health care systems, Healthy People 2010 has recognized the need in understanding cancer-related health disparities in all women. "Inferior medical care for minority women must be considered unacceptable" (Freeman & Payne, 2000).

Conclusion

The purpose of this paper is an attempt to identify research studies and other relevant materials dealing with the concept of health care access and delivery as it applies to the Hispanic/Latina and Asian/Vietnamese faith based communities, thereby highlighting one program that is regarded as a best practice in culturally appropriate health interventions. This paper is an attempt to discover data and other resources, which identify factors that either directly or indirectly contributes towards the inequality of health care access and delivery for ethnically diverse populations in the United States.

Considerable evidence suggests that screening can reduce the number of deaths from cervical cancer (Leak, Hubbartt, & King, 2004). Invasive cervical cancer is preceded by pre-cancerous changes in cervical tissue, which can easily be detected with a relatively low cost Pap test. If cervical cancer is detected early, the likelihood of survival is 100% with appropriate treatment and follow-up (Schiffman, Brinton & Devesa, 1996).

Future reductions in cancer incidence may depend on developing an effective multifaceted prevention and behavior change program. In addressing cancer in ethnically diverse communities it is imperative to focus on language, literacy, involvement of community leaders, support networks and reduction of economic barriers (Eisler & Hersen, 2000).

While limited data exists for Hispanic/Latina populations, it is significantly lacking for Asian American/Vietnamese women. Acculturation issues need to be taken into account due to the large influx of Asian and Hispanic immigrants – which have

changed the two ethnic groups. As mentioned in the literature review, there needs to be a better way to classify in regards to cancer data registries.

Recommendations

This study aimed to prove the following: 1) That the St. Joseph Health care Trust cancer screening project is a “best practice” model for serving the underserved in Tarrant County and 2) Additional research in the area of cultural competency as it relates to health interventions is a must.

Efforts should develop a single source of reliable data on cancer rates, mortality, and survival for specific subgroups within Hispanic/Latina women as well as with Asian American/ Vietnamese women. Increased surveillance and research are necessary to gain a greater understanding of cancer incidence, mortality and survival for these groups (Abraido-Lanza, Chao, & Gammon, 2004). It is recommended that the St. Joseph Healthcare Trust institute a process to measure and collect data regarding each screening, and documenting follow-up that may be required. Since the program is non-profit it the recommendation is to contract students at local graduate institutions to develop a mechanism to retain data.

Recent cancer prevention and control initiatives have demonstrated that neighborhood-based, culturally sensitive interventions can increase breast and cervical cancer screening in minority women (Schiffman, Brinton, & Devesa, 1996). By

providing a setting that is comfortable for participants this program addresses the trust factor and acts as a testimony to the relationship between existing communities based organizations (established church communities) and culturally appropriate health interventions. Addressing the communication issue, the availability of low cost screening services should be publicized in both Vietnamese and Latina communities (Taylor et al., 2004).

In planning program implementation it is crucial to seek out additional resources. In the case of cervical cancer screening, there must be a protocol to follow in the event that abnormal results surface. Strong emphasis should be placed on follow-up to stress the importance of compliance to medical directed care.

Considering the changing demographics and the varying ranges along the accumulation continuum, there is an evident need for health professionals to develop essential competencies to work with persons with diverse backgrounds. The process of becoming culturally competent is more than attending a session or conference on the subject it is an ongoing process. A serious problem with cultural insensitivity in the health system stems to low percentages of ethnically diverse individuals entering the health professions.

In addition, researchers need to make methodological advances, such as developing sound approaches to measuring cancer relevant cultural issues and to design interventions targeted to specific problems such as the failure of physicians to recommend appropriate cancer screening for women of all ages, culture and income

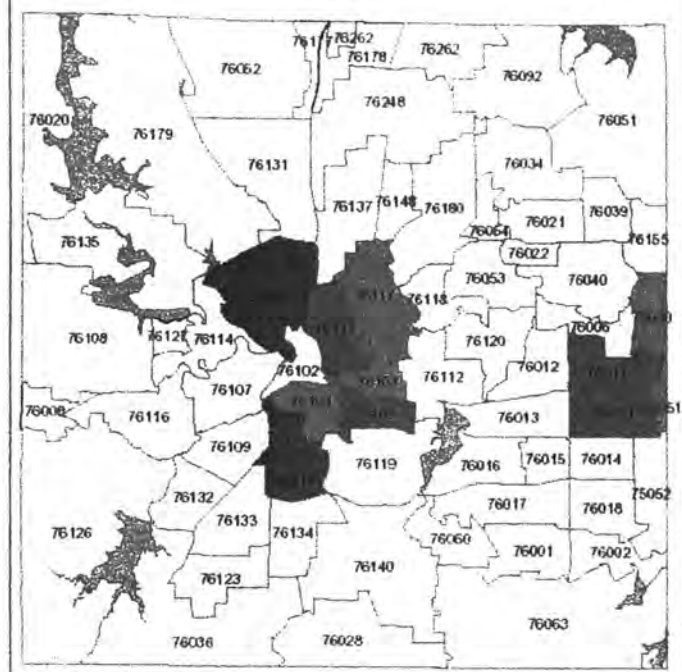
(Eisler & Hersen, 2000). Health research designs must become more sophisticated to account for the complexity of factors (acculturation) that influence health status among all human beings. Health service workers should incorporate important cultural values related to family, spirituality and community.

APPENDIX A

Tarrant County Community Health Report 2003

Geographic Distribution of Linguistic Isolation

Geographic Distribution of Linguistic Isolation

Fig 8: Tarrant County Linguistic Isolation by ZIP Code, 2000

The geographic distribution for linguistic isolation shows a high concentration in central and east Tarrant County. The ZIP Codes with the highest percentage of households that are linguistically isolated are 76106, 76110 and 76115.

Rates are given as percent of households in that ZIP Code.

Legend	2000
	12 % - 16 %
	8 % - 12 %
	4 % - 8 %
	< 4 %
	No Case or no Data



APPENIDIX B

National Cancer Institute

SEER Cancer Statistics Review 1975-2001

SEER Incidence and U.S. Death Rates, Age Adjusted and Age Specific Rates by Race

Table V-2

CERVIX UTERI CANCER (Invasive)SEER INCIDENCE* AND U.S. DEATH^b RATES, AGE-ADJUSTED AND AGE-SPECIFIC RATES, BY RACE

	<u>Incidence^a</u>			<u>US Death^b</u>		
	<u>All Races, Females</u>	<u>White Females</u>	<u>Black Females</u>	<u>All Races, Females</u>	<u>White Females</u>	<u>Black Females</u>
<u>AGE-SPECIFIC RATES, 1997-2001</u>						
<u>AGE AT DIAGNOSIS/DEATH:</u>						
<1	-	-	-	-	-	-
1-4	-	-	-	-	-	-
5-9	-	-	-	-	-	-
10-14	-	-	-	-	-	-
15-19	-	-	-	-	-	-
20-24	1.5	1.6	-	0.2	0.2	-
25-29	6.6	7.4	5.2	0.7	0.7	0.8
30-34	11.3	11.7	11.6	1.6	1.6	2.4
35-39	12.7	12.7	12.2	2.7	2.6	4.1
40-44	14.6	13.9	18.3	3.8	3.4	6.3
45-49	14.9	13.6	20.7	4.8	4.5	7.4
50-54	12.8	11.5	15.2	5.4	4.9	8.9
55-59	13.4	12.2	21.9	5.7	5.0	10.9
60-64	15.4	13.3	26.3	6.4	5.6	12.5
65-69	14.6	12.7	28.5	6.6	5.6	15.6
70-74	11.6	10.0	26.5	6.8	5.8	16.6
75-79	13.3	10.5	31.8	7.5	6.5	17.9
80-84	13.4	10.2	34.4	8.5	7.3	21.4
85+	13.1	11.1	38.5	10.8	9.1	29.5
<u>AGE-ADJUSTED RATES, 1997-2001</u>						
<u>AGE AT DIAGNOSIS/DEATH:</u>						
All ages	8.4	7.8	12.2	2.9	2.6	5.6
Under 65	7.7	7.3	9.5	2.2	2.0	3.7
65 and over	13.2	11.0	30.8	7.6	6.5	18.9
All ages(IARC world std) ^c	6.6	6.2	9.1	2.1	1.9	3.9

SEER 9 areas. Rates are per 100,000 and are age-adjusted to the 2000 U.S. standard population by 5-year age groups, unless noted.

NCHS public use data file for the total US. Rates are per 100,000 and are age-adjusted to the 2000 U.S. standard population by 5-year age groups, unless noted.

Rates are per 100,000 and are age-adjusted to the IARC world standard population.

Statistic not shown. Rate based on less than 25 cases for the time interval.

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