

PINE STUDY II: Research Article

Breast Cancer Screening Beliefs Among Older Chinese Women in Chicago's Chinatown

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Abstract

Background: Chicago's Chinatown is home to a sizeable community of first-generation Chinese American immigrants. This qualitative study seeks to describe the attitudes toward, and barriers and facilitators of, breast cancer screening among Chinese women in Chicago's Chinatown to inform strategies for future interventions.

Methods: We conducted six focus groups among Chinese-speaking adult women aged 45 and older. Focus groups were transcribed, coded, and analyzed for emergent themes.

Results: Forty-seven women participated in focus groups; 10 (21%) had received a breast cancer diagnosis in their lifetime, all participants were foreign-born, and 80% have resided in the United States for over 10 years. Participants expressed a range of breast cancer beliefs, attitudes toward screening, barriers encountered, and facilitators. Some differences were noted between women with cancer and those without. Barriers described include language, time, not wanting to burden their adult children, and transportation. Navigation services and physician recommendation were suggested facilitators to screening.

Conclusions: Our findings have important implications for development of interventions and policies to bolster breast cancer screening among Chinese women. We highlight the need to connect Chinese older adults with resources to navigate the health care system and present opportunities for community stakeholders, researchers, health professionals, and policy makers to improve the health of Chinese Americans.

Keywords: Breast cancer—Mammography—Chinese—Chinese American—Qualitative research

Asians are the fastest growing immigrant population group in the United States, with Chinese Americans constituting the largest Asian American subgroup (1). They account for 22.2% of Asian Americans, numbering over 4.5 million people (2). Among Chinese Americans, cancer is the leading cause of death (3), with breast cancer being the most frequently diagnosed cancer among Chinese American women (4). However, mammography screening rates are low among this population, with only 68% of Chinese women aged 50–74 years reporting having had a mammogram in the past 2 years (2)—far below the Healthy People 2010 goals (5). Furthermore, an estimated 76% of Chinese in the United States are foreign-born (6), but Chinese immigrant women face lower 5-year breast cancer survival rates than U.S.-born Chinese women (7).

Prior research has identified a range of cultural and structural barriers to cancer screenings among Asian Americans. Studies have

illuminated cultural factors such as health beliefs and family and gender roles (8–10). Other factors associated with low uptake of cancer screening include disparate access to care, socioeconomic status, limited English proficiency, length of residency in the United States, citizenship, and physician recommendations (11–14). However, few studies have disaggregated Asian American subgroups and concerns have been raised about extrapolating findings from studies that have grouped Asian Americans together (15,16). Moreover, calls have been made for qualitative studies to tease out nuances related to cultural and structural barriers that evade most quantitative studies (11).

In the case of Chinese Americans, the cultural relevancy of preventive health and health interventions is of pivotal importance. An effective preventive health program will need to provide culturally

sensitive models of successful aging tailored toward Chinese older adults to counteract beliefs such as fatalism, the notion of “emptiness” ingrained in Chinese culture, and other cultural barriers in accessing health care services (17). The few studies that have qualitatively explored barriers and facilitators to cancer screening among Chinese Americans have primarily focused on cancer patients or cancer survivors or have aggregated multiple Asian subgroups (8,18,19). To better aid the development of cancer screening interventions and messaging for Chinese American communities, additional emphasis is needed on Chinese American women who have no history of breast cancer. Examining differences in attitudes between women with different breast cancer experiences may also shed light on future intervention approaches.

Focusing on a sample of Chinese women diagnosed with breast cancer and a sample of Chinese women who do not have breast cancer, this qualitative study seeks to describe the attitudes toward, and barriers and facilitators of, breast cancer screening among Chinese women in Chicago’s Chinatown. Findings will bridge gaps in knowledge and explore strategies for future interventions.

Methods

For this qualitative study, we conducted focus groups with Chinese older adults in Chicago, Illinois. We used a semistructured moderator’s guide with questions designed to elicit cultural explanatory models of cancer (20). Within a Cultural Framework of Health (21), cultural explanatory models seek to elicit indigenous conceptions of cancer development, detection, and treatment rooted in social, cultural, and historical influences of screening behaviors (20). Included are cultural beliefs and values, personal life experiences, as well as biomedical and popular explanations of health and illness. Questions were arranged into three topic areas: (i) perceptions about breast cancer—including awareness and beliefs about how common breast cancer is among the Chinese community; (ii) perceptions and knowledge about breast cancer screening and treatment—including any perceived stigmas associated with cancer, barriers and facilitators to cancer screening, and knowledge about treatment options; and (iii) participants’ own experiences getting breast cancer screenings and navigating the health care system. Prior to conducting the focus groups, questions were refined by our Community Advisory Board (CAB) to ensure cultural appropriateness. The CAB consisted of representatives from health and social service organizations serving Chicago’s Chinese communities as well as cancer survivors and long-standing community advocates (22,23).

Recruitment and Data Collection

Women were recruited for focus groups from flyers distributed at Chinatown community organizations and through word-of-mouth. Eligibility criteria included: (i) female; (ii) self-identification as Chinese; (iii) ability to speak Cantonese or Mandarin Chinese; (iv) being aged 45 and older; and (v) residence in Chicago’s Chinatown. Study staff screened individuals for eligibility by phone. Trained focus group moderators fluent in Chinese conducted six focus groups between March and April, 2014. Informed consent was obtained prior to the beginning of the focus group session, followed by administration of an anonymous demographic questionnaire. Focus groups took place in private rooms at senior apartments or the Chinese American Service League, a social service agency located at the heart of Chicago’s Chinatown. Groups were segmented by cancer diagnosis and by women’s preferred dialect (Cantonese/Mandarin). In total, four focus groups were conducted in Cantonese

and two in Mandarin. Each focus group ranged from six to eight participants and lasted approximately 90 minutes. Focus groups were audio-recorded. Participants received a \$15 gift card for their participation. The Rush University Medical Center Institutional Review Board approved all study protocols and procedures.

Data Analysis

Focus groups were transcribed, translated into English, and reviewed by bilingual/bicultural study staff for accuracy. Members of the research team independently reviewed transcripts to identify initial coding schemes to add to the predefined themes derived from the semistructured interview guide. Schemes were compared and discussed until consensus was reached about a refined higher-level coding scheme. Two team members then independently coded each of the transcripts using QSR International NVivo 9 software. Discrepancies in coding were resolved through discussion with the entire team. Thematic analysis of focus group participant responses focused on general agreement among participants, consistency of findings as well as differences across groups, and concordance among coders’ assessments. As is standard practice, we used qualitative descriptions and exemplar quotes to convey the breadth and strength of agreement with a statement, rather than quantifying responses (24).

Results

Sociodemographic Characteristics of Focus Group Participants

Sociodemographic characteristics of focus group participants are presented in Table 1. Of the convenience sample of 47 women who participated in the focus groups, 10 (21%) had received a breast cancer diagnosis in their lifetime. Over two-thirds (68%) were over the age of 65. Over half (55%) had received less than a high school education. All 47 focus group participants were foreign-born and were primarily from Mainland China (80%) or Hong Kong (15%). The large majority of women (80%) have resided in the United States for over 10 years. Most women had public insurance, Medicaid and/or Medicare, but one-fifth (21%) were uninsured.

Perceptions About Breast Cancer

Participants expressed mixed opinions regarding how common breast cancer is in the Chinese community, with some women believing it is common and other women believing it is not common (Table 2). Their beliefs about the prevalence of breast cancer in the Chinese community primarily stemmed from their personal experiences and those of their family, friends, and networks. For example, one woman described, “I knew ten to eight people having breast cancer. One of my friends and her daughter all have been diagnosed with breast cancer.” Another woman recollected, “I know ten persons having breast cancer, cervical cancer, and colorectal cancer. Two of them have passed away and one is having chemotherapy.”

When asked to reflect upon what kind of stigmas, if any, are associated with breast cancer, responses differed between those who have been diagnosed with cancer and those who have not been diagnosed with cancer. Focus group participants who have been diagnosed with cancer openly expressed their opinions against stigmas. These women commented, “There is nothing wrong with health problems” and “I do not think having cancer is something shameful. Once you receive the surgery, everything will be fine.” Another

Table 1. Sociodemographic Characteristics of Study Population by Screening Results

	Women With Breast Cancer Diagnosis (N = 10), n (%)	Women With No Breast Cancer History (N = 37), n (%)
Age		
46–55	0 (0.0)	6 (16.2)
56–65	2 (20.0)	7 (18.9)
66 and older	8 (80.0)	24 (64.9)
Education (years) ^a		
Less than junior high or eighth grade	5 (50.0)	14 (46.7)
Less than high school	0 (0.0)	3 (10.0)
High school graduate or GED	1 (10.0)	8 (26.7)
Some college, trade, or technical school	0 (0.0)	2 (6.7)
College graduate or more	3 (30.0)	3 (10.0)
Born outside the United States	10 (100.0)	37 (100.0)
Years in the United States ^a		
0–5	1 (10.0)	3 (10.0)
6–10	1 (10.0)	3 (10.0)
10+	8 (80.0)	24 (80.0)
Country of origin ^a		
Mainland China	7 (70.0)	28 (80.0)
Hong Kong/Macau	2 (20.0)	5 (16.7)
Other	1 (10.0)	1 (3.3)
Insurance ^b		
Medicare	6 (60.0)	17 (56.7)
Medicaid	8 (80.0)	14 (46.7)
Private or HMO	0 (0.0)	5 (16.7)
No insurance	2 (20.0)	8 (26.7)

Note: GED = General Educational Development; HMO = health maintenance organization.

^aHas missing data. ^bPercentage over 100% due to possibility of checking multiple items.

woman expressed, “I am not afraid of discrimination. Being sick or having cancer is not like doing something that is criminal.” Yet another woman stated, “I am not afraid. I was very open, and I could tell anyone about my cancer.”

However, perceptions of stigma were high among focus group participants with no history of breast cancer. In general, these women agreed, “Chinese do not want others to know about it.” Participants noted that some stigmas associated with cancer were rooted in superstition. As one woman described, “A friend of mine went to a pharmacy. I asked her where she was going and she said she was at the pharmacy to get some water. Many Chinese regard illness as ominous so they always say that they are healthy.”

Overall, knowledge was low about breast cancer symptoms. When participants with no history of breast cancer were asked to describe symptoms of breast cancer, some women described milky discharge and breast lumps, but many women admitted to not being very clear about the symptoms.

Perceptions About Breast Cancer Screening and Treatment

Focus group participants expressed a range of opinions regarding the importance of breast cancer screening (Table 3). Those who were diagnosed with breast cancer universally agreed that screening is very important. Those with no breast cancer history held opinions ranging from highly valuing screening to believing screening was harmful, wasteful, only for the symptomatic, or just up to physicians to decide. Among women who believed screening was important, their reasons included peace of mind (“you feel much better if you get negative results from screening”) and more effective

treatment (“you can receive early treatment from early detection”). Among focus group participants who did not think screening was important, reasons included not feeling sick (“I do not feel anything wrong with my breast, why should I do screening?”) and perceived harms from, and costs of, mammography (“Especially x-ray. It will do harm to your cells. It’s also a waste of money.”) A frequently mentioned factor was the physician’s recommendation or lack of recommendation for screening. For example, one woman stated, “The doctor doesn’t ask me to, so I don’t.”

When asked about their perceptions regarding potential treatment options for breast cancer, responses varied. Chinese traditional medicine was discussed by only a few participants. Western therapies were described generally as “very effective in treatment” and necessary “when the cancer cells have already spread.” Other participants, including both women diagnosed with breast cancer and those without a cancer history, simply stated, “I will do what the doctor asks me to do.”

Barriers and Facilitators to Cancer Screening

Focus group participants discussed a number of perceived barriers to cancer screening (Table 4). These included language, time, not wanting to burden their adult children, transportation, health insurance status, and cost of screening. For insurance and cost, some participants were direct in their assessment, for example, stating: “I don’t have insurance card, so I cannot do screening” and “I don’t have money.” With respect to language barriers, the issue extends to perceived availability of English-speaking assistance from family and friends. One woman described, “I cannot speak English [...] My children take me to the hospital. If they are not available, one of my friends will help me.” Time constraints did not necessarily affect the

Table 2. Perceptions of Cancer

Themes	Subthemes	Representative Statements	
		Women With Breast Cancer Diagnosis	Women With No Breast Cancer History
Prevalence of breast cancer	Common among Chinese	“I know ten persons having breast cancer, cervical cancer, and colorectal cancer. Two of them have passed away and one is having chemotherapy.”	“I knew ten to eight people having breast cancer. One of my friends and her daughter all have been diagnosed with breast cancer.” “I know some people have breast cancer. But everyone has different health conditions. Some did surgery and recovered, some discovered late. It is very dangerous.”
	Not common among Chinese	“I did not pay too much attention about it because I thought it was not common among Chinese.” “Asian women are less likely to have breast cancer, uterine cancer, and cervical cancer than Americans.”	“(Do you think breast cancer and cervical cancer are common in Chinese communities?) Never heard of it. But according to what my doctors said, it is bleeding.”
No longer stigmatized	Due to medical advancements	“There is nothing wrong with health problems.” “Now we have very advanced technology that could help us treat the cancer.” “I do not think having cancer is something shameful. Once you receive the surgery, everything will be fine.”	
	Open to sharing	“Everyone has their own ideas about this. I am not afraid of discrimination. Being sick or having cancer is not like doing something that is criminal.” “I am not afraid. I was very open, and I could tell anyone about my cancer.”	
Still stigmatized	“Saving face” values		“Some people prefer to exaggerate their condition of illness, some people would not like others to know their illness.” “Chinese do not want others to know about it.”
	Fear of discrimination	“Think about the actress Chen Xiaoxu. She cared about her appearance, didn’t take much treatment, and she died after that.”	“Many people would not notify others like neighbors of their illness. They hide it, afraid of others’ discrimination. Some people have blind faith. For example, a friend of mine went to a pharmacy. I asked her where she was going and she said she was at the pharmacy to get some water. Many Chinese regard illness as ominous so they always say that they are healthy.” “Sometimes breast cancer is genetic.”
Causes	Genetic influence		“Everyone has cancer genes. It depends on your health condition. If you are strong enough, you will not have cancer.”
Symptoms	Changes in breast/nipple appearance or discharge	“At that time my doctor did not find any problems with my breast, but I was certain that there would be something wrong with it.” “My domestic helper told me that if two breasts look different, you need to check in the hospital. Sometimes it will be milky discharge. The most important thing is a breast lump. You should go to the hospital once you find that.” “I found it by myself. There was a milky discharge.”	“I have a big family, one of my great-grandmothers had breast cancer, but she didn’t pay attention to it. I did a lot of reading. I know that a purple lump around the breast is a sign of breast cancer. If it’s not purple, then it’s a lymph node. It also depends on where the lump is. Whether the limp can move or not is another indicator.” “I think there may be breast lumps on both sides.” “Sometimes there is a milky discharge.”
	Not known		“(what are the symptoms of breast cancer and cervical cancer?) I haven’t heard about this. I did not have it. I am not very clear about the symptoms.”

focus group participants directly, but rather, their adult children who would take them to medical appointments: “If you go to the hospital to do screening, you need someone to help you. My son in-law takes me to the hospital. He was born here. My daughter does this, too. But sometimes they don’t have time, so it’s very troublesome.” Women expressed the notion that older adults did not want to be

a burden to their adult children: “They don’t want to trouble their children every time they feel sick. If there is a small problem, they won’t trouble their children.”

Although numerous barriers to screening were raised, women also discussed several possible facilitators to cancer screening—including people and resources that would help them complete screenings.

Table 3. Perceptions of Cancer Screening and Treatment Options

Themes	Subthemes	Representative Statements	
		Women With Breast Cancer Diagnosis	Women With No Breast Cancer History
Opinion on screening	Important	“Screening is very important. It can help us see if we have the symptoms or not.”	“Yes, [screening] is important. It is often too late to receive treatment if we discover it by ourselves.” “Yes. You feel much better if you get negative results from the screening.” “Screening is good, whether to prevent or treat. Surely it’s good for your health.” “It is of course important. You can receive early treatment by detecting it early.”
	Only screen when sick		“I haven’t done the screening. I do not feel anything wrong with my breast, so why I should do the screening?” “When I was sick, I did the screening. I will not do screening when I am not sick.”
	Harmful/wasteful		“There are so many organs, which part do you screen? X-rays especially will do harm to your cells. It’s also a waste of money.”
	Up to the physician		“It depends on the doctors. The problem is that if you ask for screening, some of them just give you some pills and say you are fine.” “I think screening is good. Our doctors often urge us to do the screening again and again. If you tell them that you feel something wrong with your body, they will still ask you to complete the screening.” “I see my family physician every three months. I will go through the screening only when my physician tells me that I have to do it.” “The doctor doesn’t ask me to, so I don’t.”
Preferred options	Traditional Chinese medicine (TCM)		“I don’t know how Americans do it. I have seen my father do external applications with certain types of Chinese traditional medicine to treat patients with breast and colon cancer. Western medicine is very effective in treatment. Sometimes you have to spend one year eating traditional Chinese medicine, but for western medicine, you only need 15 days.”
	Chemotherapy	“You need to take chemotherapy when the cancer cells have already spread.”	
	Physician recommendation	“I will do what [cancer treatment] the doctor asks me to do.”	“I will do what the doctor asks me to do.”
Nonpreferred options	Chemotherapy	“I prefer not to do chemotherapy. It’s very harmful. Many people died from chemotherapy but not cancer.”	
No knowledge			(difference between Chinese and U.S. treatment) “I don’t know.” (do you know how breast cancer is treated?) “I don’t know.”

Navigation services and educational workshops at community centers were noted as facilitators: “I hope community centers could navigate us to receive regular screening. It will also be great if we can have more focus group discussion or workshops that help us gain a better understanding of breast cancer.” Gaining physician buy-in was another recommended strategy for increasing screening in the community. Women believed that as is, their physicians would be resistant to increasing screening rates, whether that is due to their patient volume or otherwise. One participant described, “doctors will feel tired if everyone requested breast screening. They have more than one patient,” whereas another woman stated, “The problem is that if you ask for screening, some of them (the doctors) just give you some pills and say you are fine.”

Discussion

Participants in this qualitative study of women in Chicago’s Chinatown expressed their breast cancer beliefs, attitudes toward screening, barriers encountered, and facilitators to cancer screening. This study is among the first to explore differences in attitudes between Chinese American women with different breast cancer histories. We found that women had different notions and levels of stigma surrounding breast cancer. Although survivors rallied against perceived stigmas, perceptions of stigma were high among women without a prior breast cancer history. Although focus group participants with breast cancer believed that screening was important, those with

Table 4. Barriers and Facilitators to Cancer Screening

Themes	Subthemes	Representative Statements	
		Women With Breast Cancer Diagnosis	Women With No Breast Cancer History
Barriers	Language	<p>“I cannot speak English, I even cannot read Chinese. My children take me to the hospital. If they are not available, one of my friends will help me. My husband works in a restaurant. He cannot take me to the hospital. My friend will help me if I feel sick.”</p> <p>“I have communication problems, it would be better if I have an interpreter.”</p>	<p>“I haven’t gone for a screening in nearly 10 years. Firstly, I am lazy. Second, I cannot speak English, so I have to ask help to people who can speak English. So if I don’t have to, I will not do screening. I know it’s important, but I am old, so I let it go.”</p>
	Time	<p>“Last time I had a backache, I made an appointment, but I still waited for 9 hours, from 7 am to the evening.”</p> <p>“The appointment is too long, sometimes 2 weeks, sometimes 3 weeks. And you cannot be late even for half an hour.”</p> <p>“In the U.S., the doctors and nurses are very good. I said I have no money, they still treat me well. But you have to make an appointment and wait for a long time. Sometimes you just have a cold, and when it’s your turn to see the doctor, you have already recovered.”</p>	<p>“It is ok if no reservation is needed. We waste a lot of time on making reservations.”</p> <p>“You have to wait everywhere.”</p>
	Insurance	<p>“I do screening all the time, I have insurance.”</p>	<p>“I don’t have an insurance card, so I cannot do screening.”</p> <p>“I don’t have money.”</p>
	Lack of doctor recommendation		<p>“(Does doctor ask you to get screened?) No.”</p>
	Stigma/embarrassment		<p>“(Why some people don’t like screening?) Some people feel it’s embarrassing. Some people think they are old. Sometimes the doctor is male and it’s very embarrassing.”</p>
	Family assistance constraints	<p>“In Chinatown, everyone speaks Chinese, so there is no problem. But if you do go to the hospital to get a screening, you need someone to help you. My son in-law takes me to the hospital. He was born here. My daughter does this too. But sometimes they don’t have time, so it’s very troublesome.”</p>	<p>“[Elderly people] don’t want to trouble their children every time they feel sick. If there is small problem, they won’t trouble their children.”</p>
Facilitators	Community participation/convenience	<p>“I rarely get screenings. After I moved into this building, they (the building manager) will notify us when it is the time to receive the screening.”</p>	<p>“I hope community centers could navigate us to receive regular screenings. It would also be great if we can have more discussions or workshops that help us gain a better understanding of breast cancer.”</p>
	Advertisements	<p>“Elderly people have time and will attend. But young people have to work. Like what she said, medical newspapers work, people can read at work.”</p>	
	Reach out to physicians		<p>“You should talk to the doctor, ask him do breast examination for everyone. They won’t be happy if you ask for screening initiatively.”</p> <p>“You should talk to the doctor, express that you need every patient’s breast screening result, then the doctor will agree. Otherwise doctors will feel tired if everyone requests breast screening. They don’t only have one patient.”</p>

no breast cancer history expressed opinions ranging from highly valuing screening to believing screening was harmful, wasteful, only for the symptomatic, or just up to doctors to decide. Barriers to screening noted by focus group participants included language, time, not wanting to burden their adult children, transportation, health insurance

status, and cost of screening. Navigation services, educational workshops at community centers, and physician recommendation were suggested facilitators to screening. From these findings, we make specific recommendations for development of interventions and policies to bolster breast cancer screening among older Chinese women.

A prevailing sentiment held by most focus group participants was the centrality of a physician's directive. Our findings are generally consistent with several previous qualitative studies among Chinese women with respect to unwillingness to question physicians (18), conviction about adhering to the recommendations from health care providers (19), and high levels of trust in physicians in clinical encounters (25). However, our study illuminates additional layers within older Chinese women's perceptions of their patient-provider interactions—that they would encounter resistance from their physician and felt they would burden them if they asked for screening. To an extent, this may indicate a lack of understanding among older Chinese women about how mammography screenings are performed (they are not performed by the physician). This may also more broadly reflect the need for education and training to empower older Chinese women in taking charge of their health care, as older Chinese women's reliance on physicians as primary decision makers is incongruent with U.S. medical practices that emphasize shared decision-making and patient-centered care.

Several cultural beliefs illuminated in this study—such as hiding one's illness, bad luck, and belief in Chinese traditional medicine—add nuance to previous studies of Chinese cultural beliefs regarding cancer and cancer screening. Previous studies have suggested that contagion and stigma are images of cancer in the minds of Chinese women (26), that hiding disease from others would prevent perceptions of bad luck and derision for both the cancer patient and their family (9), and that Chinese traditional treatments are preferred over Western treatments (18). It has been suggested that intervention messages must serve to counter these cultural views (10). However, we found that the cultural beliefs expressed by our focus group participants were often departures from those reported in the literature. For example, Chinese traditional medicine was not widely championed by our sample of older Chinese women; there were no mentions of fatalistic views, and the stigmas associated with having cancer were emphatically refuted by women who had received a cancer diagnosis. One possible explanation for the differences in key cultural beliefs among our study and those of prior studies is that our sample of focus group participants have resided in the United States for some time—80% have lived in the United States for over 10 years. Longer time in the United States may result in changing knowledge and attitudes as well as better access and navigation of the U.S. health care system (11). Although cultural influences among our sample Chinese women may have been dampened due to their lengthier residence in the United States, our qualitative study revealed that structural barriers persist. These challenges included limited English proficiency, lack of transportation, and time constraints.

Our findings have important practical and policy implications. Women expressed that language and transportation barriers contribute to their reliance on their adult children. This reliance on their adult children, in combination with recent literature describing the effects of informal caregiving as a chronic stressor (27), suggests that support mechanisms beyond family-based interventions may be needed, such as evolving roles for physicians, community organizations, and health delivery systems (28). Improving patient-provider interactions is one possible area of intervention, as providers were noted during our focus groups as among the most influential to Chinese women. Future studies are also needed to understand the quality of breast cancer screening services received by Chinese immigrant women as well as to develop interventions to build self-efficacy in women to select health care providers, as preference for Chinese-speaking physicians often result in women seeking care from Chinatown neighborhood physicians whose standards of care

may be more variable than those of providers within larger health care systems (29).

From the dearth in understanding of the workings of the U.S. health care system illuminated in this study, we suggest that patient navigators—who make appointment reminder calls; provide informational, logistical, and emotional support; provide interpreter services; and refer patients to community health and human resource wraparound services—are other promising directions for addressing barriers to screening experienced by older Chinese immigrant women. In fact, a patient navigation study scaled to a Chicago suburban county safety net delivery system found that navigators were able to mitigate language barriers challenges with respect to breast cancer screening and follow-up (30). Especially with the prevalence of community-dwelling older adults presenting with multiple chronic conditions (31), navigators may be crucial for supporting complex care coordination. Community health workers may also have a critical role in meeting the health needs of older Chinese women. Particularly, the limited knowledge of breast cancer causes and symptoms demonstrated among this study's focus group participants suggests an urgent need for accessible cancer education to improve health literacy levels generally and breast cancer knowledge specifically.

Unlike the negative past experiences related to diagnosis of breast cancer and treatment experiences described by Chinese women with breast cancer in other focus group studies (19), the women in our study who had breast cancer reported more positive experiences with, and attitudes toward, their overall cancer experience and their experiences with the U.S. health care system. They articulated the curability of cancer, lauded advancements in medical technology, scoffed at stigmas associated with cancer, and were open to telling others about their cancer. Their outlook was notably different than those of women with no prior breast cancer history. One potential way to leverage the positive outlook of Chinese cancer survivors may be to design interventions using cancer survivors as health advocates. Similar strategies in African American communities using breast cancer survivors to provide culturally appropriate messages in community settings have demonstrated efficacy in increasing mammography uptake (32).

As a whole, our findings suggest the need for culturally sensitive multilevel interventions in the Chinese community to increase breast cancer screening rates. At the level of the individual, patient education is warranted to address misconceptions women have about breast cancer, such as relying on appearance of symptoms and worrying about the effects of x-rays. Their hesitation to seek screening due to language barriers also indicate lack of awareness about the language access services (eg, on-site/over-the-phone interpreter) that all health care providers who receive federal funding (eg, Medicaid, Medicare) must provide by law (33). Our focus group findings suggest that patient education on a number of topics is warranted to increase awareness and knowledge—including topics such as the U.S. health care system, health insurance, selection of health care providers, and risk factors for breast cancer. However, a systematic review of cancer screening interventions among Asian Americans found that media campaigns and print materials alone are ineffective; they are likely to work only if combined with interventions targeting health care workers (34). Future studies should develop and evaluate multilevel community interventions to address the cultural and structural barriers that Chinese women face with respect to breast cancer screening.

Key limitations of this qualitative study should be noted. First, the data represented a convenience sample of Chinese older adults

in the Chicago Chinatown area. As all focus group participants were foreign-born, and most have resided in the United States for over 10 years, generalizing study findings to U.S.-born Chinese Americans and more recent immigrants requires caution. Another limitation is that these focus groups were conducted prior to implementation of the Affordable Care Act. Changes in the health care delivery landscape could likely influence women's attitudes and beliefs. However, although the Affordable Care Act has opened the doors for many to the health care system, it is expected that some of the most vulnerable patients—especially immigrant, non-English-proficient patients—will be left behind (35).

Conclusions

This qualitative study highlights the increased need to connect Chinese older adults with resources and assistance to navigate the health care system. Many Chinese older adults are disadvantaged in the United States due to cultural, linguistic, and structural barriers and are vulnerable to poor health and low cancer screening utilization (36). Nevertheless, these challenges represent tremendous opportunities for community stakeholders, researchers, health professionals, social service agencies, and policy makers to improve the health and well-being of Chinese Americans.

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Conflict of Interest

None.

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