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We Should Know Ourselves: Burmese and Bhutanese Refugee Women's Perspectives on Cervical Cancer Screening

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Abstract

Refugee women are at increased risk for cervical cancer and have low rates of cervical cancer screening both in their countries of origin and in the U.S. Using the Behavioral Model for Vulnerable Populations as a conceptual framework, we conducted eight focus groups with Burmese and Bhutanese refugee women to gather information about factors influencing cervical cancer screening (31 Burmese and 27 Bhutanese participants). Less than one-third (28%) reported being screened for cervical cancer before coming to the U.S. and only 45% reported being screened after resettling in the U.S. Participants had limited knowledge about cervical cancer and the need for screening, and faced multiple barriers including competing priorities and cost. However, trusted providers and interpreters were seen as means of facilitating screening. Cervical cancer screening among Bhutanese and Burmese refugee women could be improved with culturally tailored health education and increased access to female providers and trained interpreters.

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Keywords

Cervical cancer; screening; focus groups; refugee; women's health

Cervical cancer is one of the most common cancers among women worldwide and accounts for more than 266,000 deaths each year.[1] In countries where there is access to effective methods to prevent and detect cervical cancer, such as the United States (U.S.), cervical cancer incidence and mortality rates have been decreasing.[1–3] However, this is not the case in less developed countries where cervical cancer is endemic and there is limited access to preventive care.[1,4–6] Most refugee groups in the U.S. emigrate from countries with high cervical cancer incidence rates, and have higher rates of cervical cancer morality than those born in the U.S.[7–9] Research has also shown refugee women are unlikely to have been screened for cervical cancer prior to resettlement and have low rates of screening uptake following resettlement.[10–14]

Refugees from the Asian countries of Burma (currently known as Myanmar) and Bhutan are two of the largest refugee groups arriving in the U.S., constituting 56% of all resettled refugees in 2011.[15,16] The Office of Refugee Resettlement estimated that 79,499 Burmese and 60,773 Bhutanese refugees arrived in the U.S. from 2008 – 2012.[16] In Burma, gradual government takeovers of territories formerly controlled by ethnic minorities (such as the Karen and Rohingya) led to the displacement of more than a million people to neighboring countries (including Malaysia and Thailand) during the 1990s.[17] After living in refugee camps for many years, Burmese refugees welcomed the opportunity to resettle in third countries (such as the U.S.), starting in 2005.[17] The majority of refugees from Bhutan living in the U.S. are descendants of Nepalese migrants who were referred to as Lhotshampas.[17] As a result of government crackdowns, more than 100,000 Lhotshampas were forced to flee Bhutan and settle in Nepalese refugee camps in the early 1990s.[17] Unable to repatriate, Bhutanese refugees were allowed to resettle in third countries, starting in 2007.[17]

Unfortunately, there is little information about rates of cervical cancer and cervical cancer screening among women living in Bhutan and Burma. However, available data indicate that screening rates are very low. For example, 2012 Bhutanese data showed only 30% of women ages 50–59 had ever been screened, and 2002–2003 Burmese data showed less than 1% of all women had been screened in the previous three years.[18,19] To our knowledge, only one previous study has focused on cervical cancer screening among refugee women from Bhutan and no previous studies have focused on cervical cancer screening among refugee women from Burma.[20]

Our study sought to understand the factors contributing to Burmese and Bhutanese refugee women's decisions about cervical cancer screening in order to inform interventions to promote screening in these vulnerable populations. The conceptual framework for our study was the Behavioral Model for Vulnerable Populations (BMVP), which has been used previously to explain patterns of cervical cancer screening among other racial/ethnic minority and immigrant groups.[12,21,22] The model posits that the interaction of predisposing (i.e., demographic characteristics, health beliefs, and social structure), enabling (i.e., personal, family, and community resources), and need-for-care factors (i.e., perceived and evaluated health) determine the use of health services (in this case, cervical cancer screening).[23,24] Previous studies have found that predisposing factors for immigrant groups include demographic characteristics such as age and marital status in addition to social structure characteristics such as length of time in the U.S., immigration status, language, literacy level, and living conditions.[24] Enabling factors include health care insurance and access to health services.[23,24] Lastly, need-for-care factors relate to a person's perception of need which, may be low for refugees if they are unaware of certain health conditions.[9,23,24]

Methods

Study site.

Focus groups were conducted in King County, Washington, which serves as the primary resettlement site for refugees in Washington State, and is one of the top resettlement sites in the U.S.[25–27] (Seattle is the county seat and the largest city in the state.) Most Bhutanese and Burmese refugees in Washington State are eligible for Apple Health (Washington's Medicaid program). The Bhutanese and Burmese refugee populations in King County primarily live in multiple geographically contiguous communities in the southern part of the county, and are served by several community clinic systems that have expertise in working with refugee patients. These clinic systems offer reduced cost services to the uninsured and interpreter services to those with limited English proficiency.

Procedures.

We conducted eight focus groups (four with Burmese women and four with Bhutanese women) from September 2015 to December 2015. We recruited two female focus group moderators from the local community, one who was Burmese and fluent in Karen and one who was Bhutanese and fluent in Nepali. Moderators also collaborated with health and social service organizations to recruit study participants. Each focus group had seven participants on average, ranging from five to 10. Individuals were eligible for the focus groups if they were 1) a female refugee from Bhutan and spoke Nepali (the language spoken by nearly all Bhutanese refugees) or a female refugee from Burma and spoke Karen (the most common language spoken by Burmese refugees), and 2) in the 20–65 years age range. Participants provided spoken consent and received a $20 gift card as a token of appreciation for their time. The Fred Hutchinson Cancer Research Center Institutional Review Board approved all study procedures.

We developed a focus group guide that included questions concerning knowledge, attitudes, and experiences with cervical cancer and screening based on our conceptual framework (Box 1). Participants also completed a short survey of demographic characteristics and cervical cancer screening history. All of the focus group materials were translated into Karen and Nepali prior to the focus groups. Karen- and Nepali-speaking moderators and assistants received a half-day training on how to lead the focus groups including basic information about cervical cancer and screening, moderation skills, practice using the interview guide, and practice administering the short demographic survey. The focus groups were held in private community locations such as rooms at the local library, were all digitally audiorecorded, and lasted between 90 and 150 minutes. Field notes were taken during and after the focus groups by moderators and research team members.

Analysis.

After the moderators orally translated the Karen and Nepalese focus group recordings into English, the English recordings were professionally transcribed. Four members of the research team reviewed the focus group transcriptions in English and noted preliminary themes. We then developed a coding scheme based on the transcripts, the interview guide and our conceptual framework. Each transcript was coded independently by at least two research team members and then entered into the Atlas.ti software for data management and analysis.[28]

Any coding discrepancies were resolved among the four data coders based on consensus coding. We reviewed coded quotations to identify common or discrepant themes across the focus groups. All of the derived themes were reviewed with the larger research team, as well as Burmese and Bhutanese community advisors for accuracy.

Results

In the following sections, we describe the characteristics of the refugee women who participated in the study and the main themes from the focus groups categorized by the constructs of the Behavioral Model for Vulnerable Populations.

Participants.

A total of 58 women participated in eight focus groups (Burmese n=31; Bhutanese n=27) (Table 1). Mean ages were 34 years for Burmese women and 41 years for Bhutanese women. A majority of women were married (78%) and reported speaking English poorly or not at all (59%). Among Burmese women, a majority (60%) had seven or more years of formal education, while most Bhutanese women (67%) had less education. Women had been in the U.S. an average of four years. Few women (28%) had ever been screened for cervical cancer before coming to the U.S., and only about one-half (45%) had been screened for cervical cancer after arriving in the U.S. Screening rates in the U.S. were higher among Burmese women (64%) than among Bhutanese women (44%).

Predisposing factors.

Health practices and perceptions are shaped by experiences in country of origin.—Women's understandings of health and their own bodies were greatly shaped by experiences in their countries of origin (i.e., Bhutan or Burma) and/or refugee camps (in Nepal and Thailand). For example, some participants noted they only sought health care when they were symptomatic because of limited resources in their home countries, and thus, were unfamiliar with the idea of preventive care as practiced in the US. (Box 2 gives example quotations for all themes). Additionally, some women had suffered or been exposed to traumatic reproductive health and childbirth experiences, such as miscarriages, difficult labors, and infant and maternal death during pregnancy or delivery. These experiences contributed to feelings of fear and mistrust about seeking reproductive health care. Others shared stories about exposure to political violence, deprivation, and the death of family members during their migration to refugee camps. They noted that these experiences affected them to the current day and, in some cases, led them to undervalue the relevance of preventive screening

Enabling factors.

Barriers to accessing health services.—Several factors were cited as reasons for not seeking health care services, including limited English proficiency and problems with interpreters, financial and transportation concerns, and problems navigating the U.S. health care system as well as embarrassment and stigma related to cervical cancer and screening.

Limited English proficiency and issues with interpreters.—Women mentioned their limited English proficiency was a significant barrier to communicating their symptoms and illness experiences effectively to health care providers, even when working with an interpreter. Often times, women weren't able to access an interpreter during their clinic visits because there were few available interpreters who spoke Nepali and Karen. For those who did receive interpretation, it was often through a telephone or video call. They also shared negative experiences with interpreters, particularly those accessed via telephone or video because they could not see or hear the interpreter or felt rushed.

Cost of health care and competing financial priorities.—There was general confusion about health insurance policies and co-payments. Some participants were surprised when they were asked for co-payments during clinic visits, and stated that this was a reason why they sometimes did not seek health care. Several women also reported experiencing financial hardships since resettling in the U.S., noting that financial priorities such as food, rent, and utilities take priority over the cost of preventive health care.

Difficulties navigating the U.S. health care system.—Some women expressed confusion about how to access health care in the U.S. For example, some women had difficulty making appointments and seeing specialists through referrals. Others reported missing appointments due to miscommunication or an overall lack of understanding on how to navigate the U.S. health care system.

Embarrassment, fear, and stigma related to cervical cancer and screening.—Women were unfamiliar with cervical cancer screening and felt embarrassed or uncomfortable undressing in front of health care providers and interpreters, particularly male providers. In addition, some women described being fearful of getting a Pap smear. Most of the women who had completed Pap smears agreed they felt more comfortable around female health care providers and preferred them to male providers for this procedure specifically. Focus group participants also noted possible stigma related to both cervical cancer and screening being viewed negatively in their community.

Facilitators to using health services in the U.S.—Participants also noted factors that helped facilitate or improve their health care experiences, including positive relationships with doctors and other health care providers in the U.S., as well as receiving health information from family and friends, while retaining the confidence to make their own health care decisions.

Positive relationships with doctors and health care providers.—Most participants had very positive relationships with their doctors, which made them feel more comfortable discussing their private health issues and concerns. Women valued doctors they saw as kind, patient, empathetic, and protective of their privacy. Because of these positive relationships, they also depended on their doctors for health information. Women also appreciated the confidentiality of receiving health care services in the U.S., which in turn made them more willing to share information with their providers.

Use family and friends for health information and decision-making.—Newly-resettled women depended on social networks within their refugee community for health information and help with decision-making. Older women noted they depended on their children for this type of support. Others emphasized the importance of sharing problems with and seeking help from elders.

Confident making independent decisions.—Women also said they were comfortable making their own health-related decisions and did not always need to consult with family or friends. Thus, although social supports were important, women understood that they know their bodies best and can make independent health-related decisions as needed.

Need for care.

Knowledge and beliefs about cervical cancer.—When asked about cervical cancer, women from both communities were unfamiliar with female reproductive anatomy. Women commented that they did not know what or where their cervix was and therefore were unsure about how they would know the symptoms of cervical cancer. Bhutanese women commonly described cervical cancer as a wound or lump on the uterus, cervix, or ovaries and mentioned that women with cervical cancer are unable to have children. Burmese participants also described cervical cancer as a wound; however, they more often mentioned abnormal vaginal discharge as associated with cervical cancer.

Some women also had misconceptions about the etiology of cervical cancer, commenting that it was related to personal hygiene and cleanliness. For example, they thought that women who did not keep themselves clean during menstruation or after the birth of a child might be at risk for cervical cancer. Bhutanese women also expressed the view that reproductive health issues could be related to women undertaking heavy labor or work shortly after the birth of a child. They discussed the importance of subsistence farming in Bhutan, and described how women labor on the farm shortly after giving birth. Finally, some Burmese women thought engaging in sexual intercourse too soon after giving birth might also cause cervical cancer.

Knowledge and beliefs about cervical cancer screening.—Cervical cancer screening was rarely available in the participants’ countries of origin or in their refugee camps. Since resettling in the U.S., women had become more exposed to and familiar with preventive health care practices through visits with health care providers. Therefore, they understood that cervical cancer screening was important and beneficial for women. Some of the women were familiar with cervical cancer screening procedures, such as Pap smears, and were able to describe parts of it to other focus group participants who were less familiar.

There was confusion among the Bhutanese focus group participants about which tests were specifically related to screening for cervical cancer. Some participants stated that doctors checked for cervical cancer using X-rays or with a physical exam. Women also had varied responses when they were asked about who should be tested for cervical cancer. Some felt that only married women should be tested while others said that any woman of reproductive age should be tested, regardless of whether she was sexually active or not.

Discussion

Using the Behavioral Model for Vulnerable Populations we identified predisposing, enabling, and need-for-care factors that relate to cervical cancer screening among refugee women from both Bhutan and Burma. While themes were similar across both groups, there were differences in the level of education between the two groups (Bhutanese reported lower levels), as well as the specific misconceptions women had about cervical cancer (i.e., cancer etiology and types of screening tests). Only 64% of Burmese women and 44% of Bhutanese women in our sample had been screened for cervical cancer in the U.S. These rates are similar to those observed in a recent convenience sample survey of Bhutanese refugee women in Ohio.[29] A population-sample survey of Minnesota's Somali refugee community also found that only 45% of women have ever been screened for cervical cancer.[12] Below, we discuss our findings and identify implications for research, practice, and policy.

Predisposing factors can serve as barriers to cervical cancer screening.

Both Burmese and Bhutanese women noted that in their cultures, only married women are expected to be sexually active, and thus were the only ones that needed to be screened. Previous studies among Chinese and Southeast Asian immigrant women have found that married women were more likely to have been screened recently than their unmarried counterparts.[5,13,14,30] Single refugee women may be more embarrassed than married women to seek screening or less likely to perceive a need for screening.

Women described traumatic reproductive health and migration experiences that have made lasting impressions on them and provide context for some of their health care-related behaviors and decisions. For example, many women reported having difficult a pregnancy or childbirth experience, some even resulting in child or maternal death. Refugee patients —even refugee children—have often experienced trauma prior to resettlement in the U.S., such as exposure to political violence and death of family members.[31] Depression, post-traumatic stress disorder (PTSD), and anxiety are also prevalent among refugees and often go unrecognized.[31] Thus, it is crucial that health care providers consider their refugee patients' migration histories and take these histories into account in their interactions with them.[31,32]

Enabling factors that serve as barriers to cervical cancer screening.

Women mentioned their limited English proficiency was a barrier to making appointments and communicating with health care providers. Previous studies of refugee women have found that those who could not speak English were more likely to delay receiving their first Pap test after arriving in the U.S.[33,34] Furthermore, language barriers may lead refugees and immigrants only to seek health care services when they are very sick or not at all.[34,35]

Most women reported that cost was a barrier to screening and were confused by health insurance coverage and when co-payments were needed. Currently, preventive health services like Pap smears are fully covered under Washington State's Medicaid program. Additionally, The Affordable Care Act mandates full coverage of cervical cancer screening by most private insurance companies.[36] However, some women were not aware of these benefits. Voluntary agencies that provide initial reception services to newly arrived refugees might provide useful information about insurance coverage for preventive care.

Women reported being dissatisfied with the availability of interpreters who spoke their native language, as well as the quality of the interpretation services they had received. Previous studies have noted that dissatisfaction with interpretation services can lead immigrants to skip appointments.[6] A study of Bhutanese women in Nebraska found that participants were uncomfortable with male interpreters from their community when discussing women's health topics.[20] Therefore, refugee women may be more likely to seek cervical cancer screening if there are female interpreters available. Clinics that serve refugee patients should make every attempt to provide high-quality and gender-matched interpreter services.

Enabling factors that promote cervical cancer screening.

Most women reported that having a regular primary care doctor who was kind, patient, and understanding was important to them. In a recent study of Somali immigrant and refugee women, those who had a regular source of health care were more likely than others to have been screened for cervical cancer.[37] Most of our participants also mentioned they preferred female providers for cervical cancer screenings, which is consistent with previous studies showing that immigrant and refugee women were more likely to have had a recent Pap test if they had a female physician.[13,37] Agencies should ask women if they would prefer a female provider when they establish primary care during the resettlement period, and refugee women who have established care with a male provider should be offered appointments with a female provider for gynecologic exams.

Participants mentioned that family and friends were a valuable source of social support after resettling in the U.S. Given that many refugees struggle with social isolation during early resettlement, previously resettled community members can be an important resource for newly arrived refugees. Specifically, they can help them navigate the U.S. health care system effectively by providing transportation to appointments, serving as interpreters at clinic visits, and explaining referral processes.

Perceived need for cervical cancer screening.

Consistent with previous studies, women reported that they had not received preventive health care in their home countries and had limited knowledge of cervical cancer and screening guidelines.[20,32,38] Refugee women who are unfamiliar with cervical cancer screening may not see it as a priority, especially if they are asymptomatic.[6,10,13,33] Culturally, linguistically, and literacy appropriate educational materials that explain female anatomy, the etiology of cervical cancer, and the importance of screening should be developed for refugee women. These materials could be used by agencies during the resettlement period, as well as by community-based organizations and clinics that serve refugee women.

Limitations.

Our study included Burmese and Bhutanese refugee women residing in King County, Washington, and our findings may not be generalizable to Burmese and Bhutanese refugee women living in other areas. Furthermore, we only included Karen-speaking refugees from Burma, and our results may not extend to Burmese women who speak other languages. Our focus group moderators were skilled in building rapport with the participants, allowing in-depth discussion of a sensitive health topic. However, the fact that some of the recruited women knew one another prior to recruitment may have influenced their willingness to speak or the content of what they shared. Based on both the focus group moderators' perceptions and the content of the discussion, we believe most participants felt comfortable disclosing personal information. The cervical cancer screening history information we collected from the survey was self-reported by the participants and may have some inaccuracies due to participants' education levels or unfamiliarity with certain terms. Lastly, most of the research team did not speak Nepali or Karen. Therefore, we relied on the few members of the research team who did speak Nepali and Karen for communication with participants and translation of the qualitative data.

Conclusion.

Future research should focus on developing interventions that address enabling and need-for-care factors to increase cervical cancer screening among Bhutanese and Burmese refugees. Our findings suggest that Burmese and Bhutanese women have a need for culturally tailored health education and point to the importance of refugee women establishing a regular source of care early in the resettlement process. Multiple randomized trials that included refugees from Southeast Asian counties (Cambodia, Laos, and Vietnam) have demonstrated the effectiveness of lay health worker education interventions (with or without navigation assistance) in promoting the use of Pap testing and other cancer-related screening tests.[39] In addition, both lay health worker and multimedia interventions have been shown to be effective in increasing knowledge and screening among Latinas.[40,41] Future trials might usefully evaluate the effectiveness of these approaches to increasing cervical cancer screening participation among recent refugee groups from Asia and elsewhere.

Concerning practice and policy, this study suggests that voluntary agencies and community-based organizations working with refugee women should provide culturally and linguistically appropriate educational materials that explain the female anatomy and the importance of preventive care. Additionally, resettlement agencies should ask refugee women if they prefer female providers when establishing primary care. Health care providers working with refugee patients should consider their migration histories, including previous exposure to trauma. They should also be aware that misconceptions about cervical cancer may vary depending on their patients' country of origin. Providers should prioritize cervical cancer screening for refugee women within the first year of their arrival and try to integrate screening into other health care visits. Clinics serving refugee women should strive to provide female providers and trained interpreters to reduce cultural and linguistic barriers to care. While our study focused on cervical cancer screening, the findings are relevant to the use of other preventive procedures and management of chronic health conditions in refugee populations. For example, the impact of pre-migratory trauma experiences and the importance of high quality interpreter services are relevant to multiple facets of refugee health care. Together these strategies may increase cervical cancer screening in this vulnerable population.

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Box 1.

EXAMPLES OF SURVEY AND FOCUS GROUP QUESTIONS BASED ON THE BEHAVIORAL MODEL FOR VULNERABLE POPULATIONS

BMVP Construct	Examples of Demographic Survey and Focus Group Questions
Predisposing (Demographic Survey and Focus Groups)	How old are you? How long have you been in the US? How well do you speak English? What is your marital status? What were some of the most important health issues for women back home? Can you describe things women from your country do to stay healthy?
Enabling (Focus Group)	Can you talk about your experiences with the health care system here (in the US)? How has it been talking with doctors here? What things make it difficult for women from your country to get health care here? How do women from your country make decisions about their health care?
Need-for-care (Focus Group)	Have you heard of cervical cancer? How do you think people get cervical cancer? How do you think people can protect themselves from getting cervical cancer? How do you find out or how do you know if you have cervical cancer? Why do you think some women from your country do or do not get checked for cervical cancer? What concerns do you have about getting checked for cervical cancer? How do women from your country get information about women's health issues like cervical cancer? Have you heard of a Pap smear?

Box 2.

THEMES AND EXAMPLE QUESTIONS FOR PREDISPOSING, ENABLING, AND NEED-FOR-CARE FACTORS

Predisposing Factors

Health practices and perceptions are shaped by experiences in country of origin

"Back in our country in Bhutan nobody used to check and that's why they do not get checked here." [Bhutanese]

"Women back home suffered and died during labor and most of the babies died in the womb because we don't have a good place or equipment to use and help mom during labor." [Burmese]

"My mother had 11 children in total but only four survived. We had no place to work and feed four children, but always on the run. Wherever the Burmese soldiers came, children are dying because of [no] food and clean water and other sicknesses." [Burmese]

Enabling Factors

Limited English proficiency and issues with interpreters

"I have that kind of problem, and then when we go to the hospital, we are not able to tell our problems openly or clearly. They will give us an interpreter by phone because we are not in a condition to speak. But the interpreter tells us to speak louder … Sometimes the interpreter themselves won't understand what we are saying because we are not in the condition to speak due to pain, and keeps asking." [Bhutanese]

"It's very, very hard, because we don't understand the language. That's why it's so hard. The clinic always has to call an interpreter for me. I have to say that I am lucky, if I get a kind and patient—a kind interpreter." [Burmese]

Cost of health care and competing financial priorities

"If we have health insurance from our spouse's work, we have to pay a co-payment. Some are not covered for every visit, and so sometimes we hesitate to see our doctor because we don't have money to pay for our co-payment. We want to visit a clinic, but we don't have enough money." [Burmese]

Participant responding to why women don't get screened:

"Maybe due to money problems thinking that they might get a big amount of bill, to those who does not have insurance. Some might not want to spend money on that. Some don't have enough money that they may be having a hard time even to pay rent." [Bhutanese]

Issues navigating the US health care system

"Even if we know that we should get checked for cervical cancer, we don't know what to do; how to set up an appointment; how to go and how to contact the doctor." [Burmese]

Embarrassment, fear, and stigma related to cervical cancer and screening

Participant responding to why women don't get screened:

"Feeling a little shy. I also felt scared … I also asked the doctor what will you do with this? And then he said, 'This will go inside and then it will take tissue from there' and so I denied [the procedure]." [Bhutanese]

"Maybe they will think that you don't keep clean, or you sleep around." [Burmese]

"Maybe other people would think that the husband is bad or the wife is bad. Some people may be afraid." [Burmese]

Positive relationships with doctors and health care providers

"From my experience I really like my doctor, because my doctor is kind. On top of that, she is a female doctor and so we could talk and then I feel safe. Because she is a female doctor we can understand each other, or we can understand our problem as women." [Burmese]

"If the doctors don't tell us, then we won't know about it. Maybe some other woman knows about it, but I didn't know about it until the doctor started talking to me about these issues." [Burmese]

"But when we go to the doctor, they said that everything will be kept confidential. Everything that comes out from our mouth or the interpreter's mouth will be kept secret, and so we don't have to worry about that; that they will tell other people about our health information." [Burmese]

"The doctors here are good. They don't share your information to the public, even to your family members if you don't allow them. I really like that about it, and so I dare to share how I feel and suffer and everything to my doctors. I feel safe, I share everything with my doctors here." [Burmese]

Use family and friends for health information and decision-making

"Even though we are not educated, our children can read and write. They are educated. We don't know. We are uneducated and so if we get letters, we don't even know how to read them. Because the children are educated they will explain to us." [Bhutanese]

"You will feel better and let go, if you share your problems with family and friends and get the support." [Burmese]

Confident making independent decisions

"We should know a little ourselves. We need to know what kind of bleeding is that and whether it is menstrual (sic) blood or a different kind, or a mixing of blood or water. If we know that, then only our doctor will check fast if we tell him or her." [Bhutanese]

A participant voiced that she was the most informed person to make a decision about her health needs:

"Me, too, I decide on my own even when I have my tube tied (sic), whether taking a birth control pill or the Depo shot. Whenever I asked my husband he doesn't know, and so he told me to do whatever I decided to do." [Burmese]

Need-for-care
Knowledge and Beliefs About Cervical Cancer
"I don't know what an ovary is and how it looks. What is ovary or cervix?" [Bhutanese]
"But I don't know where my cervix is, and so I won't know when I have pain or the location of the pain that will indicate I have cervical cancer. I only know when I have abdominal pain." [Burmese]
"When the woman had abnormal vaginal discharge and don't go to see the doctor … then it might turn into cancer." [Burmese]
"Firstly, being neat and cleanliness [is important] … Over there we used to give birth at home. Many were born in a dirty place and used to use dirty cloths, but here it's safe. They put a pad, but over there we used to use old, dirty cloths. I think that will cause cancer." [Bhutanese]
"Before moms used to have (sic) too many children. They used to give birth every year, and also they had to work at home and work on farms, and need to cut grass and lift heavy objects. They had to work at farms and cut grass within two to three days of their delivery. For these reasons, they have ovarian problems." [Bhutanese]
Knowledge and Beliefs About Cervical Cancer Screening
"It is good to check, because if we have disease then we will know and treat it. If we don't have a disease, then we know that we don't have a disease." [Bhutanese]
"They look at your cervix through your vagina, and put a tool in to get solid fluid—something like that—and examine it. If there is nothing there after it, they say that it is normal." [Burmese]

Table 1.

PARTICIPANT CHARACTERISTICS

	Burmese (n=31)		Bhutanese (n =27)		Total (n=58)	
	N	**%**	**N**	**%**	**N**	**%**
Age (Mean Years)	34		41		37	
20 – 29	12	39	11	41	23	40
30 – 39	10	32	0	0	10	17
40 – 49	4	13	7	26	11	19
50+	5	16	9	33	14	24
Marital Status						
Married	23	74	22	82	45	78
Single/Divorced/Widowed	8	26	5	18	13	22
Formal Education (years)						
≤ 1	8	26	13	48	21	36
2 – 6	4	13	5	19	9	16
7 – 11	14	45	3	11	17	29
≥12	4	13	6	22	10	17
No answer	1	3	0	0	1	2
Years in the U.S. (mean)	4		4		4	
0 – 4	20	65	13	48	33	57
5 – 9	11	35	14	52	25	43
English Fluency						
Fluent or Well	0	0	4	15	4	7
Some	9	29	11	41	20	35
Poor or Not at all	22	71	12	44	34	58
Checked for cervical cancer before coming to U.S.						
Yes	9	29	3	11	12	21
No	22	71	20	74	42	72
Not sure	0	0	4	15	4	7
Checked for cervical cancer after coming to U.S.						
Yes	20	64	12	44	32	55
No	9	29	7	26	16	28
Not sure	2	7	8	30	10	17