Breast and Cervical Cancer Screening:

Knowledge, Attitudes, and Practices of Vietnamese Canadian Women

Living in Toronto, Ontario

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Dedication

To my little girl, Di An, for a next generation without breast and cervical cancer.

To my husband, Binh, for his love always.

To my research supervisor, Dr. Darlene Steven, for her endless support and patience.

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Statement of the Purpose

Breast cancer is the most common cancer, and cervical cancer is the second most common cancer, among Vietnamese women in North America. This ranking replicates the order of cancer prevalence among women residing in Vietnam. Unfortunately, Unfortunately, Vietnamese women are less likely to report ever having had recommended screening procedures for these cancers and are more likely to be overdue for them than women in the general populations (Miller, Kolonel, & Bernstein, 1996). Many factors have been highlighted from previous studies to shed light into this cancer prevalence. These factors include but not limited to accessibility of service, lack of knowledge on breast and cervical cancers, inadequate number of female physicians, language barrier, etc. Therefore, the overall purpose of this project is to examine the knowledge, attitudes, and practices of Vietnamese Canadian women ages 40 to 60 toward breast and cervical cancer screenings.

Objectives of the Study

1. To identify the possible barriers in race or ethnicity, culture, and socioeconomic status (SES) that Vietnamese Canadian women face in their efforts to take preventive measures and participate in breast and cervical cancer screening.

2. To make recommendations and develop strategies for ethnic-focused breast and cervical cancer health promotion.

Conceptual Framework

The conceptual framework for this study was the health behaviour framework (HBF), which represents a synthesis of some of the major theoretical formulations in the area of compliance, including the health belief model, the theory of reasoned

action/planned behaviour, the transtheoretical model of change, the social influence theory, and many major components of PRECEDE (Bastani, Gallardo, & Maxwell, 2001; Curry & Emmons, 1994; Gritz & Bastani, 1993). The PRECEDE framework was originally taken from Andersen's model of behavioural factors in health care utilization (Curry & Emmons; Glanz, Kristal, Tulley, & Hirst, 1998; Green & Kreuter, 1991). The PRECEDE specifies that factors affecting behaviour can be broadly classified as predisposing, reinforcing, or enabling.

This conceptual framework was chosen because unlike most behavioural models, it assumes that factors affecting health choices are culturally determined and does not specify that the same variables (e.g., perceived susceptibility to disease) are determinants of behaviour across communities (Green et al., 1999). This framework for this study has been successfully used to develop survey instruments and intervention programs for diverse racial/ethnic groups, including Asian Americans, and screening behaviours (Bastani et al., 2001; Bastani, Maxwell, Bradford, Das, & Yan, 1999; Maxwell, Bastani, & Warda, 1997, 1998; Maxwell, Bastani, Vida, & Warda, 2003). It is a general heuristic framework, and not all of its elements are applicable to every population or specific research question; the researcher chose to use the HBF as the conceptual framework because unlike most models, it does not specify that the same factors are determinants of behaviour across population subgroups (Bastani et al., 1999, 2001). The relevant HBF constructs identified by quantitative and qualitative studies and included in the survey were effectiveness, knowledge, barriers, social support, and communication with provider (see Figure 1).

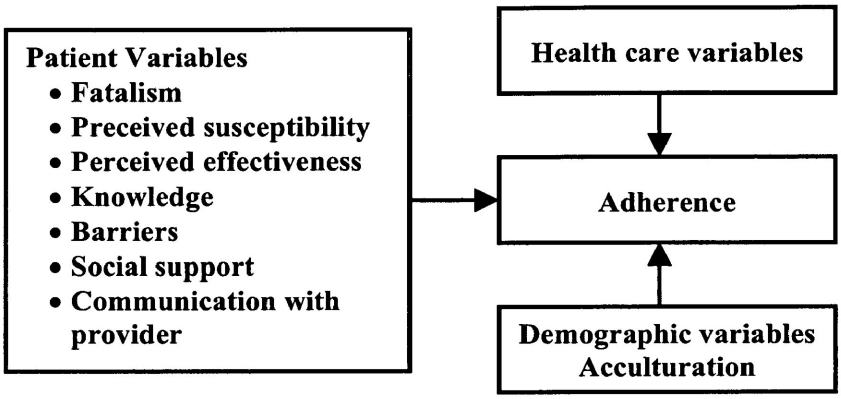

Figure 1. Application of the HBF.

Source: Green et al., 1999.

Literature Review

Introduction

Canada is known for its multicultural mosaic. Toronto is home to "virtually all of the world's culture groups and is the city where more than 100 languages are spoken" (City of Toronto, 2005). Over the years, particularly after World War II, Toronto saw an influx of new immigrant groups, an event that has led to the more recent and dramatic change to the racial and ethnic mix of its population. The Toronto Census Metropolitan Area comprises more than 90 ethnic groups. Based on country of origin, the top six groups are European (997,180), East and Southeast Asian (488,350), British (457,990), Canadian (311,965), South Asian (291,520), and Caribbean (167,295). In 2001, immigrants made up 50% of Toronto's population. People of Vietnamese ancestry now comprise one of the fastest growing Asian/Pacific Islander ethnic groups in Toronto. The Vietnamese Canadian population in Toronto was the 10^{th} largest at 24,000, and demographers predict that by 2010, half of Toronto's population will be comprised of Asians (Statistics Canada, 2005).

Given these trends in population growth patterns and the cultural diversity they represent, advancing our knowledge of effective transcultural approaches to health promotion is critical. (City of Toronto, 2005). Because of the persistent disparities in the stages of diagnosis and survival rates for breast and cervical cancer among population subgroups, this study will primarily examine the knowledge, attitudes, and practices of Vietnamese Canadian women in Toronto, Ontario that pertain to breast and cervical cancer screening. It will also attempt to identify possible barriers to screening associated

with race or ethnicity, culture, and SES in the Vietnamese Canadian community in the Toronto area.

Breast Cancer

Breast cancer is the most prevalent cancer affecting women in Canada. One in every 9 Canadian women will develop the disease in her lifetime, and one in every 27 will die from it (Canadian Cancer Society (CCS), 2005). In 2005, the Canadian Cancer Society (CCS) estimated that 21,600 women would be diagnosed with breast cancer that same year and that approximately 25% of these cases would be terminal. An estimated 8,200 women in Ontario were diagnosed with breast cancer in 2005, and 2,000 of them died (CCS). Breast cancer continues to be the most frequently diagnosed form of cancer for women in Ontario (CCS). It is the second leading cause of cancer death after lung cancer.

Cervical Cancer

The CCS (2005) estimated 1,350 new cases of cervical cancer and 400 deaths from cervical cancer in 2005. Based on a national population of 31,949,000, one in every 138 Canadian women will be diagnosed with cervical cancer, and one in every 385 will die from it (CCS). Sexually active women should undergo Pap tests and pelvic examinations every 1 to 3 years, depending on provincial health guidelines. Prevention practices and early diagnosis will reduce the mortality rate of cervical cancer.

Efficacy of Cancer Screening

Mammograms and Pap smears are effective screening tests for the early detection, timely treatment, and concomitant reductions in morbidity and mortality of breast and cervical cancers (McPhee et al., 2002). Hiatt et al. (1996) reported that breast and cervical

cancers are the two types of cancer that have screening tests of proven efficacy. Although there has not been any research confirming the effectiveness of clinical breast examinations (CBEs) and breast self-examinations (BSEs), these "low-cost measures remain part of recommended current preventive care practice" (Hiatt et al., p. S13). Acknowledging that it is possible to reduce mortality rates through the utilization of effective screening techniques, the CCS (2005) recommended that:

1. Women who are between the ages of 50 and 69 should have a mammogram every 2 years.

2. Women who are over the age of 40 should have a CBE at least every 2 years.

3. All women should practice BSEs regularly and report any changes to their family doctor.

Although progress has been made over the past decade in the fight against breast and cervical cancers, differences among race or ethnic groups in the survival rates may be the result of differences in screening adherence (Baquet & Ringen, 1986; Farley & Flannery, 1989; McWhorter & Mayer, 1987; Ruffin, Gorenflo, & Woodman, 1999). According to Ruffin et al., despite the suggested guidelines for breast and cervical screenings, the participation levels of women in these screenings is very low:

> The proportion of women aged 40 to 49 years with documentation of breast self-examination discussion ever, clinical breast examination in the past 2 years, and mammography in the past 2 years was 29%. The proportion of women aged 50 years and older with documentation of breast self-examination discussion ever, clinical breast examination in the past year, and mammography in the past year was 17%.... Only 8.6% of women aged 40 to 49 years had documentation of their

> receiving a Papanicolaou smear in the past 3 (with an intact cervix), breast self-examination discussion ever, clinical breast examination in the past year, mammography in the past 2 years (or all cancer screening procedures for their age and sex). Only 3% of women aged 50 years and older had documentation of receiving a Papanicolaou smear in the past 3 years (with an intact cervix), breast self-examination discussion ever, a clinical breast examination in the past year, a mammography in the past year...(or all cancer-screening procedures for their age and sex). These proportions were so small that we could not develop logistic regression models. (p. 4)

A significant public health challenge lies ahead in encouraging women from different ethnic groups to undergo regular breast and cervical cancer screening.

Differences in Screening Practices

Studies have shown that members of racial and ethnic minorities in the United States are at greater risk for disease than white individuals (Casper, Barnett, Armstrong, & Giles, 1997; Cooper & Rotimi, 1997; Escobedo, Giles, & Anda, 1997; O'Malley, Prehn, Shema, & Glaser, 2002; Sorlie, Rogot, Anderson, Johnson, & Backlund, 1992). In addition, members of racial and ethnic minorities participate in breast and cervical cancer screening at lower rates (McPhee et al., 2002; Suarez, Goldman, & Weiss, 1995).

Fitch, Greenberg, Cava, Spaner, and Taylor (1998) concluded that low-income women face many barriers to cervical cancer screening. They conducted their study in North York with a sample of 110 women between the ages of 20 and 60. Open-ended questions about the women's experiences regarding access health care, concerns about cervical screening, and suggestions for cervical screening recruitment strategies were

explored in 11 focus-group sessions. Fitch et al. described the four main themes arising from their findings:

> The first theme, being able to talk with doctors is important, described women's need to have access to the doctor without barriers (e.g., limited office hours, difficulties in getting child care or transportation, and long waiting times); conversations with the doctor that were unhurried, provided easy to understand information, and did not make the woman feel "stupid"; and a sense of comfort and trust with the doctor.
>
> The second theme, being treated as a person, is important, focused on women's interactions with the healthcare [*sic*] system. Women wanted to be cared for holistically rather than just for their physical health, to be sensitively listened to, and to have privacy during a Pap test.
>
> The third theme, finding answers to many questions about cancer is important, emphasized [*sic*] that women had many questions about cancer treatment options, outcomes, and side effects; cancer prevention; and where to find good information sources.
>
> The fourth theme, having a Pap test is uncomfortable, related to women's uncertainties about the purpose of the Pap test and the actual procedure. Many women needed to mentally prepare for the Pap test and felt it was an embarrassing, humiliating, and unpleasant experience. (pp. 444-446)

In the United States, cervical cancer incidence rates among Vietnamese American women are the highest of any race or ethnic group: 43/100,000 versus 8.7/100,000 among White women (Miller, Kolonel, & Bernstein, 1996). American data for 1988 to 1992

showed an average age-adjusted incidence rate of 37.5 per 100,000 for invasive breast cancer (Miller et. al.). Moreover, Vietnamese American women are one third as likely to develop breast cancer but nearly five times as likely to develop cervical cancer (Miller et al.). In Vietnam, breast cancer is the most common cancer, and cervical cancer is the second most common (Anh, Hanh, Parkin, & Du, 1993).

Various studies have investigated the attitude, knowledge, and practices of Vietnamese American women toward breast and cervical cancers. Researchers have focused on the impact of demographic, environmental, and cultural factors on the acceptance of and participation in breast and cervical cancer screenings (Jenkins et al., 1999; Lam et al., 2003; McPhee et al., 1996; Nguyen, McPhee, Nguyen, Lam, & Mock, 2002).

Hiatt et al. (1996) studied the relationship of race or ethnicity, SES, and culture to breast and cervical cancer screenings. Individuals from five race or ethnic groups (i.e., Latina, White, Black, Chinese and Vietnamese) in the San Francisco Bay area were selected to be the study sample ($N = 4,228$). Hiatt et al. concluded:

> Among the groups, Latinas had the highest levels of compliance, Vietnamese women had the lowest, and Chinese women were intermediate between them.... The two groups of women reporting the lowest rate of recent screening were the Chinese and the Vietnamese. (p. S20)

The researchers came from different disciplines and cultures. Further to assessing the knowledge, attitudes, and practices of these women, Hiatt et al. also investigated possible barriers to screening utilization. "Analyses revealed the importance of education and insurance in obtaining recommended screening regardless of race or ethnicity. However,

race, ethnicity, and culture are important to the tailoring of effective interventions" (Hiatt et al., p. S10).

A telephone survey in California showed that among Vietnamese women, cultural factors (e.g., immigration and fluency in English) and structural factors (e.g., marital status, SES, and cost of screening) are associated with screening utilization (Centers for Disease Control and Prevention [CDC], 1992). In California, the rate of cervical cancer among Vietnamese women is four times that of the general population, and the average rate derived from regional surveys of Latinas is twice the national rate for either Anglo-American or African American women (McPhee et al., 1996; Perez-Stable, Otero-Sabogal, Sabogal, & Napoles-Springer, 1996). Surveys of Vietnamese and Latino women have found that the rates of screening for breast and cervical cancers are significantly lower in these vulnerable communities than in the general population (Harlan, Bernstein, & Kessler, 1991; McPhee et. al.; Miller et. al., 1996; Perez-Stable et al.; Yi, 1994). Moreover, stage of diagnosis for cervical and breast cancers generally is less favorable for Vietnamese and Latinos than for the general California population.

Because data on sexual behaviour may be unavailable or unreliable, the National Cancer Institute (2002) identified women who have never had a Pap test and those without recent tests as high risk for cervical cancer. The University of California and a community coalition of 11 organizations in Santa Clara County used a demonstration project, "REACHing Vietnamese-American Women: A Community Model for Promoting Cervical Cancer Screening," as its framework (as cited in Lam et al., 2003). These two agencies each recruited 10 lay health workers (LHWs), who then recruited 20 women. The 20 women were randomly and equally divided into two groups: The 10

women in Group 1 (n_1 = 200) received Lay Health Worker Outreach (LHWO) and media education (ME), and the 10 women in Group 2 (n_2 = 200) received only ME. The LHWs transferred their knowledge of Pap tests to the recruited women through self-organized meetings, and they also encouraged and motivated these women to go for Pap tests.

The project was funded by the CDC (2005) through its Racial and Ethnic Approaches to Community Health (REACH) 2010 Program. The goal of the project was to increase Vietnamese-American women's cervical cancer awareness, knowledge, and screening through an ME campaign and an LHWO program. After analyzing the pre- and postintervention questionnaires, Lam et al. (2003) reported the promising results:

> At post-intervention [*sic*], significantly more Lay Health Worker Outreach (LHWO) + Media Education (ME) women understood that human papillomavirus and smoking cause cervical cancer. The number of women who had obtained a Pap test increased significantly among women in both LHWO + ME and ME groups, but substantially more in the LHWO + ME group. Significantly more LHWO + ME women said they intended to have a Pap test. (p. 516)

It was clear that "media education campaigns can increase Vietnamese women's awareness of the importance of Pap tests, but lay health workers are more effective at encouraging women to actually obtain the tests" (Lam et al., 2003, p. 516). LHWs were employed to recruit the study participants because the Vietnamese community is characterized by its solidarity, generosity, and helpfulness. It was expected that the Vietnamese women would offer their homes for meetings, be willing to invite friends and relatives to educational events, and enthusiastically support these efforts to improve women's health in their community (Bird, Otero-Sabogal, Ha, & McPhee, 1996).

Bird et al. (1998) reported on the success of their controlled trial study on the importance of engaging LHWs to promote cancer screening among Vietnamese American women. Interventions (i.e., the LHWs conducted small-group sessions for Vietnamese women in a low-income district of San Francisco, California) occurred from 1992 to 1996. Women in Sacramento, California, served as study controls. A total of 232 sessions took place (56 on general prevention, 86 on cervical cancer, and 90 on breast cancer), and 306 of the 373 participants were surveyed pre- and postintervention. In the intervention community, recognition and acceptance of screening tests increased significantly between the pre- and postintervention surveys: CBEs, 50% to 85% (recognition), 44% to 70% (acceptance); mammograms, 59% to 79% (recognition), 54% to 69% (acceptance); and Pap smears, 22% to 78% (recognition), 46% to 66% (acceptance), respectively. These results clearly showed that by offering appropriate and cultural sensitive health promotion programs, Vietnamese women's recognition, acceptance, and maintenance of breast and cervical cancer screening tests could be increased significantly.

Similarly, another Vietnamese community health promotion project that also incorporated a media-led education campaign succeeded in increasing women's recognition of and intention to undertake screening tests (Jenkins et al., 1999). However, the intervention had no effect on any of the women staying current for any of the tests (Pap smears, CBE, mammogram). The project, which was implemented over 24 months, targeted Vietnamese American women in the Alameda and Santa Clara Counties in northern California. Women in Los Angeles and Orange Counties in southern California served as controls. Jenkins et al. conducted telephone interviews to evaluate the impact of

the project. A total of 451 randomly selected women in the intervention area and 482 women in the control area were interviewed at the pretest stage. At the posttest stage, telephone interviews were conducted with 454 women in the intervention area and 422 women in the control area (Jenkins et. al.). The researchers concluded:

> At posttest, after controlling for demographic differences in the surveyed populations, the odds ratio for the intervention effect were statistically significant for having heard of a general checkup, Pap test, and clinical breast examination (CBE; planning to have a checkup, Pap test, and mammogram; and having had a checkup and Pap test). The intervention had no effect on being up to date for any of the tests. (p. 395)

Nguyen et al. (2002) assessed the factors associated with Vietnamese American women's awareness, intention to obtain, and acceptance of the Pap test. The researchers interviewed a total of 1,566 Vietnamese American women in Santa Clara County, California, and Harris County, Texas, 18 years of age or older by telephone in 2000. Data on sociodemographics; health care system access and attitudes; as well as Pap test awareness, attitudes, intentions, and practices were collected. Nguyen et al. reported:

> Of 1566 subjects, 74% had heard of the Pap test, and 76% had had at least one. Only 42% of those who never had a Pap test had considered obtaining one. There were no significant differences between two sites. Women aged ≥ 65 had the lowest rates for all three outcomes. For all women, younger age, being married, having requested a Pap test, physician recommendation, and preferred female standby if the doctor was male were associated with Pap test intention. Being married, higher level of education, having a female doctor, having a respectful

doctor, having requested the test, and physician recommendation were associated with Pap test receipt. (p. 207)

In conclusion, for these particular Vietnamese American women, the patient-doctor interaction was an important factor; therefore, "efforts to increase Pap test utilization in this population need to be directed at encouraging physicians to offer the Pap test and empowering women to ask for the test" (Nguyen et al.).

There are limited data on Vietnamese Canadian women and breast and cervical cancer screenings. In fact, the prevalence of and risk factors associated with these cancers in Vietnamese Canadian women remain unstudied. Donnelly's unpublished data (personal communication, September 2005) supported previous research findings of barriers such as language, culture, and living 'in-between' to Vietnamese Canadian women's participation in breast cancer and cervical cancer screenings. He concluded that Vietnamese Canadian women's health behaviour is influenced by their cultural knowledge and values, that is, their socially constructed position, race, gender, and class. He recommended to this researcher that physician-patient relationships be improved and that immigrant women's different modes of awareness of health education and strategies be incorporated into programs.

Steven et al. (2001) investigated the knowledge, attitudes, beliefs, and practices regarding breast and cervical cancer screenings of four selected ethnocultural groups (i.e., Italian, Ukrainian, Finnish, and First Nations). A sample of 105 women ages 40 years and older were interviewed in person by the researchers in the participants' language of choice. These women were selected from a convenience sample in Northwestern Ontario. Snowball sampling was used to recruit other eligible participants. The questionnaire was

adapted from an earlier version of the questionnaire used by Choudhry, Srivastava, and Fitch (1998). The main findings confirmed the results of past studies:

> First Nations women were more likely than any other group [Italian, Ukrainian and Finnish] to: have not had a breast self exam, refused a breast examination or mammogram, have not been told how to do a breast self exam, have not received written information about breast examination and were uncomfortable and fearful about cervical cancer screening procedures (33% refused an internal examination as compared to 0-8% in other ethnic groups). (Steven et al., p. 2)

Concrete recommendations were derived from Steven et al.'s (2001) study. Grouped by category, they include education, accessibility of screening services, and research. Following are the main recommendations from their study:

> To develop culturally sensitive health education programs and resources (pamphlets, videos, and television programs).
>
> To develop educational programs for health care professionals on cultural sensitivity regarding breast and cervical cancer for specific populations.
>
> To work in collaboration with community representatives to overcome barriers to accessing services (i.e., transportation/travel and child care).
>
> To advocate for a female examiner in breast and cervical screening programs.
>
> To conduct a longitudinal study on compliance with breast and cervical cancer screening in selected populations.
>
> To evaluate the effects of low-income on individuals' knowledge, attitudes, and beliefs toward breast and cervical cancer screening. (pp. 33-34)

Given that cervical cancer is preventable through routine exam, prevalence of this illness is sufficient to warrant substantial investigation. Canada's ethnic population is at higher risk for developing the disease as a result of lower screening rates. Also notable is the significance of cervical cancer among low income groups (Fitch et al., 1998; Paskett at al., 1998; Simoes, Newschaffer, Hagdrup, Ali-Abarghoui, Tao, Mack, & Brownson, 1999). Research is limited for these aggregates and further examination is warranted (Band, Gallagher, Threlfall, Hislop, Deschamps, & Smith, 1992)

Summary

Steven et al.'s (2001) study and other studies concurred on one significant finding: Culturally appropriate and sensitive programs are the key to successful breast and cervical cancer screenings in ethnocultural groups. The above literature review suggests that Vietnamese women may not be generally predisposed to or may be unable to obtain cancer screening tests. A variety specific explanations for this lack of screening have been suggested, including lack of knowledge,lack of a preventive care orientation, language barriers, limited access to health care, and preference Eastern (traditional) medicine (McPhee et al., 1996). More studies should be undertaken to enhance the knowledge of ethnocultural groups in regard to breast and cervical cancer attitudes, beliefs, and practices related to screening.

Cancer-related morbidity and mortality are higher among the underserved. Experts have recommended that cancer research for underserved populations must be based on cancer prevalence and preventability of cancer-related behaviors, must make accommodations to culture, and must emply practical strategies (Chen, 1994). To date, however, there have been few intervention studies targeting barriers to cancer screening

among Vietnamese women. Therefore, This study of Vietnamese-Canadian women and breast and cervical cancer screening further contributes to the data pool in identifying demographic factors as well as environmental and cultural practices that impact their acceptance of and participation in preventive measures and practices.

Methodology

Several models have been proposed over the past several decades to better understand the complex set of factors that ultimately influence patient and provider behaviors. Most notable among these are the Behavioral Model of Utilization developed by Anderson, Aday, and colleagues (Aday, & Anderson, 1974; Anderson, & Davidson, 1994; Phillips, Morrison, Anderson, & Aday, 1998) and the PRECEDE-PROCEED Model of Green and Kreuter (Green et el., 1999), both of which emphasize a multisectoral, multilevel ecological approach to program analysis, planning, and evaluation. This project's surveying tool, which was developed by Steven et al., (2001), was chosen because it proved to be successful in identifying factors at the public policy level, the community level, the organizational level, and the individual level. It also examined the practice setting through open-ended questions which emphasized the interaction in a synergistic manner that affect provider delivery and patient utilization of services. Both models are well stressed in the questionnaire with emphasis on the need for careful assessment of these factors when choosing interventions to improve quality and address specific individual and public health needs. Moreover, the health behavior conceptual framework and Steven's surveying tool addressed this project's objectives thoroughly. Possible barriers in race or ethnicity, culture, and socioeconomic status (SES) that Vietnamese Canadian women face in their efforts to take preventive measures and participate in

breast and cervical cancer screening were identified. The researchers were also able to make recommendations for ethnic-focused breast and cervical cancer health promotion.

Sample Selection

Toronto is an urban, industrialized city. In 2001, the city had an ethnically diverse population of approximately 4,647,955 million residents. The non-Latino White population constituted 43% of the total, with the remaining population classified as follows: 15% African Canadian, 20%Asian and Pacific Islander, and 19%Latino (City of Toronto, 2005). According to 2001 Canadian Census estimates, the largest Asian populations in the city were South Asian (10.2%) and Chinese (8.8%). 34,572 Vietnamese lived in Toronto and accounted for 76% of Vietnamese population in Canada (City of Toronto, 2005). This project was undertaken hoping to enhance the knowledge of the Vietnames ethnocultural group in regard to breast and cervical cancer attitudes, beliefs, and practices related to screening.

The study took place in Toronto, Ontario, Canada.. Toronto was chosen because it has high density of Vietnamese residents and because it has geographic proximity to the researcher. The survey was administered between February 2006 and March 2006. A sample of convenience of 49 women, not 25 as originally intended, ages 40 years and older participated in the study. All of the participants were Vietnamese or Chinese-Vietnamese origin. Chinese-Vietnamese individuals are ethnic-Chinese individuals who were born in Vietnam. A snowball sampling approach was utilized to identify more individuals who met the eligibility requirements. After the questionnaire was completed, the initial participants were asked to provide the names of other women who were

interested in participating in this study. These women were contacted, and if they agreed to participate, questionnaires were mailed (or hand delivered) to them.

With the approval of the Ethical Review Committee of Lakehead University, the survey was administered between mid-February and mid-March of 2006. A package that included the survey questionnaire in English (see Appendix A) or Vietnamese (see Appendix B), a cover letter (see Appendix C), a consent form (see Appendix D), and a self-addressed stamped envelope was distributed to each eligible individual at places such as monthly meeting of Vietnamese women's clubs, Vietnamese and Chinese supermarkets, dental and doctor offices, and so on. The respondents had the options of answering the survey in English, Vietnamese, or both. If they answered in Vietnamese or a blend of Vietnamese and English, a translation was done by a registered nurse in Toronto, who participated as an impartial third party.

Research Design

The study was primarily quantitative, but qualitative data were reported wherever possible. The use of a quantitative design served as a vehicle for hypothesis testing and answering research questions while, qualitative research incorporated broadly stated questions about human experiences in natural setting to obtain descriptive data to enhance the understanding of the human health experience (LoBiondo-Wood & Haber, 2002). The survey's strengths are: less time required, increased sense of privacy and anonymity among participants, and simplicity of coding and analysis. On the other hand, lower response rate (thus more likely to over-represent views of persons more likely to respond to surveys) and no assistance provided to respondents in understanding questions are two major weaknessess of survey method. The survey questionnaire was hand

delivered or mailed to identified, eligible participants. They were asked to return the completed questionnaire to the researcher using the self-addressed stamped envelope.

The survey instrument was adapted from one utilized previously by Steven et al. (2001). The interview guide contained information regarding knowledge, attitudes, beliefs and practices about BSE, CBE, mammography and cervical cancer screening procedures. A pilot study was conducted as to the appropriateness of the tool when it first adapted by Steven (2001). Forty women of four ethnic groups (Native, Italian, Finnish, Ukranian) participated in the pilot study. The original survey was also reviewed by an expert committee to confirm and enhance its validity and reliability. The survey consisted of 96 items developed in English, translated into Vietnamese, and translated back into English to ensure lexical equivalency. The tool was piloted on 5 already identified, eligible participants and then revised for accuracy and cultural appropriateness. Items on the survey encompassed demographic, SES, age, education, employment, geographic area, and marital status data. There were also questions about general health as well as breast and cervical screening information.

Data Analysis

A statistical analysis of the data was done using SPSS. The analysis focused on describing the participants' baseline knowledge, attitudes, intentions, and practices related to cancer screening. Comparisons based on these baseline data were done among the age groups. The relative roles of demographic factors such as age and education were evaluated in the desired screening behaviours. Marital status were defined as "never married" or "married" to include all participants who self-identified as married, divorced, widowed, separated, or cohabitating.

Differences among the different age groups, educational levels were examined using analysis of variance (ANOVA). When the ANOVA revealed significant differences among the groups, Newman-Keuls post-hoc comparisons were used to identify which of the groups were different. Chi square was used to analyze the differences among percentages. For all of the tests, any findings of $p < .01$ were considered significant.

Results

Response Rates

Overall, of 97 eligible women, 49 (51%) completed and returned the surveys to researcher. More participants would be needed for comparison among different age groups. Over 79% responded in Vietnamese, 14% responded in both Vietnamese and English, and less than 7% responded in English.

Characteristics

Demographic information on age, education, marital status, and number of children is presented in Table 1.

Table 1
Demographic Information

Age		Marital Status		Education		Number of children		Geographic Location	
Under 40	2%	Single	6%	Grade school	60%	1	20%	Rural	0%
40-45	12%	Married	61%	Diploma	22%	2	39%	Urban	100%
46-50	31%	Common-law	2%	Degree	18%	3	27%		
51-55	14%	Separated	6%	Graduate	0%	4	7%		
56-60	20%	Widowed	12%			5	5%		
61-65	16%	Divorced	12%			6	2%		
Over 65	4%								

urban setting. Approximately 60% of them reported having one or two children. One woman has six children. Levels of education varied among the women: Sixty percent had

completed grade school, 40% had either a diploma or a degree. Approximately 94% of the women are married or were once married; only 6% of the women are single, and none of the divorced women (12%) had remarried.

Incidence of Breast and Cervical Cancer

Only one woman has breast cancer. She is 56 years old and of Chinese Vietnamese ethnicity. She has a family doctor whose is a Caucasian male. She has 3 children.

General Health Indices

Table 2 summarizes information about family doctors, illnesses the women have been diagnosed with, and medications that the women were taking at the time of the study. Forty-nine percent of the participants had a male family doctor, and 53% had a female family physician. Seventy-three percent of the family doctors spoke the participants' language, which was either Vietnamese or Chinese Vietnamese. High blood cholesterol (43%) was the leading illness, followed by high blood pressure (35%) and heart disease (31%). Medications taken were consistent with the illnesses, with 45% of the participants taking medication for high cholesterol, 39% for high blood pressure, and for heart disease.

Table 2
General Health Indices

Indicator	Percentage
Doctor	
Have a family doctor	84%
Doctor is male	49%
Doctor speaks your language	73%
Illnesses	
High blood pressure	35%
High blood cholesterol	43%
Heart disease	31%
Diabetes	14%
Cancer	2%
Medication	
Blood pressure	39%
Cholesterol	45%
Heart	29%
Hormones	2%
Thyroid	0%
Insulin	12%
Check-Up	
Within last year	84%
Last 2 years	10%
More than 2 years ago	6%
Internal exam at last checkup	16%
Reason for last check-up	
Something troubling you	43%
Routine check-up	45%

The majority of women reported having a check-up within the last year, and approximately 94% had had a checkup within the last 2 years. "Routine checkups" and "Something troubling you" were the two main reasons for the last checkups. Only 16% of the women received an internal exam during their most recent checkups.

The researcher asked the women to rate their perceived level of health. In response to the question "In general, how would you describe your health?," 35% of the women described their health as "not so good" or "poor." When asked, "How would you describe your health in comparison to other women your age?," only 18% rated their health as "better than," with 53% reporting that they had "not very much control" or " "uncertain that they have control" and 3 women commenting that they had "no control."

The women were also asked, "In order to keep yourself healthy, what kind of things do you do?" The responses, which are summarized in Appendix E, were categorized as exercise, eating well, especially watching fats and controlling weight control, more resting/sleeping, visiting the doctor regularly, and living a healthy balanced life. A follow-up to this question was, "In order to do the things you have just told me that keep you healthy, do you encounter any difficulty or problem? Most people did not report any problems. The most commonly cited problem was finding the time to exercise. Cold weather, tiredness, and conflicted schedule were other mentioned problems.

Health-Related Behaviours

Smoking. Only 8 (16%) of the women reported ever smoking cigarettes. Two had stopped smoking prior to being surveyed. Most of the participants who were smoking at the time of the study claimed to inhale moderately and deeply. These women had started to smoke at around age 23 ($M = 22.8$).

Exercise. The majority of women exercised, but 35% of them only exercised two times or less per week. The most common type of exercise was walking. Two women reported doing no exercise whatsoever.

Eating and drinking habits. Table 3 showed the percentage of women who regularly engaged in high-risk eating and drinking behaviours. Overall, the majority of women ate lean meats, skinless poultry, or fish. They used both high-fat and low-fat dairy products. They were equally as likely to prepare food in both high-fat (deep fat frying, frequent frying, etc.) and low-fat (boil, bake, etc.) ways. Only a small percentage (12%) of the women added salt to food at the table. In contrast, 65% of the women reported occasionally eating fast foods. Moreover, 75% of them consumed two servings or less of

vegetables and fruits daily. Only 33% of the women drank alcoholic beverages. None of them drank four or more alcohol drinks at one time. This also applied to caffeinated beverages.

Table 3
Health Behaviour

Health Behaviour	**Percentage**
Smoking Behaviour	
Ever smoked?	16%
Smoke now?	13%
Inhale moderately or deeply?	88%
Age started (M)	22.8
High-Risk Eating Behaviour	
Meat (fat not trimmed)	29%
Dairy products (high fat)	20%
Desserts (high fat)	16%
Cooking (high fat)	12%
Mostly refined grains	27%
Fruit & Veg. (2 or fewer servings/day)	71%
Fast foods (occasionally)	65%
Add salt at table	12%
High-Risk Drinking Behaviour	
Alcohol (2 or more days/week)	33%
Alcohol (4 or more drinks/day)	0%
Caffeine (4 or more cups per day)	0%
Exercise	
No exercise	4%
Low intensity (less than 2 times/week)	35%

Breast Screening

Table 4 shows the percentage of women who responded positively to questions about breast screening. Approximately 50% or less of the respondents answered "Yes" to the following statements:

- Aware that women can examine their own breasts (49%).
- Been told how to do a breast self-examination (BSE; 41%).
- Been demonstrated BSE (37%).
- Received any written information about BSE (39%).
- Had done a BSE (38%).

- Being comfortable doing a BSE (49%).
- Able to detect any abnormality when doing BSE (35%).
- Know anyone who has breast cancer (27%).
- Know about breast x-ray or mammography (55%).
- Know about breast screening (53%).
- Has had a breast x-ray or mammography (51%).

Table 4
Percentage of Women Who Answered Yes to Questions about Breast Screening

Questions Related to Breast Screening	**Percentage**
Have you ever had your breasts examined?	76%
Have you had a lump in your breast?	0%
Has your doctor/nurse ever discussed examining your breasts with you?	4%
Have you ever refused to have a breast examination?	78%
Are you aware that women can examine their own breasts?	49%
Has anyone ever told you how to do a breast self-examination (BSE)?	41%
Has anyone ever demonstrated BSE to you?	37%
Have you ever received any written information about BSE?	39%
Have you ever done a BSE?	38%
Do you feel comfortable doing BSE?	49%
Do you feel you would be able to detect any abnormality?	35%
Do you know anyone who has breast cancer?	27%
Do you know about breast x-ray or mammography?	55%
Do you know about breast screening?	53%
Have you ever had a breast x-ray or mammography?	51%

The aforementioned findings must be viewed with initial caution because they were confounded with age differences. Because most of the participants were under the age of 50, they may not have been eligible to have breast x-rays. Also, older women are more likely to know someone who has breast cancer because it is an age-related disease. Furthermore, for a high percentage (76%) of the women who have had their breasts examined, none of them received reports of any unusual masses. Interestingly, only 4% of these women have had a doctor/nurse discuss breast examinations with them.

The women who have had a breast examination were asked, "How did you feel about this examination being done? Detailed results are found in Appendix E. The majority of the women felt that the examination was acceptable and not problematic for them. Some of the women were more positive, expressing either relief that the results were negative or that they felt comfortable taking the test. Others simply saw it as a necessity. There were a number of negative comments. Twenty-two women had negative comments: 13 felt embarrassed or shy, 8 felt "weird," and one woman said that it was painful. Selected responses are as follows:

- I do not like it but it is necessary.
- Embarrassed.
- Weird.
- Scared at first but was relieved when no lumps were found.
- I felt fine and comfortable because a Vietnamese female doctor examined me.

Another question asked, "When you think about examining your own breasts, tell me how you feel? More than 30% of the women felt apprehensive or anxious because they were concerned that they might find a lump. However, a larger percentage (47%) had negative comments about the examination. Some people were uncomfortable, and several did not know how to do it. Selected responses were:

- Unsure what to feel for.
- Fearful that I may find a lump.
- I do not like it; it is weird.
- I do not mind do [sic] it myself, but I do mind when a male doctor does it.
- I feel OK, but I think it would be better if the doctor does it.

A final question about breast screening was, "If we wanted to tell women like yourself about breast cancer and BSE, what would be some good ways (strategies) that we could use?" Many of the women mentioned the value of pamphlets, although others pointed out that visual presentations such as videos or television programs might be more effective. Others emphasized the value of one-on-one presentations at home or in the doctor's office, with direct demonstrations using breast models and other visual aids. The participants suggested that strategies be developed to motivate women to do BSEs and have regular checkups. Suggestions included small workshops, presentations by breast cancer survivors, and inclusion of this information in ESL classes for newcomers.

Some of the women mentioned being uncomfortable with this issue and preferred to discuss it with a female doctor. More than 90% of the responses emphasized the need to have these strategies carried out in the women's first language. For example, the women stated that they would prefer a Vietnamese-language television program on BSE. They expressed the same sentiment in regard to pamphlets, books, leaflets, and so on. Following are selected comments:

- Movie or TV program in my language is better than books.
- Booklet, leaflet, or brochure has to be in my language, and it is better if I could take them home as references.
- Discussion with friends, demonstration, and lecture by someone who has gone through it. This could be organized by the Vietnamese Women's Club.
- The topic should be taught in ESL classes for newcomers.
- Articles published in Thoi Bao (a Toronto-based magazine for the Vietnamese community).

Table 5 illustrates a significant finding between education level and prevalence of BSE. The higher the participants' education level, the more likely it was that the participants did BSEs. As presented in Table 6, there were insignificant differences between the percentage of women who have had BSEs, Pap smears, or mammography and the gender of the examiner. The percentage of women who had their breasts examined by female or male doctors was approximately the same (see Table 7). The finding revealed that 83% of these doctors were Vietnamese or Chinese Vietnamese, a clear indication of the women's preference to be examined by a doctor of their own ethnic background (see Table 8).

Table 5
Education and BSE Rates

Education	**BSE**		**p**
	Yes	**No**	
Below diploma	22%	81%	*
Above diploma	78%	19%	

* Variable on which the groups differed significantly

Table 6
Gender of Family Doctor and Breast Screening (BS), Pap Smear (PS), Mammography (M)

Breast Screening	**Family Doctor**		**p**
	Female	**Male**	
Yes	92%	69%	
No	8%	31%	
Pap Smear			
Yes	83%	69%	
No	17%	31%	
Mammography			
Yes	67%	48%	
No	33%	52%	

Table 7
Breast Examination and Examiner

Examiner	Percentage
Self	21%
Doctor (male)	35%
Doctor (female)	40%
Nurse	4%
Other	0%

Table 8
Ethnicity of Examiner

Ethnicity	Percentage
Vietnamese and Chinese Vietnamese	83%
Caucasian	14%
Others	3%

Cervical Screening

Table 9 contains summary information about the percentages of women who answered positively to questions about cervical screening. The most dramatic finding was that 35% of the women had refused at some time to have an internal examination. The combined percentage of women being discussed or received written information on the importance of Pap smears was approximately the same as the percentage of women had went for Pap smears.

Table 9
Percentage of Women Who Answered Yes to Questions Related to Cervical Screening

Questions Related to Cervical Screening	Percentage
Have you ever had a Pap Smear?	78%
Have you had a Pap Smear every year or two?	66%
Have you had unusual symptoms (bleeding)?	5%
Has a doctor/nurse ever discussed the importance of regular Pap Smears?	53%
Have you ever refused an internal examination (Pap smear)?	35%
Have you received any written information about having regular Pap Smears?	20%

The participants who have had a Pap smear were asked, "How did you feel about having this examination done?" The majority of the respondents found the procedure uncomfortable, weird, or embarrassing. Some women saw it as part of a normal physical examination. Many of them indicated that the experience would be much better if the

examiner were a female doctor. One woman specified that she would rather have it done by a foreign male doctor if no Vietnamese female doctor were available. Following are selected comments:

- I do not like it as it is uncomfortable. A female doctor is preferred.
- Nobody likes it, but it is something you have to get done.
- Uncomfortable and embarrassing.
- It is OK, but only with female doctor.

Another question asked about Pap smears was, "Are there any strategies you could suggest to prepare you for this examination?" The women were also asked, "Describe some of the reasons why you would not have a Pap smear." The overlapping responses to these questions confirmed previous answers. Many of the women preferred to have a female doctor or nurse conduct the examination. Some of the women commented on the need for more information about what to expect during the examination. The recommended that each step of the examination be presented simply and clearly. Following are selected comments:

- I prefer a female doctor, a Vietnamese female doctor is better because I would not understand these technical terms in English.
- Leaflet and brochure...explain its [*sic*] importance, as well as lay out step-by-step what women should expect of the procedure.
- Relax and distraction are the keys [*sic*].

Discussion

This study investigated a convenience sample of 49 women of Vietnamese or Chinese Vietnamese ethnic origin to assess their knowledge, attitudes, beliefs, and practices toward personal breast and cervical cancer screening. Therefore, before the results can be generalized to a larger population of women, the results must be interpreted with caution. The data reinforced the need and rationale for interventions to promote breast and cervical screening among Vietnamese women. The data confirmed that this is an appropriate population for an intervention targeting ethnic women because (a) the respondents reported a limited knowledge of cancer screening and preventive care. For example, only 38% had ever done a BSE, and only 55% knew about breast x-rays or mammography; (b) the respondents frequently reported never having been advised about cancer screening procedures (e.g., only 51% had ever had a breast x-ray or mammography, and 66% reported having a Pap smear every year or 2); (c) as in previous studies of this ethnicity, doctors or nurses were the preferred contacts for information on health-related topics such as BSE, mammography, and Pap smears. This partiality has not been given an appropriate amount of attention (e.g. only 4% of the women's doctors or nurses had ever discussed examining their breasts with them, and only 53% of the women's doctors or nurses had ever discussed the importance of regular Pap smears).

The overall Pap test receipt rate within the last two years of 66% for Vietnamese Canadian women was lower than that of other ethinic groups and urban minorities (Mandelblatt, Gold & O'Malley, 1999; Maxwell, Bastani & Warda, 2000; Skaer, Robison, Sclar & Harding, 1996). Results support prior findings regarding the socio-demographic factors related to Pap test receipt in this population (Jenkins et al., 1999;

McPhee, Bird, Davis, Ha, Jenkins & Le, 1997; McPhee, Stewart, Brock, Bird, Jenkins & Pham, 1997; Yi, 1998). The oldest women were less likely to have had a Pap test. If they had never had a Pap, they were less likely to intend on obtaining one. Women who were less educated had lower Pap test awareness.

Studies of Vietnamese American women and other populations have showed that having a regular place of health care or a regular physician was positively associated with test receipt (Ettner, 1996; Hsia, Kemper & Kiefe, 2000; Jenkins, Le, McPhee, Stewart & Ha, 1996; Mandelblatt et al., 1999; McPhee et al., 1997). The same is not found in this study. Access to culturally concordant care may be more important than access to any care for the provision of Pap tests to Vietnamese women (McPhee, 2002). In this study, the participants were more likely to have had a Pap if their doctor was female. Taylor, Schwartz & Jackson also found that having a female physian was associated with recency of Pap testing in Cambodian women (Taylor, Schwartz & Jackson, 1999). Regardless of provider ethnicity, it was reported that Vietnamese women were more likely to have had a Pap test if the provider is female.

As of qualitative data, three major themes emerged:

Theme 1: Being able to talk with doctors is important

Theme 2: Having a Pap test is uncomfortable

Theme 3: Cultural competency

In the first theme, several barriers to accessing physicians as outlined by participants were limited office hours, difficulties in finding child care, bat tien transportation, long waiting at doctor office. Many women expressed concerns because they did not know how to formulate questions. Furthermore, answers to their questions

were given using difficult medical terminology. Women found it difficult to seek a physician visit for themselves and sought advise only when "there was a definite problem bothering them". Overall, poor experiences with physicians and office receptionists , and unavailibility of female Vietnamese doctor were shown to decrease the likelihood of a return visit of cancer screening purpose.

Misconceptions about Pap tests found in this study were similar to what Fitch et al. (1998) and Steven et al (2004) found in their study. Many women had not been aware of how pap smear helped in early detection of cervical cancer. They thought that it would indicate that a woman had cancer. Most women mentioned that they had to get ready for the procedure or "be prepared" for it. The majority of participants described the procedure as embarrassing, humiliating, and unpleasant. Leg position, conversation through the exam, and physician gender were said to play a role in comfort levels.

As for the third theme, almost all women indicated that they would have done the tests (i.e. Pap smears, mammography, breast self examination) if their family doctors have explained and encouraged them to take those tests. Cultural competency encompasses cultural sensitivity, cultural knowledge, and cultural skills. Cultural sensitivity refers to attitudes, perceptions, and values that show heightened awareness of providers' own culture and that of the population being served. Cultural knowledge refers to knowledge of integrated systems of learned behavior as well as their attitudes, feelings, and values. Cultural skills connote abilities, roles, and functions to systematically examine beliefs, values, and practices of the group and to determine health care needs within the cultural context of this group (Kim-Goodwill, Clarke, & Barton, 2001).

Several studies have reported that relationships with healthcare providers have a significant influence in reported intentions to engage in cancer screening (Burnett, Steakley, & Tefft, 1995). These results are consistent with the conclusions of Coughlin & Uhler (2002) indicating that Hispanic women are more likely to undergo cancer screening if they have a regular health care provider. In terms of breast health, "...healthcare providers can reinforce positive cultural values and recognize cultural beliefs that may encourage breast cancer screening" (Giammona, 2002, p. 10).

In addition to the strong influence of healthcare providers on cancer screening behavior, agencies that coordinate services for Vietnamese need to maintain a high level of cultural capacity in order to promote successful outreach and service delivery.

Repeatedly, Vietnamese in this study mentioned several Vietnamese organizations such as Vietnamese Association, Vietnamese Women Club, Vietnamese Senior Club as their preferred knowledge-transfer agencies. Culturally competent agencies work to hire unbiased employees and seek advice and consultation from their clients. These agencies seek staff who represent the racial and ethnic communities being served...and [are] capable of negotiating a diverse and multicultural world...Further, culturally competent agencies understand the interplay between policy and practice, and are committed to policies that enhance services to a diverse clientele (cited in Quality Health Services for Hispanics: The Cultural Competency Component, 2000, p. 16).

An integral, culturally sensitive intervention program embedded in a well-defined Health Behavior Framework may eliminate and/or reduce the multiple barriers for low-income Vietnamese cited in the breast cancer screening literature, and result in increased annual screening rates. The insights presented in this case study reinforce the importance

of providing culturally competent, well-coordinated services. The authors concur with Rackinzcki and DiClemente (1999) when they state: "Approaches that have demonstrated promise should form the basis for refinements and experimentation, grounded in theoretical underpinnings, until a technology of prevention can be fully developed. In the end, empirically grounded theory and extensive field testing will result in the development of effective programs. The promise of a 'quick fix' must be understood to be an illusion. The demand for ready solutions should be responded to with the development of technically sound solutions (p. 6)".

Overall, this sample of women required education and information regarding BSE. Strategies suggested to enhance knowledge regarding BSE and breast cancer included the availability of pamphlets and videos that are culturally oriented, workshops on the topics, and the use and demonstration silicon breast model. These women also suggested that the following strategies be considered for cervical screening practices: education by health professionals about expectations during the procedure, dissemination of pamphlets that are culturally sensitive, and trust in the family physician. Moreover, the relationship between service provider (i.e. family doctor) and patient (i.e. Vietnamese women who are in need for breast and cervical screening) should be explored to further indentify relevant factors affecting breast and cervical screening rates

Limitations of the Study

There were several limitations of this research design. The first one concerned the accuracy of the self-report procedure utilized by the sample. Self-reported rates of screening test acceptance may be inaccurate because of limited recall or distorted because of acquiescence bias (i.e., overreporting of behaviours perceived to be desirable). Also, one cannot generalize the results of this study on a sample of Vietnamese women from Toronto to the Vietnamese population elsewhere in Canada or the United States. More in-depth qualitative data could have been obtained if face-to-face interviews instead of a mail-in survey had been conducted. Moreover, a larger sample size would have presented a clearer pattern of differences in breast and cervical screening for each age group. Finally, questions on income, year of migration, and English proficiency should be added to assess the relationship of these sociodemographic variables and the sample's knowledge, attitudes, beliefs, and practices toward personal breast and cervical cancer screening.

Recommendations

These women require education and information regarding both breast and cervical cancer including demonstrations and screening guidelines. Support and encouragement to participate in screening programs is highly recommended. Appropriate, culturally sensitive educational intervention programs are suggested to target this population.

Education

- To develop culturally sensitive health education programs and resources (pamphlets, videos, and television and media programs).

- To develop educational programs focusing on the importance of screening, prevention, and early detection of breast and cervical cancer for newcomers whose are attending ESL classes.
- To develop educational programs for health care professionals on cultural sensitivity regarding breast and cervical cancer for this specific population

Accessibility to Screening Services

- To advocate for more female examiners in breast and cervical screening programs.
- To advocate for more Vietnamese female doctors to provide screening tests after hours and on weekends.
- To work in collaboration with community representatives and Vietnamese organizations in Toronto to overcome barriers such as transportation, child care, and language to accessing services.

Research

- To conduct a provincewide study on breast and cervical screening practices.
- To evaluate the effects of certain characteristics related to sociodemographics and the individual's knowledge, attitudes, and beliefs about breast and cervical cancer screening.

Summary

This study examined the knowledge, attitudes, and practices of Vietnamese Canadian women ages 40 to 60 toward breast and cervical cancer screenings. The study was designed to be appropriate to the culture, language, and education of emigrated Vietnamese women and aimed to identify the possible barriers in race or ethnicity,

culture, and socioeconomic status (SES) that Vietnamese Canadian women face in their efforts to take preventive measures and participate in breast and cervical cancer screening. This study also indirectly raised awareness on cancer screening amomg the participants. Results indicate that there's difference in cancer screening practice amomg Vietmamese women who have different education level. The higher the year of school completed, the higher the prevalence of cancer screening. Moreover, language and gender of examiner are the two frequent mentioned barriers to cancer screening practice, where gender of examiner is scored as more important. Vietnamese women would more likely to make a Pap Smear's appointment with a female doctor/nurse of any ethnicity than with a Vietnamese male doctor/nurse. In addition, results clearly reveal a gap in cancer screening knowledge among these Vietnamese women. Most of them are having little or no knowledge of breast and cervical cancer screening tests. They all express a desire to acquire this information through culturally appropriate communication chanels such as Vietnamese Women's Club, Vietnamese television and radio's programs, leaflets and brochure in Vietnamese language, etc. The insights presented in this case study reinforce the importance of providing culturally competent, well-coordinated services. Overall, it can be suggested that culturally sensitive media intervention would be an appropriate strategy for achieving a necessary and, therefore, valuable first step toward early detection of cancer. Furthermore, this study may be the point of departure to further research among the same population to examine the relationships between a culturally competent system of care, ethnocentric support systems, and annual breast and cervical screening rates. To our knowledge, very few reports (Bobo et al., 1999) have comprehensively investigated the factors associated with annual breast cancer screening

among low-income women with access to free testing, and their level of satisfaction with the services they receive. Data of this nature is urgently needed to enhance public health delivery. The authors suggest that future studies should examine the feasibility and impact of this complex model in another geographical area with low-income Vietnamese, and isolate the most effective strategies that result in increased annual breast and cervical screening rates.

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APPENDIX A

Interview Guide Data Code Sheet (English Version)

Part A Demographic Data

1. How old are you? **Coded Response**
    1. under 40
    2. 40-45
    3. 46-50
    4. 51-55
    5. 56-60
    6. 61-65
    7. Other (specify)_____

2. What is the highest education you received?
    1. Grade School
    2. Diploma
    3. Degree
    4. Graduate

3. Are you currently working?
    1. Yes, Full Time
    2. Yes, Part Time
    3. Not employed

4. What is your usual job or occupation?

_____

_____

5. Where do you live?
    1. Urban (city centre)
    2. Rural

6. To which ethnic or cultural group do/did your parent belong?

_____

7. What is your marital status? **Coded Response**
    1. Single
    2. Married
    3. Common-law relationship
    4. Separated
    5. Widowed
    6. Divorced

8. If married (common-law), what is the highest level of education your husband obtained?

1. Grade School
2. Diploma
3. Degree
4. Graduate

☐

9. Is your husband/spouse presently working?

1. Yes, full time
2. Yes, part time
3. Not employed

☐

10. What is your husband's usual job/occupation?

_____

_____

11. If you are married or living in a common-law relationship, please indicate:

	1st	2nd	3rd	4th
Date of marriage	19___	19___	19___	19___
Age at marriage				
Age of husband				
Length of relationship				
Marriage ended in (separation/divorce/death (please specify)				
If husband died, please specify cause of death				

12. Do you have children?

1. Yes
2. No

☐

If yes, how many children do you have?_____

How old are your children?

_____

_____

13. Do you have a family doctor? **Coded Response**

1. Yes
2. No

☐

14. What is the gender of your family doctor?

1. Male
2. Female

☐

15. What is the ethnic background of your family physician?

_____

Part B **General Health**

16. Have you ever been diagnosed by a physician as having any of the conditions listed below?

1. High blood pressure
   No Yes If yes, age at diagnosis_____

2. High blood cholesterol
   No Yes If yes, age at diagnosis_____

3. Heart disease
   No Yes If yes, age at diagnosis_____

4. Diabetes
   No Yes If yes, age at diagnosis_____

5. Cancer
   No Yes If yes, age at diagnosis_____

What type of cancer was it?_____

17. Are you currently taking medications for any of the conditions listed above? Please specify.

No	Yes	Blood pressure medication
No	Yes	Cholesterol reduction
No	Yes	Heart medication
No	Yes	Birth Control pills
No	Yes	Hormones
No	Yes	Thyroid
No	Yes	Insulin

18. Have you ever smoked cigarettes? **Coded Response**
   No Yes

19. Do you currently smoke?
   No Yes ☐

If yes, how many cigarettes do you smoke per day?_____

20. At what age did you start smoking?

☐ Age (years)

21. When did you stop smoking? (if stopped)

☐ Age (years)

22. When you smoke (smoked) did you inhale, specify to what extent?

Do not inhale
Inhaled, slightly
Inhaled, moderately
Inhaled, deeply

Part C **Eating habits** **Coded Response**

23. Meat/Protein

1. Eat regular cuts of red meat
2. Eat a mixture of regular meats and some protein
3. Eat only lean meats, skinless poultry, or fish
4. Eat very little red meat, mostly poultry or fish
5. Seldom or never eat meat, eat vegetable proteins

☐

24. Dairy Products/Eggs

High fat: sour cream, yellow cheese, whole milk, eggs, butter

Low fat: skim milk, low fat yogurt or cottage cheese, egg whites, or egg replacers

1. Nearly always eat high fat products
2. Eat mostly the high fat products, some low fat
3. Eat both about the same
4. Eat primarily low fat products, some high fat
5. Eat only low fat products or none at all

☐

25. Desserts **Coded Response**

High fat: cake, deep fried pastry, pies, ice cream, custards, chocolate

Low fat: fruit salads, gelatin, melons, grapes, dried fruit, home baked goods using vegetable oil in moderation

1. Nearly always eat high fat products
2. Eat mostly the high fat products, some low fat
3. Eat both about the same
4. Eat primarily low fat products, some high fat

☐

5. Eat only low fat products or none at all

26. Cooking Fats/Food Preparation

High fat: frequent frying, deep fat frying, primarily use shortening, frequently add butter or other fats to foods for flavoring, use regular amount of fat called for in recipes

Low fat: broil, bake or boil, primarily use vegetable oil, flavor food with seasonings, keep added very low fat

1. Food nearly always cooked the high fat way
2. Food mostly cooked the high fat way
3. Food cooked both ways the same
4. Food cooked primarily the low fat way
5. Food prepared only the low fat way

27. Breads and Grains

Refined: white bread, rolls, biscuits, crackers, regular pancakes, waffles, white rice, typical breakfast cereals and baked goods

Whole grain: whole grain bread, rolls, brown rice, oatmeal and other whoel grain cereals such as Shredded Wheat, grapenuts.

1. Nearly always eat refined grains
2. Eat mostly refined grains
3. Eat both about the same
4. Eat primarily whole grain products
5. Eat only whole grain products

28. Fruits and Vegetables **Coded Response**

How often do you eat fruits and vegetables?

1. 5 or more servings per day
2. 4 servings per day
3. 3 servings per day
4. 2 servings per day
5. 1 or less serving per day

29. Fast foods

How often do you eat fast food meals such as hamburgers, tacos, fried chicken, hot dogs, French fries?

1. Every day

2. Several times per week
3. Occasionally
4. Seldom or never

30. Salt

How often do you add salt to your food at the table?

1. Always
2. Most of the time
3. Little of the time
4. Never

31. Alcoholic Beverages

In the past two weeks, on how many days did you drink any alcoholic beverages such as beer, wine or liquor?

1. Did not drink in past year
2. None in past two weeks
3. One to three days
4. Four to six days
5. Seven to ten days
6. Eleven to fourteen days

32. Number of Drinks **Coded Response**

How many drinks did you have per day on the average?

1. One
2. Two
3. Three
4. Four
5. Five
6. Five or more drinks

33. Caffeine

How many caffeine containing drinks do you usually have per day?

1. None
2. 1 per day
3. 2-3 per day
4. 4-5 per day
5. 6+ per day

34. What type of exercise do you do?

Aerobics	Active Sports (specify)
Bicycling, easy pace	Bicycling, fast pace
Canoeing	Racqueball
Walking briskly	Walking at an easy pace
Skating	Cross country skiing
Swimming	Stationary bicycle
Tennis	Outdoor work (lifting, carrying, shovelling)

35. How often do you exercise per week?

☐ times/week

36. In general how would you describe your health?

1. Very good
2. Good
3. O.K.
4. No so good
5. Poor

☐

37. In your opinion, how would you describe your health in comparison to other women of your age?

1. Better than
2. About the same
3. Worse than

☐

38. In order to keep yourself healthy what kinds of things do you do?
(Probe: Is there any special activity such as exercise, walking, regular visits to the doctor?)

_____

_____

39. In order to do the things that you have just told me that keep you healthy, do you encounter any difficulty or problem? If yes, could you tell me what.

_____

_____

_____

40. When did you have your last check-up?

1. Within last year

☐

2. 1-2 years
3. 3-4 years
4. 5 years or more
5. Never
6. Don't know

41. Was an internal examination done?
    1. Yes
    2. No

42. Why did you go for an examination?

Reason	Yes	No	Do not know	No answer
Symptoms – something was troubling you				
Regular check up				
Friend or relative suggested it				
Required at work				
Required for employment				
Insurance examination				
Something you read in a magazine				
Something you saw on TV				
A doctor suggested you should				
No reason				

43. Have you ever been pregnant?
    1. Yes
    2. No

44. If yes, how many pregnancies have you had (please include all lovebirths, stillbirths, miscarriages, abortions, ectopic pregnacies).

    Pregnancies

45. How old were you at the beginning of your first pregnancy?

    Age (years)

46. How many pregnancies lasting 5 months or more you have had?

    Pregnancies

47. How old were you at the end of your first pregnancy lasting 5 months or more?

    Age (years)

48. How many pregnancies have ended in livebirths?

☐ Pregnancies

49. Did you breastfeed after any of your pregnancies?
    1. Yes
    2. No ☐

50. How many months in total did you breastfeed?

☐ Months

51. Have you ever taken oral contraceptives?
    1. Yes
    2. No ☐

52. Are you currently taking oral contraceptives?
    1. Yes
    2. No ☐

53. How old were you when you took your first oral contraceptive?

☐ Years

54. For how long did you use oral contraceptives before age 25?

☐ Years (s) ☐ Month (s)

55. For how long did you use oral contraceptives before your first pregnancy?

☐ Years (s) ☐ Month (s)

56. At what age did you stop using oral contraceptives?

☐ Age

57. Has a doctor ever refused to give you a prescription for oral contraceptives?
    1. Yes
    2. No ☐

If yes, why? _____

58. Have you ever used other methods of birth control? (circle as many as used)

1. IUD 2. Rhythm 3. Cervical Cap 7. Other (specify)
4. Sponge 5. Diaphragm 6. Spermacides

59. Have you had a tubal ligation?

1. Yes
2. No ☐

60. Are you currently using female replacement hormones?
1. Yes
2. No ☐

61. At what age did you start using female replacement hormones?

☐ Age (years)

62. For how long did you use female replacement hormones?

☐ Year(s) ☐ Month(s)

63. Which type of female hormones did you use?

1. Oral premarin (estrogen alone)
2. Oral estrogen (premarin) and progesterone (provera)
3. Patch estrogen ☐
4. Oral progesterone (provera)
5. Vaginal estrogen
6. Patch estrogen and progesterone

Part D **Clinical Examination of Breast**

64. In your opinion, how much control do you have over your health?

1. A lot of control
2. A fair bit of control ☐
3. Uncertain
4. Not very much control
5. No control

65. In the next few questions we talk about breasts and breast cancer.

Have you ever had your breast examined?
1. Yes ☐
2. No

If yes, please answer the following questions

How often have you had your breasts examined? _____

Who did this examination (Record as many as are mentioned)?
1. Self

2. Doctor (male)
3. Doctor (female)
4. Nurse
5. Other (specify) _____

What was the cultural background of the examiner? _____

Why was the examination necessary?

1. No not know
2. Routine check up
3. Had a lump in breast

How did you feel about this examination being done?

_____
_____
_____

If no, answer the following question

Has your doctor/nurse ever discussed examining your breasts with you?

1. Yes
2. No

66. Have you ever refused a breast examination?

If yes, tell me why you refused

_____
_____
_____

Part E Breast Self-Examination

67. Are you aware that women can examine their own breast?

1. Yes
2. No

This examination is done to detect cancer at an early state and it is called breast self examination or BSE.

How familiar are you with breast self examination?

_____
_____
_____

Has anyone ever told you how to do a breast self examination?

1. Yes

2. No
3. Uncertain

Has anyone ever demonstrated BSE to you?

1. Yes
2. No

If yes, who was it? _____

Have you ever received any written information about BSE?

1. Yes
2. No

If yes,

What information did you receive?

_____
_____
_____

Who gave you the information?

_____
_____
_____

What were the benefits of receiving this information?

_____
_____
_____

68. Have you ever done a breast self-examination?

1. Yes
2. No

If yes,

How often do you do it (i.e., once a month)

_____
_____

How do you do the examination?

69. In you opinion, how often should you do breast self-examination?

70. How important do you think breast self-examination is?

71. Tell me what you know about breast cancer?

72. When you think about examining your own breasts, tell me how you feel?

73. How comfortable do you feel in doing BSE? **Coded Response** ☐

1. Uncomfortable
2. Fairly comfortable
3. Very comfortable

74. What do you think about women examining their own breasts?

75. In your own opinion, if you were examining your own breasts do you feel that you would be able to detect any abnormality or anything that feels different? ☐

1. Yes
2. No
3. Unsure

76. What would you do if you did find something that felt suspicioius or different?

77. What would you tell?

Part F Breast Cancer

78. Do you know anybody who has breast cancer?
    1. Yes
    2. No

What was your relationship with that person?
    1. Mother
    2. Sister
    3. Grandmother
    4. Cousin
    5. Friend
    6. Work Colleague
    7. Neighbour
    8. Aunt
    9. Other

Tell me what happened to that person

79. Thinking about their illness/experience how do you think it has influenced you?

80. In your opinion, who can acquire breast cancer, or who is more likely to get breast cancer?

81. What are the risks for breast cancer?

Part G Mammography

82. Do you know about breast x-ray or mammography?
    1. Yes

2. No

83. Do you know about breast screening?
1. Yes
2. No

If you answered yes to questions 82 and 83

Where did you find out about mammography?

How helpful did you dind this information?

Have you ever had a breast x-ray or mammography?
1. Yes
2. No

How did you feel when the mammography was being done?

Did the individual who conducted the procedure explain what was being done?

What emotional support was provided to you when this procedure was being done?

84. If we wanted to tell women like yourself about breast cancer and breast self examination, what would be some good ways (strategies) that we could use?

Part H Pap Smear

85. In the next few questions, we talk about pap smears and cervical cancer

Have you had a pap smear?

1. Yes
2. No

☐

If yes, please answer the following questions

How often have you had a pap smear?

1. Yearly
2. Every two years
3. Other (specify) _____

☐

Who did this examination (Record as many as mentioned)?

1. Doctor (male)
2. Doctor (female)
3. Nurse Practitioner

☐

What was the cultural background of the examiner? _____

Why was the examination necessary?

1. Do not know
2. Routine check up
3. Unusual symptoms (bleeding)

☐

Have your periods been irregular?

1. Always
2. Often
3. Sometimes
4. Rarely
5. Never

☐

Have your periods been usually heavy?

1. Always
2. Often
3. Sometimes
4. Rarely
5. Never

☐

How old were you when your periods started?

☐ Year(s)

86. Has a doctor/nurse ever discussed the importance of regular pap smears?

1. Yes
2. No

87. Have you ever refused an internal examination (pap smear)?
    1. Yes
    2. No

88. How did you feel about having this examination done?

_____
_____
_____

89. Is there any strategies you could suggest to prepare you for this examination?

_____
_____
_____

90. Have you received any written information about having regular pap smears?
    1. Yes
    2. No
    3. Do no remember

Who gave this information?

_____
_____
_____

What were the benefits of receiving this information?

_____
_____
_____

Describe some of the reasons why you would not have a pap smear? (i.e., fear, embarrassment, pain, travel difficulties, no female doctor)

_____
_____
_____

Part I Cervical Cancer

91. Have you ever been diagnosed with cervical cancer?
    1. Yes
    2. No

If yes, answer the following questions

At what age were you diagnosed?

☐ Years

What were the symptoms (if any)?

1. Abnormal vaginal bleeding
2. Contact bleeding related to intercourse
3. Feeling that you have to urinate urgently
4. Pain when you urinate
5. Other symptoms (specify)

☐

_____

Are you aware of the risk factors for cervical cancer? (Probe for the answer)

_____

_____

_____

Did your mother ever take the drug DES (Diethylstilbesterol), a drug which was given for high risk pregnancies?

1. Yes
2. No
3. Do not know

☐

92. What type of treatment did you receive?

1. Cryosurgery
2. Electrocautery
3. Colposcopy
4. Cone biopsy
5. Hysterectomy
6. Radiation
7. Other (specify) _____

☐

93. What type of information were you given related to cervical cancer (i.e., treatment, follow-up)?

_____

_____

_____

94. What type of emotional support did you receive when you were diagnosed (specify by whom)?

_____

_____

_____

95. If we wanted to well women like yourself about cervical cancer and the importance of regular pap smears, what would be some good ways (strategies) that we could use?

_____

_____

_____

96. If you have had breast or cervical cancer answer the following:

Did you use other forms of alternative medicine (e.g. herbs, massage, chiropractor, sweat lodge, healing ceremonies)?

_____

_____

_____

Do you feel that these methods were of help? Explain

_____

_____

_____

THANK YOU FOR TAKING THE TIME TO PARTICIPATE IN THIS SURVEY. IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO CONTACT DR. DARLENE STEVEN AT (807) 343-8643 or TUE NGUYEN AT (416) 536-4535

Source:

Steven, D., Dhaliwal, H., Fitch, M., Choudhry, U., Clarke, E., Kirk-Gardner, R., et al. (2001). Breast and cervical cancer screening: Knowledge, attitudes, beliefs and practices in selected ethno-cultural groups in Northwestern Ontario. *Oncol Nurs Forum, 31*(2), 305-311.

APPENDIX B

Interview Guide Data Code Sheet (Vietnamese Version)

BẢNG PHỎNG VẤN

Phần A: Thông tin cá nhân

Xin vui lòng khoanh tròn câu trả lời của bạn

1. Bạn bao nhiêu tuổi: Trả lời

    1. Dưới 40
    2. 40-45
    3. 46-50
    4. 51-55
    5. 56-60
    6. 61-65
    7. Tuổi khác (Xin ghi rõ):_____

2. Trình độ học vấn:

    1. Trung học
    2. Cao đẳng
    3. Đại học
    4. Trên đại học

3. Bạn có đi làm không?

    1. Có đi làm toàn thời gian
    2. Có đi làm bán thời gian
    3. Không đi làm

4. Nghề nghiệp: _____

5. Nơi sinh sống:

    1. Thành thị (Trung tâm thành phố)
    2. Nông thôn

6. Bạn là người gốc gì? (ví dụ: Hoa, Việt , v.v.v...): _____

7. Tình trạng hôn nhân:

    1. Độc thân
    2. Đã có gia đình
    3. Sống như vợ chồng
    4. Ly thân

5. Góa chồng
6. Ly dị

8. Nếu bạn đã có gia đình, trình độ học vấn của chồng bạn là:
1. Trung học
2. Cao đẳng
3. Đại học
4. Trên đại học

9. Chồng/bạn trai của bạn có đi làm không?
1. Có đi làm toàn thời gian
2. Có đi làm bán thời gian
3. Không đi làm

10. Nghề nghiệp của chồng/bạn trai của bạn: _____

11. Nếu bạn đã có gia đình hoặc đang sống chung không giá thú, xin vui lòng nêu rõ:

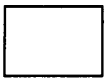
	Lần thứ nhất	**Lần thứ hai**	**Lần thứ ba**	**Lần thứ tư**
Ngày đám cưới	19__	19__	19__	19__
Tuổi lúc đám cưới				
Tuổi của chồng bạn				
Quan hệ của bạn được bao lâu				
Tình trạng hôn nhân hiện nay của bạn (Ly thân, ly dị, goá chồng (xin vui lòng ghi rõ))				
Nếu chồng của bạn đã qua đời, xin vui lòng nêu rõ nguyên nhân				

12. Bạn có con không?
1. Có
2. Không
Nếu có, bạn có bao nhiêu con?_____
Tuổi của các con bạn:_____

13. Bạn có bác sĩ gia đình không?
1. Có
2. Không

14. Giới tính của bác sĩ gia đình của bạn:

1. Đàn ông
2. Phụ nữ



15. Bác sĩ gia đình của bạn là người:_____

Phần B: Thông tin chung về sức khoẻ

16. Có bao giờ bạn được chẩn đoán có những bệnh như sau

1. Cao huyết áp
   ☐ Không ☐ Có
2. Có mỡ trong máu
   ☐ Không ☐ Có
3. Bệnh về tim
   ☐ Không ☐ Có
4. Tiểu đường
   ☐ Không ☐ Có
5. Ung thư
   ☐ Không ☐ Có

Loại ung thư:_____

17. Bạn có đang uống thuốc nếu bạn mắc những loại bệnh nêu trên không? Nếu có, xin vui lòng ghi rõ

Thuốc cao huyết áp
☐ Không ☐ Có
Thuốc hạ mỡ trong máu
☐ Không ☐ Có
Thuốc cho bệnh tim
☐ Không ☐ Có
Thuốc ngừa thai
☐ Không ☐ Có
Hóc môn
☐ Không ☐ Có
Bứu
☐ Không ☐ Có
Insulin
☐ Không ☐ Có

18. Bạn có bao giờ hút thuốc không?

☐ Không ☐ Có

19. Hiện nay bạn có hút thuốc không?

☐ Không ☐ Có

Nếu có, bạn hút bao nhiêu điếu mỗi ngày:_____

20. Bạn bắt đầu hút thuốc khi nào?

☐ Tuổi

21. Bạn bỏ thuốc khi nào:

☐ Tuổi

22. Khi bạn hút thuốc, bạn có hít sâu không? Xin vui lòng ghi rõ mức độ

☐ Không hít sâu

☐ Hít sâu, nhưng chỉ một ít

☐ Hít sâu, bình thường

☐ Hít thật sâu

Phần C: Thói quen về ăn uống

23. Thịt / Đạm

1. Thường ăn thịt đỏ ☐
2. Thường ăn thịt và một vài loại thức ăn có đạm khác
3. Chỉ ăn thịt trắng, thịt không có da, hoặc cá
4. An rất ít thịt đỏ, phần nhiều là ăn thịt trắng và cá
5. Chỉ thỉnh thoảng hoặc không bao giờ ăn thịt, ăn đạm thực vật

24. Sản phẩm từ sữa/trứng

Có nhiều chất béo - kem chua, phô-mai (cheese) vàng, sữa nguyên chất, trứng, bơ

Có ít chất béo - sữa không béo, Ya-ua ít béo hoặc phô-mai nguyên chất, lòng trắng trứng, hoặc sản phẩm thay thế cho trứng

1. Hầu như luôn luôn ăn những sản phẩm có nhiều chất béo
2. An nhiều sản phẩm có nhiều chất béo, chỉ một ít có ít chất béo
3. An cả hai thứ bằng nhau
4. An chủ yếu sản phẩm có ít chất béo, một ít có nhiều chất béo
5. Chỉ ăn sản phẩm có ít hoặc không có chất béo

25. Các món tráng miệng

Có nhiều chất béo - bánh, bánh chiên, bánh, kem, sôcôla

Có ít chất béo - xà-lách trái cây, nho, trái cây khô, các món tự làm sử dụng dầu thực vật.

1. Hầu như lúc nào cũng ăn thức ăn có nhiều chất béo
2. An nhiều sản phẩm có nhiều chất béo, chỉ một ít có ít chất béo
3. An cả hai thứ bằng nhau
4. An chủ yếu sản phẩm có ít chất béo, một ít có nhiều chất béo
5. Chỉ ăn sản phẩm có ít hoặc không có chất béo

26. Cách nấu ăn

Có nhiều chất béo – Thường xuyên chiên xào, thường thêm bơ hoặc dầu mỡ vào thức ăn, thường sử dụng nhiều chất béo khi nấu ăn.

Có ít chất béo – Hấp, nướng hoăc hấp, chủ yếu dùng dầu thực vật, nêm thức ăn bằng các chất phụ gia, ít sử dụng chất béo

1. Hầu như luôn luôn nấu ăn bằng cách có nhiều chất béo
2. Thường nấu ăn bằng cách có nhiều chất béo
3. Nấu bằng cả hai cách
4. Nấu ăn chủ yếu bằng cách có ít chất béo, thỉnh thoảng bằng cách có nhiều chất béo
5. Chỉ nấu ăn bằng cách có ít chất béo

27. Bánh mì và bột ngũ cốc

Tinh chế – bánh mì trắng, bánh qui, banh kẹp, gạo trắng, cereals và bánh nướng

Bột ngũ cốc nguyên chất – bánh mì làm bằng bột ngũ cốc, bánh cuốn, gạo lức, lúa mạch và cereals làm từ gạo nguyên chất ví dụ như Shredded wheat

1. Luôn ăn bột ngũ cốc tinh chế
2. Hầu như luôn ăn bột ngũ cốc tinh chế
3. Ăn cả hai thứ
4. Ăn chủ yếu bột ngũ cốc nguyên chất
5. Chỉ ăn bột ngũ cốc nguyên chất

28. Trái cây và rau

Bạn thường ăn trái cay và rau không?

1. 5 phần hoặc là nhiều hơn mỗi ngày
2. 4 phần mỗi ngày
3. 3 phần mỗi ngày
4. 2 phần mỗi ngày
5. 1 phần hoặc ít hơn mỗi ngày

29. Thước ăn nhanh

Bạn có thường ăn thức ăn nhanh như bánh mì kẹp thịt (hamburger), tacos, gà chiên, hot dogs, khoai tây chiên

1. Hàng ngày
2. Vài lần mỗi tuần
3. Thỉnh thoảng
4. Hiếm khi hoặc không bao giờ

30. Muối

Bạn có thường thêm muối vào thức ăn ở bàn ăn

1. Luôn luôn
2. Thường xuyên
3. Thỉnh thoảng
4. Không bao giờ

31. Thức uống có cồn

Trong hai tuần vừa qua, bao nhiêu ngày bạn uống thức uống có cồn nhu bia hoặc rượu

1. Không uống trong năm vừa qua
2. Không uống trong hai tuần vừa qua
3. Một đến ba ngày
4. Bốn đến sáu ngày
5. Bảy đến mười ngày
6. Mười một đến mười bốn ngày

32. Số chai hoặc là ly

Trung bình bạn uống bao nhiêu chai hoặc ly mỗi ngày?

1. Một
2. hai
3. Ba
4. Bốn
5. Năm
6. Năm hoặc nhiều hơn

33. Cà phê

Mỗi ngày bạn thường uống bao nhiêu ly thức uống có cà phê?

1. Không uống ly nào
2. Một ly mỗi ngày
3. Hai đến ba ly mỗi ngày
4. Bốn đến năm ly mỗi ngày
5. Sáu ly hoặc hơn mỗi ngày

34. Môn thể dục mà bạn tập

- ☐ Thể dục nhịp điệu
- ☐ Môn thể dục khác (xin nêu rõ) _____
- ☐ Đạp xe đạp, tốc độ bình thường
- ☐ Đạp xe đạp, tốc độ nhanh
- ☐ Chèo thuyền
- ☐ Racquetball
- ☐ Đi bộ, tốc độ nhanh
- ☐ Đi bộ, tốc độ bình thường
- ☐ Lướt ván

☐ Trượt tuyết đường dài
☐ Bơi lội
☐ Đạp xe đạp tại chỗ
☐ Tennis
☐ Làm việc (khiêng vác nặng, xúc đất)

35. Bạn tập thể dục bao nhiêu lần mỗi tuần?

[/] Lần/Tuần

36. Bạn tự đánh giá sức khoẻ của bạn thế nào?

1. Rất tốt
2. Tốt
3. OK
4. Không tốt lắm
5. Yếu

[ ]

37. Theo bạn, sức khoẻ của bạn như thế nào so sánh với những người phụ nữ khác cùng tuổi bạn?

1. Tốt hơn
2. Bằng
3. Yếu hơn

[ ]

38. Để giữ sức khoẻ, bạn làm gì?

(Gợi ý: Chẳng hạn nhu tập thể dục, đi bộ, hoặc là thường xuyên đi khám bác sĩ)

_____
_____
_____

39. Bạn có gặp khó khăn gì khi bạn thực hiện những hoạt động mà bạn vừa kể trên không? Xin vui lòng ghi rõ nếu có

_____
_____
_____

40. Bạn khám bác sĩ lần cuối cùng khi nào?

1. Trong tuần trước
2. Trong 1 đến 2 năm trước
3. Trong 3 đến 4 năm trước
4. 5 năm hoặc nhiều hơn
5. Không bao giờ
6. Không biết

41. Bạn có khám phụ khoa không?

1. Có
2. Không

42. Tại sao bạn đi khám bác sĩ?

Lý do	Đúng	Sai	Khoâng bieát	Không trả lời
Triệu chứng làm bạn khó chịu				
Khám định kỳ				
Bạn bè hoặc là người thân gợi y				
Yêu cầu từ chỗ làm				
Yêu cầu để tìm việc làm				
Khám theo yêu cầu của hãng bảo hiểm				
Đọc báo				
Xem Tivi				
Bác sĩ yêu cầu				
Không có lý do gì hết				

43. Có bao giờ bạn có thai chưa?

1. Có
2. Chưa

44. Nếu có, bạn đã có thai bao nhiêu lần rồi? (Tính tất cả những lần đã sinh, đang mang bầu, hư thai, nạo thai và có thai ngoài tử cung)

Lần

45. Bạn có thai lần đầu tiên lúc bạn bao nhiêu tuổi?

Tuổi

46. Bạn có thai bao nhiêu lần được 5 tháng hoặc hơn?

☐ Lần

47. Bạn bao nhiêu tuổi tính đến lúc bạn mang thai lần đầu tiên được 5 tháng hoặc hơn xong?

☐ Tuổi

48. Bạn sinh bao nhiêu lần?

☐ Lần

49. Bạn có nuôi con bằng sữa mẹ sau khi sinh không?

1. Có
2. Không

50. Tính tổng cộng, bạn nuôi con bằng sữa mẹ bao nhiêu tháng?

☐ Tháng

51. Bạn có bao giờ uống thuốc ngừa thai không?

1. Có
2. Không

☐

52. Hiện nay bạn có uống thuốc ngừa thai không?

1. Có
2. Không

☐

53. Bạn uống thuốc ngừa thai lần đầu tiên lúc bao nhiêu tuổi?

☐ Tuổi

54. Đến năm 25 tuổi, bạn đã uống thuốc ngừa thai được bao lâu?

☐ / Năm /Tháng

55. Bạn uống thuốc ngừa thai trong bao lâu đến khi bạn có thai lần đầu tiên?

[/] Năm/ Tháng

56. Bạn ngưng uống thuốc ngừa thai khi bạn được bao nhiêu tuổi?

[ ] Tuổi

57. Có bao giờ bác sĩ từ chối cho bạn uống thuốc ngừa thai không?

1. Có
2. Không [ ]

Nếu có, tại sao?_____

58. Bạn có bao giờ dùng cách ngừa thai nào khác không? (Đánh dấu tất cả những các mà bạn dùng)

1. Đặt vòng
2. Đếm ngày
3. Cột tử cung (cervical cap) [ ]
4. Miếng thấm diệt trùng (sponge)
5. Phễu hứng tinh trùng (diaphragm)
6. Thuốc diệt tinh trùng
7. Cách khác (Xin ghi rõ)_____

59. Bạn có bao giờ có tubal ligation

1. Có [ ]
2. Không

60. Hiện nay bạn có sử dụng hoc môn thay thế nữ không? (female replacement hormones) (FRH)

1. Có [ ]
2. Không

Nếu cóxin trả lời tiếp câu 61, nếu không xin sang phần D

61. Bạn bắt đầu sử dụng hoc môn thay thế nữ (female replacement hormones) khi nào?

☐ Tuổi

62. Bạn sử dụng FRH được bao lâu?

☐ Năm/ Tháng

63. Bạn sử dụng loại FRH nào?

1. Loại uống Oral premarin (estrogen alone)
2. Oral premarin (premarin) and progesteron (provera)
3. Loại dán Patch estrogen
4. Oral progesterone (provera)
5. Loại bôi Vaginal estrogen
6. Patch estrogen and progesterone

☐

Phần D: Khám bệnh về vú

64. Theo bạn, bạn có kiểm soát được sức khoẻ của bạn không?

1. Kiểm soát được nhiều
2. Kiểm soát được
3. Không chắc
4. Không được nhiều
5. Không được

☐

65. Những câu hỏi tiếp theo sẽ về vú và bệnh ung thư vú

A. Bạn có bao giờ đi khám vú?

1. Có
2. Không

☐

Nếu có, xin vui lòng trả lời những câu hỏi sau:

Bạn có đi khám vú thường xuyên không?_____

Ai khám vú cho bạn? (đánh dấu tất cả những câu trả lời thích hợp)

1. Tự khám
2. Bác sĩ (Nam)
3. Bác sĩ (Nữ)

☐

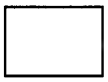
4. Y tá
5. Người khác (Xin vui lòng nêu rõ)

Người khám vú cho bạn là người có gốc (dân tộc) nào?

_____

Tại sao bạn cần khám vú?

1. Không biết
2. Khám định kỳ
3. Có khối u trong ngực



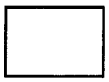
Bạn cảm thấy như thế nào về việc khám vú của bạn?

_____
_____
_____

Nếu không, xin vui lòng trả lời nhưng câu hỏi sau

Bác sĩ hoặc y tá của bạn có bao giờ nói chuyện về việc khám vú với bạn không?

1. Có
2. Không



66. Bạn có bao giờ từ chối được khám vú không?

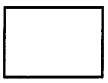
Nếu có, tại sao?

_____
_____
_____

Phần E: Tự khám vú (Khám để phát hiện ung thư thời kỳ đầu và được gọi là tự khám vú)

67. Bạn có biết là phụ nữ cũng có thể tự khám vú cho mình được?

1. Có
2. Không



Bạn có biết nhiều về việc tự khám vú không?

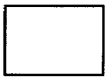
_____

_____

_____

Có ai nói cho bạn biết làm thế nào để tự khám vú không?

1. Có
2. Không
3. Không rõ



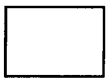
Có ai hướng dẫn cho bạn tự khám vú không?

1. Có
2. Không

Nếu có, ai?_____

Bạn có bao giờ đọc về tự khám vú không?

1. Có
2. Không



Nếu có,

Bạn đọc về cái gì?

_____

_____

_____

Ai đưa cho bạn thông tin đó?

_____

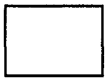
_____

_____

Lợi ích của việc đọc những thông tin trên là gì?

68. Bạn có bao giờ tự khám vú không?

1. Có
2. Không



Nếu có,

Bạn có thường tự khám vú không? (ví dụ, mỗi lần một tháng)

Bạn tự khám vú như thế nào?

69. Theo bạn, bạn nên tự khám vú thường xuyên thế nào?

70. Bạn nghĩ là việc tự khám vú quan trọng thế nào?

71. Bạn nghĩ như thế nào về ung thư vú?

72. Khi bạn nghĩ về việc tự khám vú, bạn cảm thấy thế nào?

_____

_____

_____

73. Bạn cảm thấy thế nào khi tự khám vú?

1. Không thoải mái
2. Khá thoải mái
3. Rất thoải mái

☐

74. Bạn nghĩ như thế nào về việc phụ nữ tự khám vú?

_____

_____

_____

75. Theo bạn, khi bạn tự khám vú, bạn có cảm thấy rằng bạn có thể phát hiện cái gì bất thường hoặc cái gì đó thấy khác?

1. Có
2. Không
3. Không chắc

☐

76. Bạn sẽ làm gì nếu bạn cảm thấy cái gì đó khác hoặc gây nghi vấn?

_____

_____

_____

77. Bạn sẽ nói với ai?

_____

_____

_____

Phần F: Ung thư vú

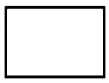
78. Bạn có biết ai bị ung thư vú không?

☐

1. Có
2. Không

Nếu có, quan hệ của bạn với người đó thế nào?

1. Mẹ
2. Chị em gái
3. Bà
4. Dì
5. Bà con
6. Bạn bè
7. Bạn đồng nghiệp
8. Hàng xóm
9. Khác



Xin nêu rõ chuyện gì xảy ra với người đó

_____
_____
_____

79. Khi nghĩ về bệnh của người đó, chuyện đó ảnh hưởng đến bạn thế nào?

_____
_____
_____

80. Theo bạn, ai có thể bị ung thư vú? Hoặc là ai có thể dễ bị ung thư vú?

_____
_____
_____

81. Nguy cơ bị ung thu vú là gì?

_____
_____
_____

Phần G: Chup X quang vu/ (Mammography)

82. Bạn có biết về chụp X quang vú?

1. Có
2. Không

83. Bạn có biết gì về khám vú (breast screening)?

1. Có
2. Không

Nếu bạn trả lời có cho câu hỏi 82 và 83

Bạn biết về chụp X quang vú ở đâu?

Bạn nghĩ là thông tin này có ích như thế nào?

Bạn có bao giờ đi chụp X quang vú không?

1. Có
2. Không

Bạn cảm thấy như thế nào khi bạn đang được chụp X quang vú?

Người chụp X quang vú cho bạn có giải thích cho bạn biết họ đang làm gì không?

Bạn nhận được hỗ trợ tinh thần như thế nào khi bạn được chup X quang vú?

_____

_____

_____

84. Nếu chúng tôi muốn nói với những người phụ nữ như bạn về ung thư vú và việc tự khám vú, những cách tốt nhất mà chúng tôi có thể sử dụng là?

_____

_____

_____

Phần H: Pap Smear (PS)

85. Trong những câu hỏi tiếp theo sẽ về Pap Smear và ung thư tử cung

A) Bạn có bao giờ có PS không?

1. Có
2. Không

☐

Nếu có, xin vui lòng trả lời những câu hỏi sau?

Bạn có PS có thường không

1. Hàng năm
2. Hai năm một lần
3. Khác (vui lòng nêu rõ)_____

☐

Ai thực hiện PS cho bạn? (Đánh dấu tất cả những câu trả lời đúng)

1. Bác sĩ (Nam)
2. Bác sĩ (Nữ)
3. Y tá

☐

Gốc (dân tộc) của người thực hiện PS cho bạn là gì?

_____

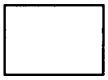
Tại sao bạn nghĩ PS cần thiết?

1. Không biết
2. Khám định kỳ
3. Triệu chứng bất thường (chảy máu)

☐

Bạn có có tháng không bình thường không?

1. Luôn luôn
2. Thường có
3. Thỉnh thoảng
4. Hiếm khi
5. Không bao giờ



Khi bạn có tháng, bạn thường ra nhiều máu hơn bình thường?

6. Luôn luôn
7. Thường có
8. Thỉnh thoảng
9. Hiếm khi
10. Không bao giờ

Bạn bắt đầu có tháng khi bạn bao nhiêu tuổi?

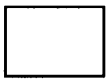
Tuổi

86. Y tá hoặc bác sĩ của bạn có bao giờ thảo luận với bạn về tầm quan trọng của việc có PS thường xuyên?

1. Có
2. Không

87. Bạn có bao giờ từ chối khám phụ khoa Paps Smear không?

1. Có
2. Không



88. Bạn cảm thấy như thế nào về việc đi (PS)?

_____

_____

_____

89. Bạn có cách nào để chuẩn bị đi khám PS?

_____
_____
_____

90. Bạn có bao giờ đọc thông tin về việc có PS thường xuyên?

1. Có
2. Không
3. Không nhớ

☐

Ai đưa thông tin cho bạn?

_____
_____
_____

Việc đọc những thông tin trên mang lại lợi ích gì cho bạn?

_____
_____
_____

Xin đưa một vài lý do bạn không đi PS? (ví dụ như: sợ, ngại, đau, không có phương tiện đi lại, không có bác sĩ nữ)

_____
_____
_____

Phần I: Ung thư tử cung

91. Có bao giờ bạn được chẩn đoán bị ung thư tử cung?

1. Có
2. Không

☐

Nếu có, xin trả lời những câu hỏi sau?

Bạn được chẩn đoán lúc bao nhiêu tuổi?

☐ Tuổi

Triệu chứng (nếu có):

1. Chảy máu âm đạo bất thường
2. Chảy máu khi quan hệ sinh lý ☐
3. Cảm thấy rất muốn đi tiểu
4. Cảm thấy đau khi đi tiểu
5. Triệu chứng khác (xin vui lòng nêu rõ)_____

Bạn có biết gì về nguy cơ bị ung thư tử cung?

_____
_____
_____

Bạn có bao giờ uống thuốc DES, loại thuốc cho các trường hợp mang thai có nguy cơ cao?

1. Có ☐
2. Không
3. Không biết

92. Bạn được điều trị như thế nào?

1. Cryosurgery
2. Electrocautery ☐
3. Colpascopy
4. Cone biopsy
5. Hysterectomy
6. Radiation
7. Other (xin vui lòng nêu rõ)_____

93. Bạn nhận được thông tin gì liên quan đến ung thư tử cung? (ví dụ như điều trị, theo dõi)?

_____
_____
_____

94. Bạn nhận được hỗ trợ tinh thần như thế nào khi bạn được chẩn đoán có bệnh?

_____

_____

_____

95. Nếu chúng tôi muốn nói cho những người phụ nữ như bạn về ung thư tử cung và sự quan trọng của việc đi PS thường xuyên, chúng tôi nên dùng cách nào?

96. Nếu bạn có ung thư vú hoặc là ung thư tử cung, xin vui lòng trả lời những câu hỏi sau?

Bạn có dùnng thuốc hoặc cách chữa trị nào khác (ví dụ như thuốc bắc, xoa bóp, châm cứu, chữa trị bằng tâm linh)

97. Bạn có nghĩ rằng những cách trên có ích không? Vui lòng giải thích

_____

_____

_____

Xin chân thành cám ơn bạn đã bỏ thời gian quí báu tham gia cuộc điều tra của chúng tôi. Nếu bạn có gì thắc mắc, xin vui lòng liên hệ Darlene Steven (807) 343-9643 hoặc Tue Nguyen (416) 536-4535

Source:

Steven, D., Dhaliwal, H., Fitch, M., Choudhry, U., Clarke, E., Kirk-Gardner, R., et al. (2001). Breast and cervical cancer screening: Knowledge, attitudes, beliefs and practices in selected ethno-cultural groups in Northwestern Ontario. *Oncol Nurs Forum, 31*(2), 305-311.

APPENDIX C

Letter to Participants

January, 2006

Dear Participant:

My name is Tue Tran Nghi Nguyen. I am currently in my last year of Masters Public Health program at Lakehead University, Thunder Bay, Ontario. I am writing to request your participation in a study examining practices of Vietnamese Canadian women aged 40 and older regarding breast and cervical screenings.

The objectives of the study are:
1. To examine the knowledge, attitudes, and practices regarding breast and cervical cancer screenings of Vietnamese Canadians in Toronto, Ontario.
2. To identify barriers (if any) facing Vietnamese Canadian women in taking preventive measures and participating in breast and cervical cancer screenings.
3. To make recommendations and strategies for ethnic-focused breast and cervical cancer screenings' health promotion programs

It will probably take you about 30 to 45 minutes to fill out the distributed questionnaires. The questionnaires come in two languages: Vietnamese and English. You are welcome to use either or both languages to answer the questions. A pre-stamped and pre-addressed envelope is provided at your convenience so that you can mail the questionnaire back to the researcher.

Participation in this study is voluntary. There is no risk of physical or psychological harm involved in this study.

All information you provide will be kept confidential. Please do not write your name on the questionnaire. The information will be compiled by the primary researcher, whose is myself. The information will be stored in a secure and confidential location for seven years at Lakehead University, Department of Public Health.

If you have any questions or concerns, please feel free to contact,

either myself at:

Tue Tran Nghi Nguyen
MPH Student, Lakehead University
(416) 536-4535
tnguyen2@lakeheadu.ca

or my research supervisor at:

Dr. Darlene Steven
Professor, School of Nursing
Lakehead University, 955 Oliver Road
Thunder Bay, Ontario
(807) 343-8643

Thank you in advance for your participation in this survey.

Sincerely yours,

Tue Tran Nghi Nguyen

APPENDIX D

Informed Consent Form

By signing this form, I indicate that I agree to participate in a study conducted by Tue Tran Nghi Nguyen, student in the Master's of Public Health Program at Lakehead University, Thunder Bay, Ontario. The study is on the knowledge, attitudes, beliefs, and practices of Vietnamese Canadian women in Toronto, Ontario, Canada, regarding breast and cervical cancer screenings.

I am aware of and agree to the following:

1. I am a volunteer and can withdraw at any time of from the study.
2. I am a Vietnamese or Chinese-Vietnamese woman who is 40 years of age or older.
3. There is no risk of physical or psychological harm to me for participating in this study.
4. I will receive a copy of the study from the researcher upon written request.
5. All information will be kept in a secure and confidential location for 7 years in Lakehead University's Department of Public Health, after which time it will be shredded and destroyed.

Signature of Participant

_____

Date

APPENDIX E

Summary of Responses to Selected Survey Questions

1. **How They Keep Healthy**

Q1: In order to keep yourself healthy what kinds of things do you do?

- Exercise: 16 people, mostly walking, swimming and aerobics
- Eat well: 15 people, more fruits and vegetables
- Rest/enough sleep: 9 people
- Visit doctor: 5 people, for routine check-up and blood test
- Other strategies: healthy lifestyles, "be happy"

2. **Difficulties Encountered with Health Behaviour Actions**

Q2: Do you encounter any difficulties or problem trying to do healthy things?

- Not enough time: 9 people
- Health problem: 1 person, tiredness
- Weather: 1 person, too cold to walk
- Other, scheduling: 1 person, babysitting grandchildren on swimming day

3. **Feelings Related to Breast Examination Being Done**

Q3: How did you feel about this (breast) examination being done?

Positive comments:

- OK, fine, no problems: 25 people
- Comfortable: 12 people
- Relieved: 1 person

Negative comments:

- Embarrassed: 11 people
- Weird: 8 people
- Shy: 2 people
- Painful: 1 person

4. **Feelings Related to Examining Own Breasts**

Q4: When you think about examining your own breasts, tell me how you feel?

Positive comments:

- Fearful may find a lump: 19 people
- Ok, no problem: 16 people
- Good: 1 person

Negative comments:

- Uncomfortable: 13 people
- Weird: 11 people
- Not necessary: 2 people

5. **Strategies to Inform Women About Breast Cancer and Breast Self-Examination**

Q5: If we wanted to tell women like yourself about breast cancer and BSE, what would be some good ways (strategies) that we could use?

- Pamphlets or books: 14 people
- Videos or TV programs: 12 people
- Through doctor using breast models: 9 people
- Informal meetings through Vietnamese clubs:7 people
- Dissussion with friends, demonstration, and lecture by someone who has gone through it, with visual aids: 5 people
- Women's magazines, daily newspaper, leaflets given out at supermarkets: 3 people
- Should be taught in ESL class: 1 person
- Through church: 1 person

**** 90% of the responses emphasized that materials or language of instruction should be in their languages which were Vietnamese or Chinese in this study.***

6. **Feelings Related to Internal Examination Being Done**

Q6: How did you feel about having this (internal) examination done?

- Uncomfortable: 16 people
- Had to be done: 14 people
- Weird: 9 people
- Nervous and embarrassed: 5 people
- OK and comfortable: 2 people
- Nobody likes it: 2 people
- No comment: 1 person

7. **Strategies to Inform Women About a Pap Smear**

Q7: What are your suggested strategies and reasons whey you might refuse to have a Pap smear done?

- No female doctor: 22 people
- No Vietnamese female doctor: 20 people
- No time: 5 people
- Conflict schedule: 2 people

- Educate women when they are very young to know what to expect.
- I would prefer a female doctor.
- Step-by-step procedure of a pap smear and the reasons why it is important.
- Try to relax and think of something else.
- Distraction is good.
- The doctor should be really nice.