

Vietnamese women and pap smears: issues in promotion

Abstract

Objective: Australian data indicate that Vietnamese-born women in Australia have a significantly higher incidence of cervical cancer than other Australian women. This study explored self-reported factors associated with Vietnamese-born women's participation in cervical screening.

Method: A structured 60-item questionnaire was used to conduct an interview survey with 199 Vietnamese-born women over the age of 18 years and resident in Adelaide.

Results: Eighty-seven per cent (87%) of the women had heard of a Pap smear and 75% had had a test at some time. Reported participation increased with age, education level, marriage and length of stay in Australia. The family doctor was the most important source of information about Pap smears and the majority of the women reported they would have a smear if recommended by their doctor. Friends and family were the second information source about cervix screening.

Conclusions and Implications: These findings have clear implications for practice. Strategies to promote preventive health messages to this group of women should involve general practitioners and peer networks.

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Incidence and death rates for cervical cancer are generally higher among migrant women than Australian-born women. Vietnamese-born women, in particular, have a significantly higher incidence of cervical cancer.¹ It is estimated that 90% of cervical cancer cases are preventable with two-yearly Pap smear screening to detect precancerous abnormalities of the cervix. Countries with an organised screening program and a high level of participation in cervix screening have experienced a 70%-90% reduction in incidence of cervical cancer.² Hence, particular attention to cervical screening among Vietnamese-born women should redress the higher incidence among this group.

The participation rate of Vietnamese-born women in cervix screening is unknown as existing data from the state-based Pap Smear Registries does not record the country of birth or ethnicity. Self-report surveys of this group can provide an indication of possible screening pattern. For instance, Young and Coles found that women born in Vietnam had less knowledge about or experience of Pap smears and were among the least likely to have had a Pap smear when compared with women from other ethnic groups, including Australian-born women.³

This paper describes a survey of self-reported participation in cervical cancer screening among Vietnamese-born women living in Adelaide. The study also examined beliefs about cancer, breast screening, osteoporosis and menopause, but only the data on cervix screening are presented here. The survey will be repeated in two years to

assess any change over time following interventions.

Methodology

The study was a cross-sectional survey conducted by personal interview in September 1996. Women between the ages of 18 and 70 living in Adelaide and who were born in Vietnam were selected as the target population. To participate in the survey the woman had to speak either Vietnamese or English. Due to the small numbers, it was not considered practicable to also include women whose main language was one of the Chinese dialects. A random sample of 200 was considered adequate to represent the 4,294 Vietnamese-born women aged between 20 and 70 living in Adelaide.⁴

A list of 600 Vietnamese households was randomly generated from the electronic version of the Adelaide telephone white pages by searching on the most common Vietnamese family names. Each interviewer was given 150 of these selected households to systematically contact (each third household) by telephone until 50 interviews were arranged. It was considered necessary to generate a list of 600 names to ensure that a final sample of 200 was reached. However, one interviewer required 78 additional households in order to generate 50 interviews. If there was more than one eligible woman per household, then the one with the most recent birthday was selected. A final sample of 199 women was obtained. After telephone contact, a time was arranged for a face-to-face interview, as this was

considered the most culturally appropriate form of data collection.

The questionnaire was a 60-item instrument designed for face-to-face interview in either the Vietnamese or English language. The instrument was adapted from questionnaires used in previous studies.⁵⁻¹⁰ Those questions taken from surveys of South Australian women were not altered to increase the validity of making comparisons between the studies. Closed-ended questions were used almost exclusively to collect self-report data that covered the following:

- use of health services;
- knowledge, beliefs and attitudes about cancer;
- knowledge, beliefs, attitudes, practices, preferences and sources of information about Pap smears; and
- demographic details.

Self-report data is not a measure of actual behaviour. Hence, the results of this survey cannot be used to make claims about participation in cervical cancer screening. Stratton concluded that self-reports must be considered as over-estimates of between 10% and 20%.² However, in the absence of direct measurement of behaviour, and when compared to other self-report data collected in a similar way, this survey methodology is of value.

The questionnaire was professionally translated into culturally appropriate 'everyday' Vietnamese language. Although cross-cultural researchers frequently use a procedure known as back translation to ensure language equivalence, advice from local language service specialists suggested that this technique has problems.¹¹⁻¹³ As perfect equivalence cannot be found between languages, differences would be expected between the original and back translation which would not necessarily indicate problems with the original translation.¹¹ To ensure that the intent of the questions remained intact from the English to Vietnamese versions, the Vietnamese research associate (who had six years of health interpreting experience) worked closely with the translator. The translated questionnaire was subjected to pilot testing with Vietnamese speaking health professionals and their clients.

Four Vietnamese-born women were recruited to be interviewers through community networks and were trained over two days at Interview Quality Control Australia (IQCA) standard. At the completion of the data collection, an audit was conducted on 5% of the interview sample. A post-data collection audit revealed a positive response to the process of the interview.

Data analysis

The data was entered into the Statistical Package for the Social Sciences (SPSS) and was analysed descriptively using cross tabulations. Unless indicated otherwise, the findings are reported at this descriptive level. However, the Chi square test was used to analyse the data further and, where the test could be considered with confidence and a finding was significant, this is reported. As this resulted in the use of a large number of tests, a conservative level of statistical significance was used to reduce the number of type 1 errors. Hence, significance is reported at $p < 0.01$. The variables used for analysis were as follows:

- age;

- level of educational attainment;
- year of arrival;
- marital status; and
- Pap smear category (never had; in past two years; more than two years).

Results

Demographic profile of the participants and their use of health services

When compared to the 1991 Census, the profile of the Vietnamese-born women in this survey reflected the characteristics of the population of Vietnamese-born women in South Australia, although the sample was more recently arrived.⁴ Fifty-two per cent of the women in this study arrived during or after 1988. The age profile of the sample of Vietnamese-born women indicated that they were younger than the population of South Australian women generally. Fifty-four per cent of the women were under the age of 39 compared to 43% of all South Australian women. Eighty-one per cent indicated that they were married or in a de facto relationship. Forty-nine per cent indicated that they had not completed a high school level of education. Eighty-six per cent indicated that they spoke only Vietnamese at home.

The major health care provider was the family doctor and while the majority of the women indicated that the ethnicity of their health care provider did not matter, most (93%) usually spoke Vietnamese when they attended a medical or health-related appointment.

General beliefs about the prevention of cancer

Most of the women (93%) indicated that they would like to be told if they had cancer, and while only 40% were conclusive in their response that cancer was preventable, between 25% and 64% thought that modifiable lifestyle factors were a cause of cancer. Superstition about cancer was not evident in the overall responses, as only 6% thought that cancer was 'God's punishment' or that it was a 'curse from someone' (1%). The importance of these points is that they indicate the potential for Vietnamese-born women to be encouraged to make some lifestyle change to prevent cancer later in life.

Pap smears

Knowledge

Most (87%) of the women had heard of Pap smear tests. A smaller percentage of women under the age of 30 and those who were single/never married had heard of the test than other women (Tables 1 and 2). The women who were the most recently arrived (since 1988) were the least likely to have heard of the Pap smear test (Table 3).

Knowledge that a Pap smear test indicates pre-cancerous changes in the cervix was high (96% of those who had heard of the test), however fewer women who were single/never married knew this (80%) than women in other marital status groups (97%-100%).

Table 1: Heard of Pap smear tests by age.

Age	Yes		No	
	%	(f)	%	(f)
20-29	77%	(24)	23%	(7)
30-39	90%	(68)	10%	(8)
40-49	86%	(48)	14%	(8)
50-59	88%	(15)	12%	(2)
60-69	93%	(14)	7%	(1)
TOTAL	87%	(169)	13%	(26)

Note:
n=195. Missing values=4.

Table 2: Heard of Pap smear tests by marital status.

Marital Status	Yes		No	
	%	(f)	%	(f)
Single/Never married	68%	(11)	32%	(5)
Married/ Defacto	89%	(140)	11%	(18)
Separated / Divorced/ Widowed	91%	(20)	9%	(2)
TOTAL	171		25	

Note:
n=196. Missing values=3.

Table 3: Heard of a Pap smear test by year of arrival.

Year of Arrival	Yes		No	
	%	(f)	%	(f)
1975-1987	93%	(87)	7%	(7)
1988-1995	82%	(84)	18%	(19)

Note:
n=197. Missing values=2.

While awareness of the test and knowledge about what it was for was high, knowledge was low that "women aged 18-70 who have ever had sex should have a routine test" (25% of those who had heard of the test). Knowledge was also low that this test "should be conducted once every two years" (47% of those who had heard of the test). Of the variables analysed only education was found to be statistically significant ($\chi^2(3)=17.78$ $p<0.0005$). Women with the least education were less likely than women in other education categories to know the recommended frequency for a routine test (21% compared to up to 71%). Although not statistically significant at the level set for this study, as age increased, the percentage of women who knew of this recommendation decreased from 50% of those aged 20-29 to only 20% of those aged 60-69.

Participation in Pap smear screening

The Vietnamese-born women's self-reported participation in Pap smear screening was high (75%), however this was 10% lower than the 85% self-reported participation for South Australian women found in the 1995 Health Omnibus survey.⁸ Women under the age of 30, those who were single/never married and the more recently arrived were the least likely of the Vietnamese women to have had a test (Tables 4-6).

The advice from community informants indicated that younger

Table 4: Women who have had Pap smears by age.

Age	%	(f)
20-29	44%	(14)
30-39	84%	(64)
40-49	84%	(46)
50-59	82%	(14)
60-69	67%	(10)
TOTAL	75%	(148)

Note:
n=197. Missing values=2.

Table 5: Women who have had Pap smears by marital status.

Marital Status	%	(f)
Single/Never Married	19%	(3)
Married/Defacto	81%	(129)
Separated / Divorced/ Widowed	73%	(16)

Table 6: Women who have had Pap smears by year of arrival.

Year of Arrival	%	(f)
1975-1987	94%	(82)
1988-1995	80%	(67)

Vietnamese-born women and women who are single or never married are less likely to be sexually active. Hence, these women would not be among the target groups for Pap smear screening and therefore their lower participation rate in screening should not be over stated, but neither should this be ignored, especially as the community becomes more acculturated and norms regarding sexual activity undergo change.

Source of information

The family doctor was the major source of information about Pap smears (54%), followed by a family member or friend (23%), the television and radio (22.5%), newspapers and magazines (17%) and pamphlets (12%). Community agencies were only a minor source of information (3-7%). Age and having had a Pap smear test were significantly associated with using the doctor as an information source about Pap smears ($\chi^2(4)=13.92$, $p<0.01$ and $\chi^2(2)=14.91$, $p<0.0001$ respectively). Women under the age of 30 and those who had not previously had a test were the least likely to have obtained information from a doctor.

The use of written material as an information source varied. Educated women were significantly more likely ($\chi^2(3)=16.58$ $p<0.001$) to obtain information from newspapers and magazines. Thirty-seven per cent of women with some tertiary education reported obtaining information in this way, compared to only 4%

Table 7: Women who were comfortable asking a doctor for a Pap smear test by age.

Age	% (f)
20-29	57% (13)
30-39	72% (49)
40-49	94% (44)
50-59	79% (11)
60-69	67% (8)

of those who never completed primary school. There was also a trend according to marital status, as 50% of the single/never married women reported obtaining information in this way compared to only 14% to 15% of women in the other marital status groups. However, this finding did not reach statistical significance. Women who arrived before 1988 were significantly more likely to use pamphlets than women who arrived since 1988 (20% compared to 5%; $\chi^2(1)=7.05$ $p<0.01$).

Views about Pap smear tests

Between 36% and 48% of the women in the survey thought that a Pap smear test was uncomfortable or embarrassing. More women who had never had a test were uncertain about whether the test was uncomfortable (37% compared to 10%-13% of other women) and were more likely to agree that the test is embarrassing (68% compared to 32-38% of other women). Women who were single/never married were more likely to agree that the test was embarrassing (80% compared to 25%-35% of other women) and women who arrived since 1988 were more likely to disagree that the Pap smear test was embarrassing (63% compared to 48%).

Opportunities to use medical appointments for prevention

Although the Vietnamese-born women in this survey were evenly divided about the statement "*Women don't have Pap smears because they only go to the doctor when they are sick*" (42% agreed, 41% disagreed, 17% not sure), 79% of the women who had not previously had a test and 70% of those who were single/never married agreed, compared to 36%-50% of the other women.

Most of the women (93%) indicated that they would be prepared to have a Pap smear test if this was suggested during a medical consultation. However, younger and older women and women who had not previously had the test were less likely to be comfortable asking a doctor for a test (Tables 7 and 8).

Practitioner preference

Most of the women who had a Pap smear test indicated that they went to their doctor for their most recent test (74%) and most also went intentionally for the test (71%) rather than this being suggested by the doctor during the consultation.

A female doctor was the preferred practitioner to perform the test (82%). Although the majority (71%) indicated that they had no ethnic preference with regard to the health practitioner, it is

Table 8: Women who were comfortable asking a doctor for a Pap smear test by whether they had previously had a test.

Whether had Pap smear	% (f)
Never had a Pap smear test	48% (9)
Last pap smear <2 years	78% (102)
Last pap smear >2 years	94% (15)

interesting to note that 93% usually spoke Vietnamese when they went to see the doctor or other health worker. So, although the women stated that they have no preference, in practice it would seem they do have a preference for a Vietnamese-speaking practitioner. This has implications for interventions with Vietnamese women as the Vietnamese-speaking doctors play a pivotal role in their health care.

Discussion

The Vietnamese-born women in this survey had a lower level of knowledge of and participation in cervix screening than that found in surveys of the general population of South Australian women. Eighty-seven per cent of the women in our study had heard of Pap smear tests and 75% had had a smear at some time. This is lower than the 96% of South Australian women who had heard of a Pap smear and the 85% who had had a smear at some time.⁸ This lower rate, however, was not as great a difference as would have been expected based on the findings of previous studies, such as those of Pham and McPhee in California in 1992 where only 58% of Vietnamese-born women had heard of a Pap smear and 54% had never had a Pap smear.⁵ As our survey was conducted after the introduction of the Cervical Screening Program nationally across Australia the higher rate of screening participation than expected could reflect the recruitment activities carried out by the Program. Some of these recruitment activities have been directed specifically to women from non-English speaking backgrounds including Vietnamese women. Activities in the Vietnamese community have included media campaigns on radio and in the press, peer education and information sessions for bilingual/bicultural workers.

Some caution is required in the interpretation of the data from this study, however, as it is based only upon the women's self-reported behaviour and the problem with the validity of self-reports has been mentioned earlier. Furthermore, the differences between the results of our study and other South Australian studies may in part be an artefact of the different language used for the interview (Vietnamese).

The patterns of participation in cervix screening that we found are similar to those of other studies. Participation in cervix screening was found to increase with length of residence in the adopted country in our study and in studies in the United States by Pham and McPhee and by Yi.^{5,14} Yi also found that participation increased with age and marriage and this follows our findings where

the least likely to be screened were those in the youngest age category and those who were single/ never married. Both the studies by Pham and McPhee and by Yi also found that participation increased with income, however we did not use this variable for analysis.

The majority of women in our study had heard of the Pap smear test but were less sure about who should have test and how often. This bears out the focus group findings of the South Australian Harrison Health Research study, conducted as a preliminary stage of the present survey that a lack of knowledge and understanding about Pap smears among Vietnamese-born women was a barrier to these women accessing the test.¹⁰ Prasad and Shinwari also reported in a study of non-English speaking background women in Brisbane that some of the barriers to having a Pap smear were lack of awareness of the Pap smear procedure and its significance, as well as embarrassment and fear of the results.¹⁵

In our study, the family doctor was the most significant source of information about cervix screening, followed by family member or friends and the television or radio. These same three sources, in the same order, were reported by Adamson and Taylor in a small study of Vietnamese-born women in Sydney and also by Prasad and Shinwari in Brisbane.^{6,15}

Conclusion

The importance of the family doctor to the Vietnamese community cannot be over emphasised. They were the major source of health information on Pap smears for the women in the survey. The majority of the women also reported that they would have a Pap smear if it were recommended in a consultation with their doctor. This has clear implications for interventions to increase the screening rate of Vietnamese women. Vietnamese-speaking doctors were clearly the major primary health care provider to these women, so it is vital that there is encouragement and support for these doctors to raise the issue of cervix screening with their patients.

The second important direction is to utilise the existing non-medical community networks through which Vietnamese women gain information, that is through family and friends. The SA Cervix Screening Program has already conducted peer education programs in the Vietnamese community in Adelaide in order to capitalise on these familial and social networks. Extension of this type of community education would appear to be warranted by the findings of this survey. The use of written materials for education is of less value, particularly with women who are most in need of education and information, that is those women who are more recently arrived in Australia.

Further interventions based on knowledge gained in this study will be put in place and the second survey in two years will determine any changes in knowledge, attitudes and behaviour of Vietnamese-born women which may have occurred as a result.

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