

Using a Culturally Competent Framework to Increase Annual Breast Cancer Screening Rates Among Low-Income Latinas: A Case Study of The Orange County Cancer Detection Partnership

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Abstract

The Orange County, California, Cancer Detection Partnership is a successful example of a multi-tiered breast cancer detection program that reaches low-income, underserved women with remarkably high breast cancer screening rates for Latinas. Between July 1999 and June 2001, 65.3 percent of Latinas eligible for free breast cancer screening services were screened by the provider network affiliated with this partnership. This case study provides evidence that culturally competent services are effective. The key elements underlying the effectiveness of this program are a strong foundation of collaboration, commitment to integrate community participation into program decision-making, and innovative implementation strategies developed within a culturally competent framework. These elements have either reduced or eliminated barriers related to infrastructure, socio-cultural issues, and financial concerns that low-income women often face when accessing services. The California Department of Health Services, Cancer Detection Section, designed a model that enables ten regional cancer detection partnerships to prevent and reduce the devastating effects of breast cancer through early detection, diagnosis and treatment by incorporating these and other key elements into their programs. This case study includes discussion and recommendations for program enhancement and future research.

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The Orange County Cancer Detection Partnership (OCCDP), in existence since 1994, exemplifies a functional and successful breast cancer detection program for low-income, underserved women with recognizably high screening rates for Latinas. This paper describes the origin and mission of OCCDP's breast cancer detection program and highlights the key elements underlying the success of the program.

Statement of the Problem

Due to a variety of obstacles ranging from infrastructure to financial, Latinas have consistently lower breast and cervical cancer screening rates compared with non-Hispanic

white women, regardless of risk status, according to Ramirez et al. (2002). In 2001, the California Department of Health Services' Cancer Detection Programs: Every Woman Counts (CDP:EWC) estimated that 22 percent of Latinas in Orange County were eligible for free breast and cervical cancer screening services. Increasing culturally competent screening services for program-eligible Latinas is a major goal of the OCCDP.

Although legislation has been passed that increases the availability of cancer detection services for low-income, monolingual women, this does not mean that women will

automatically access the services available to them. OCCDP has developed an infrastructure and culturally appropriate outreach methods that enable Latinas to access critically important cancer screening services.

Literature Review

Screening Barriers

As all women are at risk of developing breast cancer as they grow older, it is encouraging that mammography screening rates have nearly doubled in California over the last decade. However, significant disparities in screening rates exist across population groups.

The breast cancer screening literature concurs on a number of different impediments to screening services for women that may be categorized as: (1) infrastructure and provider-related barriers; (2) user-related and socio-cultural barriers; and (3) financial barriers (Breast and Cervical Cancer Task Force [BCCTF], 2000). These categories are illustrated in Table 1.

Infrastructure and Provider Related Barriers
These barriers include long waits for an appointment or during a visit, limited availability of clinicians, clinics, and hospitals; not knowing where to go for care, inability to take time off from work to visit the provider, need for child care, and lack of transportation. Lack of provider recommendation for screening is the most cited barrier in this category, particularly among older women and women of color. The lack of availability of female and bicultural/bilingual providers has also been noted to be a significant obstacle for some older and less acculturated Hispanic women (BCCTF, 2000).

User-Related and Socio-Cultural Barriers

Examples of user-related or perceived barriers for a woman considering or undergoing screening are anxiety, embarrassment, and other emotional responses (Austin et al., 2002). Members of ethnic and racial minority groups may also encounter social and cultural barriers. These barriers include a woman's knowledge and beliefs about breast cancer. The role of the family and cultural perspectives may help or hinder screening behavior. Several studies have reported that low-income Latinas tend to have more medically inaccurate breast cancer beliefs, such as the consideration of breast trauma and unhealthy behaviors (e.g., using illegal drugs) as risk factors for breast cancer (Chavez et al., 1995). Demographic variables, such as low levels of education, low socio-economic status, place of residence, immigration status, and lack of English-language proficiency can also be barriers to a woman's ability to access services.

Breast and cervical cancer screening rates are consistently lower among women who are monolingual and do not speak English (BCCTF, 2000). In states where there is a high percentage of monolingual Spanish speakers, the availability and quality of qualified interpreters and translators play significant roles in facilitating the screening process. Translation is frequently confused with interpretation when it is very different: interpretation refers to the spoken word whereas translation refers to the written word. Translation and interpretation are separate activities requiring very different training, skills, and techniques, each one being an independent profession in its own right. Therefore, a skilled translator is unable to interpret unless he/she is trained as an interpreter. Unfortunately, translation and interpretation services in many medical settings have been regarded as volunteer work and have suffered from a lack of professional quality (Smart & Smart, 1992).

Table 1
Types of Screening Barriers Faced by Low-Income Latinas

Screening Barriers Faced by Low-Income Latinas	Improving Annual Screening Rates in Orange County by Reducing Barriers
<i>Infrastructure</i>	<i>Infrastructure</i>
<ul style="list-style-type: none"> • Limited availability of bilingual/bicultural providers. • Long waits to get an appointment. 	<ul style="list-style-type: none"> • OCCDP maintains geographically balanced healthcare provider network. • 90% of primary care providers in network are bilingual (English/Spanish). • Statewide toll-free number used for prequalification and referral staffed by bilingual (English/Spanish) operators. • Statewide toll-free number staff refers prequalified women to three providers closest to where client lives. • Patient navigation assistance also provided by Partnership staff as needed.
<ul style="list-style-type: none"> • Inability to take time off from work. 	<ul style="list-style-type: none"> • Some providers offer extended hours or flexible schedules.
<ul style="list-style-type: none"> • Childcare responsibilities. 	<ul style="list-style-type: none"> • Some providers offer childcare.
<ul style="list-style-type: none"> • Lack of transportation. 	<ul style="list-style-type: none"> • High concentration of providers in areas with high numbers of program eligible women. • Some providers offer transportation.
<i>User-Related: Socio-Cultural</i>	<i>User-Related: Socio-Cultural</i>
<ul style="list-style-type: none"> • May not know there is a need to get screened. • Lack of knowledge about availability of services and location of providers. 	<ul style="list-style-type: none"> • Public education and outreach conducted by: <ul style="list-style-type: none"> ○ Mini-grantees ○ Latina Task Force
<ul style="list-style-type: none"> • Anxiety about procedure. • Embarrassment about exposing breasts. • Fear of finding cancer. • May fear detection of immigration status. 	<ul style="list-style-type: none"> • Latina Task Force events and activities address these issues. • Mini-grantees, including <i>Promotoras</i> or lay health advisors, breast cancer survivors, and Tell-A-Friend volunteers replace fears with motivation to seek screening. • Partnership projects and program components built upon cultural assets.
<ul style="list-style-type: none"> • Monolingual skills. 	<ul style="list-style-type: none"> • In addition to Task Force and mini-grantees, bilingual/bicultural staff help women navigate through screening process. • 90% of primary care providers in the network have bilingual capability. • Cancer Detection Section (CDS) and Partnership communications/materials produced in English/Spanish.
<ul style="list-style-type: none"> • Client may be illiterate and be embarrassed about it. 	<ul style="list-style-type: none"> • Patient navigation and interpretation services are available through providers' offices or the Partnership.
<i>Financial</i>	<i>Financial</i>
<ul style="list-style-type: none"> • Lack of health insurance or funds to pay for services. • May not see services as a priority. 	<ul style="list-style-type: none"> • Cancer Detection Programs: Every Woman Counts (CDP:EWC) provides screening, diagnostic, and treatment services at no cost to eligible women.

Screening Barriers Faced by Low-Income Latinas	Improving Annual Screening Rates in Orange County by Reducing Barriers
<ul style="list-style-type: none"> • Inability to pay for transportation or childcare. 	<ul style="list-style-type: none"> • Network of providers easily accessible by bus or within walking distance. • Some providers offer childcare services.
<p>Some services are not covered by federally or state-funded programs, including:</p>	
<ul style="list-style-type: none"> • Cervical screening for all program eligible women. 	<ul style="list-style-type: none"> • Some CDP:EWC providers offer Pap test on a low-cost or sliding scale basis.
<ul style="list-style-type: none"> • Clinical breast examinations for low-income, uninsured women ages 39 and under not utilizing state-funded contraceptive services. 	<ul style="list-style-type: none"> • Some CDP:EWC providers offer clinical breast exams for age-ineligible women on a low-cost or sliding scale basis.
<ul style="list-style-type: none"> • Diagnostic services for low-income, uninsured women ages 39 and under with abnormal clinical breast exam findings. 	<ul style="list-style-type: none"> • The Partnership collaborates with the Susan G. Komen Breast Cancer Foundation to pay for diagnostics for women with abnormal clinical breast exam findings who are age-ineligible for the federally and state-funded program.
<ul style="list-style-type: none"> • Support services for women diagnosed with breast cancer, including Spanish language support groups, wig banks, etc. 	<ul style="list-style-type: none"> • The Partnership provides referrals to foundation and cancer society-funded support services.

Financial Barriers

Among the most frequently cited barriers that hinder women from seeking care is lack of financial resources, especially lack of health insurance. Although Latino cultural values play a role in the screening process, there is danger in confusing culture with socio-economic status. For example, a Latina client, like any other client, may appear to be indecisive when, in fact, she may feel helpless due to economic deprivation and all of its resulting ramifications. Such a client may expect differential treatment, negative outcomes, and the possibility of abandoning the screening cycle, not because of any particular cultural characteristics, but because of the lack of economic resources (Smart & Smart, 1992).

All of these barriers have been cited repeatedly in the literature as the factors affecting or directly responsible for lower cancer screening rates among Latinas (BCCTF, 2000). Each of the above-mentioned barriers is a manifestation of

larger and more complex issues. To date, the most effective interventions to increase breast cancer screening rates are those that are multifaceted and multi-layered (Navarro et al., 1998). Integrating cultural competency throughout the organization maximizes the ability of these interventions to address multiple barriers simultaneously. Furthermore, intervention effectiveness is enhanced if educational efforts designed to motivate people to seek screening services accompany the offering of those services (Wheeler, 2003).

Cultural Competency

Cultural competency encompasses cultural sensitivity, cultural knowledge, and cultural skills. Cultural sensitivity refers to attitudes, perceptions, and values that show heightened awareness of providers' own culture and that of the population being served. Cultural knowledge refers to knowledge of integrated systems of learned behavior as well as their attitudes, feelings, and values. Cultural skills connote abilities, roles, and functions to systematically

examine beliefs, values, and practices of the group and to determine health care needs within the cultural context of this group (Kim-Goodwill et al., 2001).

Several studies have reported that relationships with healthcare providers have a significant influence in reported intentions to engage in cancer screening (Burnett et al., 1995; Burack & Liang, 1989). These results are consistent with the conclusions of Coughlin & Uhler (2002) indicating that Hispanic women are more likely to undergo cancer screening if they have a regular health care provider. In terms of breast health, "...healthcare providers can reinforce positive cultural values and recognize cultural beliefs that may encourage breast cancer screening" (Giammona, 2002, p. 10).

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

Culturally competent agencies work to hire unbiased employees and seek advice and consultation from their clients. These agencies seek staff who represent the racial and ethnic communities being served...and [are] capable of negotiating a diverse and multicultural world...Further, culturally competent agencies understand the interplay between policy and practice, and are committed to policies that enhance services to a diverse clientele (cited in Quality Health Services for Hispanics: The Cultural Competency Component, 2000, p. 16).

Background

California Department of Health Services, Cancer Detection Section

The multi-leveled, community-oriented, regional partnership model was designed by the California Department of Health Services' Cancer Detection Section (CDS), whose mission is to save lives by preventing and reducing the devastating effects of

cancer for all Californians through early detection, diagnosis, and treatment, with special emphasis on the underserved. CDS manages public health programs addressing breast, cervical, and prostate cancer. One CDS program is entitled Cancer Detection Programs: Every Woman Counts, through which OCCDP is a contractor. Until October 2002, CDS' breast and cervical early detection programs were divided into two programs known as the Breast Cancer Early Detection Program (BCEDP) and Breast and Cervical Cancer Control Program (BCCCP). By way of federal grant funds and state tobacco tax revenue, the Cancer Detection Programs: Every Woman Counts provides free breast and cervical cancer screening and diagnostic services for women who qualify.

Since 1991, CDS has provided free breast and cervical cancer screening and diagnostic services to underserved women through the regional partnership model. These services are provided to women who qualify based on the federal Breast and Cervical Cancer Mortality Prevention Act of 1990, and the California Breast Cancer Act of 1993. Approximately 900,000 women are eligible for breast cancer screening services and more than 1,800,000 are eligible for cervical cancer screening services statewide. The Cancer Detection Programs: Every Woman Counts provides life-saving breast and cervical cancer screening and diagnostic services including clinical breast exams, mammograms, pelvic exams, and Pap tests to underserved women in California. Women eligible for these services must fulfill the following criteria: age 40 and older (cervical screening is provided to women 25 and older), have an income at or below 200 percent of the federal poverty level, and have limited or no health insurance. A toll-free consumer referral line links women to services in their neighborhoods by offering referral information in six languages: English, Spanish, Mandarin, Cantonese, Korean, and Vietnamese. Spanish-speaking callers may speak directly with a bilingual person.

Ten regional cancer detection partnerships direct their efforts to make breast and cervical cancer screening a public health priority in each of California's 58 counties. The partnerships strengthen client support services, coordinate the development and delivery of social marketing campaigns, and assist clinicians and other health professionals to maximize the efficiency of screening and diagnostic services. The partnerships bring together people from local communities and develop collaborative relationships that provide outreach to and support for low-income women.

A CDS professional team based in Sacramento consists of a Health Education Consultant, Nurse Consultant, Professional Education Consultant, and a Staff Services Analyst. This team provides each regional partnership with technical assistance, resource supports, and guidance. In addition, various meetings, trainings, teleconferences, and a monthly CDS Update facilitate communication and collaboration between CDS and the partnerships.

Orange County Cancer Detection Partnership

Bordered by the counties of Los Angeles, San Bernardino, Riverside, and San Diego, Orange County encompasses 33 cities in a 798 square mile-area stretching from the Pacific Ocean to the Santa Ana Mountains. Orange County is the second most populous county in California, with a population of almost 2,850,000 residents – a population greater than that of 20 states. Orange County is one of the nation's fastest growing urban centers, with increasing numbers of working poor and medically indigent. One of the most densely populated counties in California, Orange County is five times more densely populated than San Diego County, which has roughly the same population. Rapid demographic changes have generated greater cultural and economic diversity. According to the U.S. Census 2000, of the 2,846,289 Orange County residents, 55.9 percent identify themselves as non-Hispanic white, 30.8

percent Hispanic, 12.5 percent Asian/Pacific Islander, 1.5 percent African-American, and .4 percent other. Within the Hispanic population, 87.4 percent are of Mexican origin. Segments of entire Mexican villages have relocated to Orange County neighborhoods.

The Orange County Cancer Detection Partnership was established in December 1994, with funds from the State of California Breast Cancer Act of 1993. In 2002, cervical cancer screening outreach and education was added to the Partnership's scope of work, and the current name of the Partnership was adopted. The administrative agency for OCCDP is the County of Orange Health Care Agency.

The mission of OCCDP is to decrease cancer morbidity and mortality, and improve the overall health status of people in Orange County by increasing the ability and capacity of local communities to provide ongoing, easily accessible, comprehensive, diversity-sensitive, integrated systems to ensure that all families in Orange County, especially the underserved, do not encounter barriers to cancer early detection, treatment, and education.

The goal of the Partnership is to increase the number of low-income, uninsured, and underinsured women who access free annual breast and cervical cancer screening services provided by Cancer Detection Programs: Every Woman Counts. In collaboration with local foundations and community providers, the Partnership also helps those individuals who are ineligible for the state- and federally-funded program to access free or low-cost screening and diagnostic services.

Organizational Structure

The Partnership's commitment to integrate community participation into high-level decision-making distinguishes it from other public health programs. A steering committee representative of the region is comprised of community volunteers and a member-elected Executive Council. The

Executive Council is composed of the Partnership Chair, Vice-Chair, Subcommittee Chairs, Medical Consultant, and representatives from special populations (see the organizational chart in Appendix A). These special populations include cancer advocacy groups, seniors, providers, and ethnic communities. The Executive Council reviews and approves all Partnership budgets, scopes of work, and personnel matters. Additionally, the Executive Council provides oversight of Partnership functioning to ensure that all target groups in Orange County are adequately served. CDS prescribes the overall partnership budget and requires that certain objectives be completed through a contractual scope of work.

In addition to the technical assistance provided by CDS professional team, the Partnership selectively hires consultants to focus on specific efforts when internal expertise is not available or when it would be more efficient to employ a consultant instead of a staff member. These consultants include a Latina Breast and Cervical Task Force Coordinator, a Minigrant Program Coordinator, and a Professional Education Coordinator. These subcontractors have proven invaluable as they bring a wealth of experience that OCCDP carefully and strategically applies to its mission. These consultants allow Partnership staff to devote additional time to program planning and to address unmet needs in the community.

OCCDP Program Components

Public Education and Outreach

Public education and outreach is one of two major components of OCCDP. Through the public education and outreach component, the Partnership maintains a community coalition, including three population-specific task forces whose goal is to implement tailored strategies to increase the number of underserved women accessing screening and diagnostic services.

Task Forces

The Asian and Pacific Islander, African American, and Latina task forces conduct focused outreach and educational activities in their respective communities on breast and cervical health, screening, and healthy lifestyles. Task force members recruit women, including clients, from the above populations to become spokespersons as well as members of the Partnership volunteer coalition. Key community outreach strategies consist of social marketing campaigns, proven effective interventions (e.g., The Witness Project, Lay Health Advisor outreach, Tell A Friend Program) and a minigrant program designed to solicit innovative outreach projects from the community.

Minigrants

The minigrant program funds projects through a community bid process to increase the utilization of annual breast and cervical cancer screening services by program-eligible women. Projects may include cultural and targeted outreach, training and technical assistance to community agencies, educational/ promotional materials development, prequalification and referral to medical providers, public relations and media activities, and patient navigation and support systems. Minigrant awards to community-based agencies or other entities range from \$1000 to \$5000 per year.

Clinical Services

Through the clinical services coordination component, the Partnership maintains a geographically and linguistically balanced regional healthcare provider network. Partnership clinical staff recruit primary care providers, conduct professional education courses for clinicians and provider staff, and oversee regional continuous quality improvement activities. A Continuous Quality Improvement Subcommittee aids providers in achieving compliance with CDS clinical standards. Subcommittee members regularly review aggregated CDS client data and make recommendations for regional provider continuing education,

resource development, or technical assistance.

Program Evaluation

The Partnership conducts formative, process, impact, and outcome evaluation of

its public education and outreach strategies in various ways. The ways in which the Partnership evaluates these strategies is illustrated in the table below.

Table 2
Evaluation Examples

<i>Evaluation Examples</i>
<p><i>Formative:</i> During the planning phase, task forces and mini-grantees, with the assistance of Partnership staff, conduct women’s health conferences and develop instruments to measure their success in terms of knowledge gained and willingness to adopt the desired behavior (e.g., pre- and post-tests, follow-up telephone surveys, etc.).</p>
<p><i>Process:</i> In implementing population-specific women’s health conferences, the following are routinely documented: number of fliers distributed, newspaper articles published, attendance rosters collected, and evaluation forms completed.</p>
<p><i>Impact:</i> Pre- and post-tests administered at the women’s health conferences are tabulated. In addition, women are surveyed a few weeks after each conference to assess screening status and whether they adopted a screening and/or a healthier lifestyle behavior. Also assessed is whether or not the conference attendees spoke to other women about the importance of breast cancer early detection.</p>
<p><i>Outcome:</i> Annual screening numbers for each target group are monitored to assess how many women actually obtained screening services.</p>

Methods

CDS provides data that includes breast and cervical cancer screening rates of program-eligible women served by each regional partnership. Rates are determined by matching billing claims data with the number of program-eligible women in each region. These figures are broken down by ethnicity and by region.

Results/Findings

According to CDS records for a recent 24-month time period ending June 30, 2001, OCCDP had the highest cancer screening rates for program-eligible, low-income, uninsured Latinas in California: 65.3 percent. These findings illustrate how the unique elements of the Partnership respond to the specific needs of this population, and by being responsive to these

needs, eliminate or reduce the identified barriers to breast cancer screening.

Using a Culturally Competent Framework to Increase Breast Cancer

Screening Rates Among Low-Income Latinas in Orange County

In light of the high screening rate among Cancer Detection Programs: Every Woman Counts program-eligible Latinas in Orange County, Partnership staff and consultants have been interviewed to assess their own inferences for the Partnership’s high level of performance with this particular ethnic group. The following paragraphs describe specific Partnership assumptions regarding the elimination or reduction of barriers to breast cancer screening

for Latinas and how the integration of cultural competency at all Partnership levels has impacted screening rates among this population. Such assumptions are consistently cited in the literature.

Infrastructure and Provider Related Barriers Provider Network

Of the 59 Cancer Detection Programs: Every Woman Counts primary care providers in Orange County, 53 (90 percent) have fully bilingual and bicultural staff. Many providers are located in the areas where major concentrations of low-income, Spanish-speaking women live. These two factors make it easier for Latina women to follow through with accessing a particular provider for their care. These providers are familiar with barriers that may make it difficult for Latina women to access healthcare facilities. For example, some providers will create a play area in their lobbies for children or provide free transportation for clients. These providers may also offer evening hours or Saturday hours for employed women. Some providers may even offer many other services on a sliding scale fee and set up a flexible payment schedule to make it easier for low-income Latinas to access a variety of screening and health services.

Filling Identified Gaps

In 1998, the program manager for the County of Orange Health Care Agency's Family Planning clinics brought forward the issue of uninsured, low-income women younger than age 40 not being able to access breast cancer diagnostic services after having abnormal breast exam findings under the Family Planning, Access, Care, and Treatment (F-PACT) Program. The F-PACT Program provides family planning services, including clinical breast exams, for women of reproductive age, but does not cover advanced breast cancer diagnostic services for clients with abnormal clinical breast exam findings. These women were not age eligible for the Cancer Detection Programs: Every Woman Counts program whose eligibility criteria starts at age 40. Approximately 90 percent of the women in this situation were low-income Latinas with no health insurance coverage. These women often postponed or ignored

referrals to diagnostic services due to financial reasons.

The OCCDP Coordinator was contacted to help develop a way to provide diagnostic services to these F-PACT clients. The Partnership, through its many community linkages, contacted the local affiliate of the Susan G. Komen Foundation to assess the possibility of creating a special fund to pay for diagnostic services for these clients. Due to the excellent working relationship and previous successful grants received and administered by the Partnership, the Komen Foundation decided not only to provide the necessary funds for these potentially life-saving procedures, but also to fund a bilingual (English/Spanish) patient relations specialist to help women navigate through the system. This collaboration was not in the official scope of work of the Partnership, but it was determined to be so valuable and necessary that the Partnership clinical services coordinator and the project coordinator devoted numerous hours to establish and coordinate this effort.

As a result of this collaboration, hundreds of women have received these medically necessary procedures with some being diagnosed and subsequently enrolled to receive free treatment through the Breast Cancer Treatment Fund, and more recently, the Breast and Cervical Cancer Treatment Program.

Interpretation and Patient Navigation

The use of family and friends as interpreters or translators has been a common practice in many medical settings and is problematic. Furthermore, the use of family and friends as interpreters or translators violates the right of privacy of the client and is a frequent source of misinformation due to inaccurate and gross misinterpretations (Smart & Smart, 1992). To circumvent such potential problems, OCCDP dedicated special funds to pay for an interpreter on-call for special follow-up for diagnostic appointments. The role of this interpreter was to ensure that women undergoing advanced diagnostic and treatment procedures understood all the pertinent information. This service was made available through surgeons' offices.

User-Related and Socio-Cultural Barriers

Staff members who reflect the cultural background of the population being served ensure that program implementation occurs within a culturally competent framework (Kerner, 1996; Pasick, 1997). Given that approximately 70 percent of Cancer Detection Programs: Every Woman Counts clients in Orange County are Latina, having a fully bilingual and bicultural staff provides a welcoming environment where Spanish-speaking clients can contact any person on staff to receive direction and support as they navigate through the screening process. This feature becomes even more critical when a woman is referred to advanced diagnostics or treatment. In addition, Partnership communications are internally developed in both English and Spanish. Materials provided by CDS are also available in both English and Spanish.

Integration of Cultural Competency into OCCDP

A deep understanding of Latino cultures plays a central role in motivating women to adopt positive screening behaviors. Cultural competency is integrated at every level of operation within the Partnership. The Partnership deliberately and strategically develops and implements its projects and program components in a fashion that builds upon cultural assets at both a program-wide and individual level. A completely bicultural and bilingual staff operate within this culturally competent framework.

Although the literature abounds with papers covering Hispanic/Latino cultural characteristics, such topics are beyond the scope of this paper. Our purpose here is to emphasize that in a culturally competent context, cultural characteristics can successfully propel the program's objectives and are not to be viewed as barriers. Summarized below are some core cultural elements of Hispanics in the United States, according to the Quality Health Services for Hispanics (2000) and a description of how OCCDP addresses these elements.

Core Cultural Elements

Confianza is defined as trust. To gain trust in a targeted community, one must determine who is respected in the community. The Partnership has built trust by inviting an inclusive membership composed of community-based organization representatives as well as individual community members.

Personalismo has been defined as placing high value on personal, one-to-one relationships. Viewing the healthcare professional as a friend instead of a professional helper can both impede and facilitate screening behavior, depending on how this informal relationship is oriented and understood by both parties.

Simpatía has been defined as a general tendency toward avoiding personal conflict, emphasizing positive behaviors in agreeable situations, and de-emphasizing negative behaviors in conflictive circumstances (Triandis, 1984). Positive aspects of simpatía are supportive attitudes and behaviors toward those in need. Since disagreement could be seen as a sign of conflict, it is to be avoided.

Partnership staff, providers, and minigrants are keenly aware of the above cultural elements and take them into account in personal interactions with community members and clients.

Culturally Competent Lay Support Systems

Minigrants, most of which are small, community-based organizations (CBOs), establish relationships between community members and the Partnership. These relationships extend beyond the grant period. OCCDP maintains an open-door policy where such organizations feel welcomed to continue coming to the Partnership for materials and support even after the grant period is over. The minigrants process and implementation also exemplify culturally competent practices. The acknowledgement that community members bring assets, talents, and skills requires that there be mechanisms to channel those assets. By funding both grass-roots and individual efforts, the Partnership ensures that such mechanisms are in place.

Three exemplary minigrantees illustrate specific features of cultural competency of the Partnership outreach and education modus operandi: culturally competent lay support systems.

“Lay support systems have the same ostensible goal of promoting the well-being of their members as do professional service delivery systems in promoting the health of their patients, clients or program participants” (Eng & Young, 1992, p. 24). In this case, the professional or formal service delivery system is the Partnership staff. An informal service delivery system is not viewed as a replacement for services but as a network of mediating structures that can negotiate with professionals for more and better quality services. Families, neighborhoods, churches, apartment buildings, and social clubs are examples of what people can structure for themselves to mediate and negotiate between the private sphere of individual needs and the public sphere of resources (Eng & Young, 1992).

The following three minigrantees illustrate this concept of lay support systems through role modeling (via a project resembling The Witness Project®), Promotoras, and faith-based outreach, all of which have been proven effective.

Role Modeling

One minigrantee exemplifies elements from The Witness Project®, an outreach strategy shown to significantly increase mammography and breast self-exam rates among African-American women. The church-based Witness Project enables breast cancer survivors to share their experiences with other women as well as prevention and early detection information (Bailey, Erwin & Belin, 2000). Individual minigrantee: D.M. is an eight-year breast cancer survivor whose enthusiasm and personal commitment has propelled her to conduct over 100 workshops in varied settings from the intimacy of a woman’s humble living room, to churches, to continuing education classrooms. In two and one-half years as a minigrant recipient, D.M. has reached over 500 women with the early detection message as well as over 100 women who have been diagnosed with

breast cancer and have participated in D.M.’s support groups.

Promotoras/Lay Health Advisors

“Natural helpers are lay people to whom others naturally turn for advice, emotional support and tangible aid” (Israel cited in Eng, 1992, p. 24). Interventions that build on the role of natural helpers fall under the classification of Lay Health Advisor (LHA) interventions. LHAs, commonly known as Promotoras in the Latino community, are linked to people in ways unattainable to most health professionals. LHAs fulfill three main roles: (1) assisting individuals in their social networks with needs that are difficult for professionals to address; (2) negotiating with professionals for support from the health system; and (3) mobilizing the resources of associations in their community to sustain support from the health system (Eng, 1992, 1995).

A well-established CBO that embraces the philosophy of the LHA model and employs it in successful programs received a minigrant from OCCDP. This minigrant allowed the CBO, through two of their Promotoras, to reach over 350 women through community-based workshops. The CBO obtained additional funding from a local breast cancer foundation to continue its work and retain a full-time Promotora co-trained by OCCDP. The Promotoras go door to door in certain geographical areas to visit women who have been referred to them by other women or fellow Promotoras. These Promotoras conduct small presentations in varied settings such as a woman’s living room, an apartment building patio, or community room. In addition, the Promotoras qualify women for the Cancer Detection Programs: Every Woman Counts program and refer these women to other local resources.

Faith-Based Outreach

Fox et al. (1998) demonstrated that the awareness and behavior of Hispanic women can be changed through an intensive church-based cancer control program. The authors concluded that Hispanic women can be just as receptive to church-based health promotion opportunities,

such as screening mammography, as African-American women historically have been to these programs. A faith-based organization reached over 2,000 women in a six-month period through cancer early detection message exposure in churches, and additionally reached 143 women through workshops.

These three OCCDP minigrantees have reached thousands of women by embodying cultural competency qualities. Approximately 1,500 women have attended in-depth breast health workshops of at least one-hour in duration over a 33-month period. The workshops have been conducted completely in Spanish by culturally competent bilingual presenters. The breast cancer survivor and the Promotoras not only identify themselves with the target audience but are themselves part of this audience. They are intimately familiar with the subtleties of culture, language, socio-economics, and migration process challenges faced by the participating women.

Latina Task Force

The following describes successful outreach and education strategies implemented by the Latina Task Force.

The Latina Task Force planned a one-day, holistic conference that was informational and inspirational. ¡Celebrando la Mujer! opened with a very energetic keynote address, proceeded to the content workshops, and ended with a luncheon and a serenade honoring womanhood. The women who participated were followed-up by phone to assess their mammogram and Pap test status.

The conference had many highlights. The conference was conducted entirely in Spanish to attract monolingual women who are linguistically isolated and have less access to health information. The conference format was designed for interactive experiential learning. Participants were engaged in workshops where the instructors utilized teaching tools (e.g., pears were used as props for the uterus) to address not only issues of low literacy but also the often-overlooked issues of “basic life science literacy.” Many individuals with low literacy

skills also lack basic understanding of how the body is organized: cells, tissues, organs, and systems. Without this knowledge, understanding the concept of cancer becomes much more difficult. During the conference, workshop facilitators educated participants about cancer beginning with the very definition of cells before moving to cancer etiology and early detection methods.

Even though knowledge alone is not enough to change women’s health behaviors, without basic knowledge of screening guidelines and the rationale behind the screening intervals, it is unlikely that women will follow recommended screening behaviors. Health education information may be available to this group of low-literate women, but lack of literacy even in their native Spanish prevents them from reading and comprehending the materials. Similarly, women with limited literacy skills are less likely to understand verbal education provided by their physicians. (Davis et al., 1996).

The Latina Task Force sponsored a creative form of breast cancer education on September 21, 2002. Over 120 community members were mesmerized by internationally renowned singer and National Komen Foundation spokesperson, Soraya. Soraya captured her audience not solely with her voice but with her direct, heartfelt, and well-articulated message of early detection.

An American Cancer Society (ACS) Tell A Friend (TAF) training was recently conducted with 15 participants who were recruited as a follow-up to their participation at the Celebrando la Mujer conference. In addition to the established TAF curriculum, an innovative basic cancer literacy module was presented to clarify misconceptions, unify the participant’s own understanding of what cancer is and why getting screened once is not enough, and highlight the importance of the triad of screening behaviors (breast self-exam, clinical breast exam, and mammogram). Following the training, participants will be monitored by phone and sent personalized correspondence. A reunion is planned at the culmination of the project.

Limitations

Generalizability of study results is limited by issues inherent to the case study methodology. Factors that directly affect higher cancer screening participation in this population have not been isolated; on the contrary, they have been presented here as elements of a complex, reality-based model. Due to Orange County's higher provider density as compared to some counties, client access to services and transportation may be less of a problem and therefore may confound the study results.

Conclusion and Recommendations

An integral, cultural competency framework embedded within a well-defined Partnership model may eliminate and/or reduce the multiple barriers for low-income Latinas cited in the breast cancer screening literature, and result in increased annual screening rates. The insights presented in this case study reinforce the importance of providing culturally competent, well-coordinated services. The authors concur with Rackinzcki and DiClemente (1999, p. 6) when they state: "Approaches that have demonstrated promise should form the basis for refinements and experimentation, grounded in theoretical underpinnings, until a technology of

prevention can be fully developed. In the end, empirically grounded theory and extensive field testing will result in the development of effective programs. The promise of a 'quick fix' must be understood to be an illusion. The demand for ready solutions should be responded to with the development of technically sound solutions."

This case study may be the point of departure to further research among this same population to examine the relationships between a culturally competent system of care, ethnocentric lay support systems, and annual breast cancer screening rates. To our knowledge, very few reports (Bobo et al., 1999) have comprehensively investigated the factors associated with annual breast cancer screening among low-income women with access to free testing, and their level of satisfaction with the services they receive. Data of this nature is urgently needed to enhance public health delivery. The authors suggest that future experimental studies test the feasibility and impact of this complex model in another geographical area with low-income Latinas, and isolate the most effective strategies that result in increased annual breast cancer screening rates.

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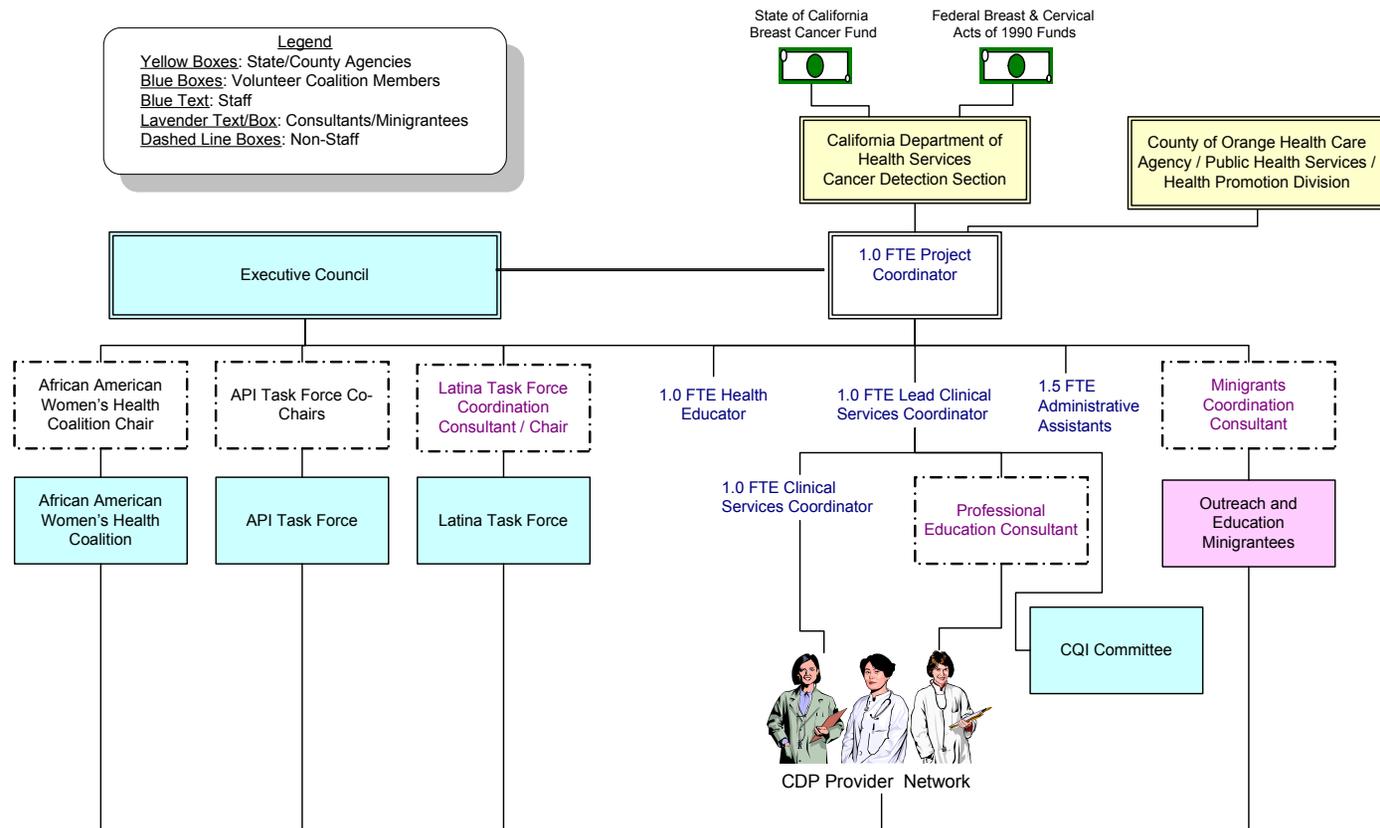
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Appendix A
 County of Orange Health Care Agency
 Orange County Cancer Detection Partnership Organizational Chart

County of Orange Health Care Agency Orange County Cancer Detection Partnership Organizational Chart

March 2003



Cancer Detection Programs: Every Woman Counts Clients

Appendix B
Promotoras Gather Together After a Training Session

