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Then and Now: Comparison of Baseline Breast Cancer Screening Rates at 2 Time Intervals

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Abstract

Background—Breast cancer is Asian American women’s most frequently occurring cancer.

Methods—Asian American women completed breast cancer-related baseline surveys for 2 studies 5 years apart.

Results—Statistically significant and rapid improvements in knowledge and screening practices were seen between the 948 participants in the first study (1995) and the 1540 participants in the second study. This increase paralleled the reported climb in early detection rates among Asian American women.

Conclusions—The data document the achievement of a tipping point in breast cancer screening rates with culturally and linguistically focused education programs and increased access to screening among disadvantaged women.

Breast cancer is the most frequently occurring cancer among women living in the United States. Asian American women have the lowest breast cancer incidence rates, but their likelihood of developing breast cancer increases with the length of time that they have lived in the United States. Hence, that low incidence rate is anticipated to increase as Asian American women’s residency in the United States extends.^{1,2} Further, as the Asian population’s average age has risen, so has its breast cancer incidence. Between 1988 and 2002, the breast cancer incidence among Asian American women increased from 77.7 per 100,000 to 92.9 per 100,000, whereas a decrease in incidence was noted when all women were grouped together (from 135.5 per 100,000 to 126.7 per 100,000). Asian women have also had lower breast cancer mortality rates than other groups, but during that same time period, their mortality rate increased from 14.0 per 100,000 in 1988 to 14.7 per 100,000 in 2002,³ whereas the mortality rate among women of all races combined decreased from 32.4 per 100,000 women in 1988 to 23.2 per 100,000 in 2002.³

Such data highlighted the need to promote breast cancer education and screening among Asian American women if a rise in mortality rates were to be prevented. Of equal concern was the data that showed Asian American women had the lowest rate of breast cancer early detection.^{4,5}

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Given the life-saving value of early breast cancer detection and the economic barriers to screening, the California legislature created the 1993 Breast Cancer Act. Effective July 1994, this funded mandate provided low income women throughout California with free access to breast cancer screening. It also funded a series of breast cancer education programs throughout the State.

In this article, we examine changes in the knowledge, behaviors, and attitudes of 2 convenience samples of Asian women who participated in separate evaluations of the Asian Grocery Store-Based program.

MATERIALS AND METHODS

Data collection was accomplished through the Asian Grocery Store-Based Cancer Education Program, a campus-community partnership with the Moores University of California, San Diego (UCSD) Cancer Center as the campus partner and over 2 dozen Asian grocery stores throughout San Diego County as the community partners. UCSD recruited bilingual, bicultural Asian American university students to work as the program's breast cancer community health educators in salaried and service learning positions. They personalized breast cancer public health messages to large numbers of Asian American women for whom language, culture, and transportation barriers might limit access to information and screening.⁶⁻¹⁴

Asian grocery stores were asked to partner with the university because they were perceived to be venues where Asian women repeatedly spent a considerable amount of discretionary time. In addition, Asian women of diverse acculturation levels, linguistic preferences and proficiencies, and socioeconomic status could be easily reached at the Asian grocery stores.⁶⁻¹⁴

The Asian grocery-store-based education programs were designed as brief interventions to heighten breast cancer awareness, to stimulate and motivate the women to gather additional information, and to get screened if they were not already adhering to the mammography and clinical breast exam guidelines. Over the duration of the studies, breast self-exam screening was gradually losing favor, but adherence continued to be evaluated because the final conclusions regarding breast self exam had not been established.¹⁵

Posters in various Asian languages and country-specific visual icons helped to attract shoppers; small tokens of appreciation (eg, small candles, small vases, sunscreen samples) were given to women who agreed to participate in the study. Once trained, health educators rotated their education sessions among the Asian grocery stores and varied the times and days of the outreach events to increase sample diversity.

From 1995 to 1998, women (N = 1202) were recruited to a demonstration project (Study 1) to evaluate the feasibility, viability, and acceptability of Asian grocery stores as sites for delivering breast cancer information.⁶⁻¹⁴ Women verbally consented and completed a baseline survey in their preferred language (Institutional Review Board [IRB] approved). Based on the success of the demonstration project, an IRB-approved, randomized controlled trial (Study 2) was conducted at the Asian grocery stores from 2000–2004 (N = 1687). In this article, we compare the baseline data between Study 1 and 2.

Description of the Sample

Participants self-identified as being female, of Asian descent, and at least 20 years of age. Whereas Study 1 focused on the 6 largest Asian ethnic groups (Chinese, Filipino, Southeast Indian, Japanese, Korean, and Vietnamese), Study 2 was focused on the 4 Asian

communities that Study 1 had shown to have the lowest adherence rates to recommended screening guidelines (Chinese, Filipino, Korean, and Vietnamese). Only the Study 1 participants ($n = 948$) from those 4 groups were included in this study with the 1540 participants from Study 2.

Of the women who reported their age (85% in Study 1; 94% in Study 2), the ages ranged from 20 to 86 years for Study 1 and from 20 to 101 for Study 2, with 46% of those in Study 1 and 73% of those in Study 2 being aged 40 and older (Table 1). This age shift from Study 1 to Study 2 ($\chi^2_1 = 124.9$, $P = 0.05$) reflected the methodologic shift to overrecruiting women aged 40 and older in Study 2 because of breast cancer's increasing risk with age.

Data Analysis

The data were analyzed using SPSS version 14.0 (SPSS, Inc., Chicago, IL). Mammography and clinical breast examination (CBE) data analysis excluded participants younger than 40 years of age. Statistical significance was determined by chi-square analysis, with a $P < .05$ considered to be significant.

RESULTS

Evaluating Change

Changes in Baseline Breast Cancer Screening Rates from Study 1 to 2—

Women showed statistically significant increases in adherence to recommended breast self-exam, CBE, and mammography screening guidelines from Study 1 to 2 (Tables 2 and 3). The increased screening rates were also noted for each of the 4 individual ethnic groups. A parallel statistically significant decrease was noted in the number of women who reported never having had a mammogram from Study 1 to 2 (Table 4).

Anticipating Future Programmatic Content and Structure

Women's Perceptions of the Adequacy of Their Breast Cancer Knowledge—

To help the research team plan future interventions, women were asked about their perceptions of the adequacy of their current breast cancer knowledge (Table 5). Less than half of the women in Studies 1 and 2 reported feeling that they possessed sufficient knowledge, and there was no significant difference from Study 1 to 2. When participants were compared by ethnic subgroup, Korean women reported a statistically significant increase in the perceived adequacy of their breast cancer knowledge by Study 2, whereas Chinese women reported a statistically significant decrease in the adequacy of their breast cancer knowledge at Study 2.

Women's Reported Preferences for Receiving Future Health Information—

To facilitate addressing identified needs for additional information, women were asked to indicate their preferences for how they would like to receive future health information and could select either by mail, by telephone, or both. Receiving information by mail was the participants' clear preference, with two thirds of the women indicating that they preferred to receive their future health information by mail in Study 1 and three fourths by Study 2 ($P < .05$). This shift reflected changes seen mostly among Filipino and Vietnamese women.

The frequency with which women opted to receive their health information by phone also increased significantly, a finding that was consistent among all 4 ethnic subgroups (Table 5). In Study 1, less than one third of the women preferred to receive health information by phone; by Study 2, over 50% of women preferred to receive their health information by phone. Between those 2 groups was a smaller group of women who selected both mail and

phone, 22% for Study 1 and 33% for Study 2, respectively ($P < .05$). This shift was significant for every ethnic group except Korean women.

DISCUSSION

Consistent with the findings from Study 1, previous studies had also shown that Asian American women engaged in breast cancer screening at suboptimal rates.^{16–18} In Study 1, screening rates were far below the 70% goal then set in the National Cancer Institute's and the American Cancer Society's Year 2000 Goals, suggesting a cohort at significant risk of late stage breast cancer detection.^{4,19–22}

These data raised grave concerns for Asian American women's breast cancer related risks because adherence to screening guidelines has been consistently correlated with early stage detection, which has, in turn, been correlated with increased survival rates.^{23–25} In California, such findings prompted interventions directed at Asian American women through California's Breast Cancer Early Detection Program, Komen for the Cure, the American Cancer Society, and the National Cancer Institute.

The cumulative outcome of this plethora of media campaigns and public health programs directed toward Asian American women may have increased their awareness of the need for screening and contributed to the dramatic shift in screening rates seen by Study 2.^{26, 27} This occurred across the sample as a whole as well as across all 4 ethnic subgroups studied.

These shifts are consistent with shifting increases in earlier stages of breast cancer detection more recently reported by the California Cancer Registry.²⁸ According to the data in the California Cancer Registry, the early stage detection among Asian American women has steadily improved to the point that Asian American women surpassed Hispanic American women's early detection rates in 1994, equaled African American women's rates in 2001, and surpassed white women in 2003.²⁹

This study suggests that many Asian American women realize they need more breast cancer information and offers several information delivery strategies. The women's preferences to receive information by mail or phone or both suggest educational strategies that might be employed. The Asian grocery stores clearly offer an additional, well-tested strategy.

A key strength of this campus community partnership with Asian grocery stores was the diversity of the women reached and the greater likelihood that they may be underserved, from a medical and public health perspective. Most reported preferences for using a language other than English: Study 1 (96%) and Study 2 (86%). This characteristic increases their risk of barriers to accessing information and services.

A limitation of this study was that the 2 studies data were drawn using convenience samples and may not be representative of all Asian American women. Further, at the time of this survey, standardized instruments that might have been appropriate for this study's focus were either not available or had not been validated for Asian American women. It was also not possible to verify the participants' self-reported screening adherence data due to the monetary limitations of this study.

In spite of these limitations, the statistically significant increase in reported adherence to screening guidelines from Study 1 to Study 2 suggests that women at least knew the "socially desirable responses" they should be giving by Study 2, and this shift was parallel to the shift toward increased rates of early breast cancer detection being reported in the California Cancer Tumor Registry. Thus, for 4 Asian groups included in this study, the data

offer additional insight into the breast cancer knowledge, attitudes, and behaviors of this cohort of Asian American women.

CONCLUSION

The findings reported from this data analysis, in combination with the decreasing numbers of Asian women being reported by the California Cancer Registry to have been detected with late stage breast cancer, suggest that the efforts of public and private organizations and individuals are making a significant, positive impact on improving the breast health of Asian American women. Vigilance is still warranted, however, since as Asian women's tenure in the United States extends, so too will their risk of developing breast cancer, making it essential that health care providers across the state continue their efforts to reach Asian American women with information and screening appointments plus prompt follow-up appointments when abnormal breast changes are detected.

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TABLE 1
Sociodemographic Characteristics by Study Group of Women

Characteristic	Study 1*	Study 2†	P Value
	n (SD)	n (SD)	
Age, y			
Mean (SD)	42.4 (11.7)	48.5 (12.0)	<.001
Mode	45	48	
Median	41.0	48.0	
Range	20–86	20–101	
	n (%)	n (%)	2
Age groups			
20–39 y	369 (39)	338 (22)	1.40
40–49 y	242 (26)	466 (30)	70.87‡
50+ y	191 (20)	652 (42)	252.10‡
Unspecified	146 (15)	84 (6)	16.71‡
Full Sample	948 (100)	1540 (100)	212.20‡
Ethnic group§			
Chinese	302 (32)	390 (25)	11.19‡
Filipino	248 (26)	418 (27)	43.39‡
Korean	123 (13)	376 (25)	128.28‡
Vietnamese	275 (29)	356 (23)	10.40‡
Full Sample	948 (100)	1540 (100)	55.53‡
English as the native language			
Chinese	16 (2)	52 (13)	12.55‡
Filipino	17 (2)	102 (25)	33.11‡
Korean	3 (1)	49 (13)	11.23‡
Vietnamese	3 (1)	8 (2)	1.23
Total	39 (4)	211 (14)	171.45‡

* N = 948.

† N = 1540.

‡ For Study 1, the goal was to recruit the same portion of participants in each ethnic group.

§ For Study 2, the goal was to recruit equal sized ethnic groups with follow-up data rather than meeting the same proportions of participants as had been recruited in the earlier study.

TABLE 2
 Baseline Breast Self-Exam Screening Adherence Rates Increased Significantly from Study 1 to Study 2 Among all Ethnic Groups and Ages ($P < .05$)*

Ethnic Group	Age 20–39 y		Age 40–49 y		Age 50 and Over	
	n	%	n	%	n	%
Chinese (Study 1)	141	27	65	25	120	28
Chinese (Study 2)	96	62	120	59	275	64
	2	28.13	20.21		41.79	19.70
Filipino (Study 1)	72	46	75	48	137	49
Filipino (Study 2)	53	74	120	83	342	84
	2	9.63	27.31		62.18	31.84
Korean (Study 1)	59	32	27	22	51	26
Korean (Study 2)	117	52	140	63	234	62
	2	6.29	15.19		22.55	7.63
Vietnamese (Study 1)	84	20	66	33	109	32
Vietnamese (Study 2)	71	48	85	53	261	60
	2	13.32	5.79		24.22	15.74
Full Sample (Study 1)	356	30	233	34	417	36
Full Sample (Study 2)	337	57	465	65	1112	69
	2	52.23	60.44		137.07	69.90

*The numbers represent only women who provided valid data for these questions.

Baseline Adherence to Clinical Breast Exam and Mammography Screening Guidelines Increased Significantly Among and all Ethnic Groups and Ages (P < .05)*

TABLE 3

Ethnic Group	Annual Clinical Breast Exam Age 40 y and Over		Annual Mammography Age 50 y and Over		Annual Mammography Age 50 y and Over	
	n	%	n	%	n	%
Chinese (Study 1)	120	53%	120	34%	55	35%
Chinese (Study 2)	275	90%	275	83%	155	83%
²	68.89		89.64		46.24	
Filipino (Study 1)	137	48%	137	53%	62	58%
Filipino (Study 2)	344	90%	345	86%	224	88%
²	103.12		60.01		28.72	
Korean (Study 1)	51	49%	51	22%	24	29%
Korean (Study 2)	232	86%	234	77%	94	90%
²	35.48		58.05		41.76	
Vietnamese (Study 1)	109	54%	109	39%	43	33%
Vietnamese (Study 2)	262	89%	261	84%	177	89%
²	55.63		75.21		62.99	
Full Sample (Study 1)	417	52%	417	39%	184	47%
Full Sample (Study 2)	1113	89%	1115	83%	650	77%
²	260.69		269.98		173.10	

*The numbers represent only women who provided valid data for these questions.

TABLE 4

Women who Reported Never Having had a Mammogram at Baseline Decreased Among all Ethnic Groups and Ages ($P < .05$)*

Ethnic Group	Women Age 40-49 y		Women age 40 y and Over		Women Age 50 y and Over	
	n	%	n	%	n	%
Chinese (Study 1)	65	66%	120	66%	55	66%
Chinese (Study 2)	120	18%	275	18%	155	17%
²	42.31		89.64		46.24	
Filipino (Study 1)	75	52%	137	47%	62	42%
Filipino (Study 2)	121	18%	345	14%	224	12%
²	24.70		60.01		28.72	
Korean (Study 1)	27	85%	51	78%	24	71%
Korean (Study 2)	140	32%	234	23%	94	10%
²	26.38		58.05		41.76	
Vietnamese (Study 1)	66	56%	109	61%	43	67%
Vietnamese (Study 2)	84	25%	261	16%	177	11%
²	15.04		75.21		62.99	
Full sample (Study 1)	233	61%	417	60%	184	59%
Full sample (Study 2)	465	24%	1115	17%	650	13%
²	93.56		269.98		173.10	

*The numbers represent only women who provided valid data for these questions.

TABLE 5

Differences in Knowledge Preferences by Cultural Subgroups*

Ethnic Group	Sufficient Knowledge About Breast Cancer		Prefer to get New Health Knowledge by Mail		Prefer to get New Health Knowledge by Telephone		Prefer to get New Health Knowledge Both Ways	
	n	%	n	%	n	%	n	%
Chinese (Study 1)	184	57%	302	74%	302	19%	302	13%
Chinese (Study 2) ²	355	47%	379	79%	379	44%	379	22%
	4.36 [†]		2.10		46.52 [†]		9.46 [†]	
Filipino (Study 1)	182	47%	248	68%	248	30%	248	23%
Filipino (Study 2) ²	372	51%	409	78%	409	61%	409	39%
	0.53		8.91 [†]		57.98 [†]		17.24 [†]	
Korean (Study 1)	81	25%	123	76%	123	34%	123	28%
Korean (Study 2) ²	303	48%	366	76%	366	48%	366	24%
	14.37 [†]		0.03		7.52 [†]		0.64	
Vietnamese (Study 1)	200	49%	275	52%	275	39%	275	29%
Vietnamese (Study 2) ²	303	51%	345	72%	345	77%	345	48%
	0.22		26.86 [†]		91.71 [†]		23.82 [†]	
Full Sample (Study 1)	647	48%	948	66%	948	30%	948	22%
Full Sample (Study 2) ²	1333	49%	1499	76%	1499	57%	1499	33%
	0.45		29.50 [†]		176.62 [†]		34.02 [†]	

*The numbers represent only women who provided valid data for these questions.

[†]Chi-square indicates significant differences between the Study Groups, $P < .05$.