An Exploration of Hmong Women’s Perspectives on Cancer

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Purpose  The purpose of this study was to explore the perspectives of Hmong women on cancer, using focus groups as the research method.

Methods  Two focus group interviews were conducted and the narrative data were analyzed using thematic content analysis.

Results  Themes that emerged from the focus group discussions included “fatalistic and ‘black and white’ thinking”, “valuing rumors rather than scientific information”, “strong adherence to traditional medicine”, “male leaders controlling health care decisions”, “embarrassment discussing women’s bodies”, and “preferred strategies in addressing cancer”.

Conclusion  Many Hmong people in the United States believe that both traditional and Western health care practices are effective, but when health professionals do not address differences in language, communication, and beliefs about health, trust between the provider and client may erode. The findings of this study provide new insight into the importance of cultural accommodation to improve early cancer detection in the Hmong community. [Asian Nursing Research 2008;2(2):82–91]

Key Words  acculturation, focus groups, preventive health services, qualitative research, traditional medicine
Although most Hmong people were exposed to a rudimentary level of Western health care while living in refugee camps, the majority arrived in the United States with limited knowledge of the complexities of American medicine. Many had heard rumors about American medical care that led to misconceptions and fears that in some cases have persisted (Culhane-Pera & Xiong, 2003). As a younger generation of Hmong men and women has grown up in the U.S., many have become more comfortable viewing illness from a scientific standpoint and utilizing Western health care. However, both younger and older Hmong Americans—especially women—continue to face challenges and issues associated with their culture and status as they attempt to navigate and access health care in the U.S. Similar to other immigrant populations from developing countries, traditional health care practices—many based on religious beliefs—may be implemented or sought before seeking Western medical services.

The study was conducted in Milwaukee, Wisconsin, in the Midwestern United States. Of the 170,000 Hmong living in the U.S., the state of Wisconsin has the third largest statewide population (Migration Policy Institute, 2005; U.S. Census Bureau, 2000) and Milwaukee has the fourth largest city-wide population of Hmong people of any U.S. metropolitan area (Karon, Long, & Veroff, 2007). Aware of the cancer risk in Hmong women, the University of Wisconsin-Milwaukee College of Nursing developed an outreach program to provide screening and diagnostic testing for breast and cervical cancers in collaboration with the Wisconsin Well Woman Program (Wisconsin Department of Health and Family Services, 2006). As the program progressed, it was evident to the nurses that while there was a growing body of literature concerning Hmong health beliefs and experiences, more information about Hmong women’s beliefs specifically regarding cancer was needed in order to improve community-based strategies for early cancer detection. This study was designed to provide Hmong women with a forum to voice their perspectives on cancer in the context of their community, and to recommend health promotion and early detection strategies that are culturally appropriate for the Hmong population.

**METHODS**

**Research design**

A qualitative research design with a feminist lens is a productive method for gathering meaningful data about women’s perspectives in a patriarchal culture like the Hmong’s (Madriz, 2000), where women may be less educated than men and feel they have diminished voice (Johnson, 2002). In this qualitative study, focus groups were the chosen interviewing method as they have been found to “stimulate free discussion among participants on the subject of inquiry” (Khan et al., 1991, p. 145) and allow researchers to gather a large amount of information in a limited time. The collective power of participants in focus groups strengthens women’s voices and allows them to validate their responses with each other in a non-linear method of participation.

Focus groups are particularly appropriate for community health planning (Stevens, 1996) and is a recommended method for identifying strategies for public health marketing (U.S. Centers for Disease Control and Prevention, 2006). Mahloch et al. (1999) reinforced the use of qualitative methods in developing health education programs, particularly for Southeast Asian women.

In qualitative research, the trustworthiness or rigor of the study is defined by its credibility, transferability, dependability, and confirmability. The credibility of this study was enhanced by: the cultural awareness of the European-American researcher who had not only lived in Asia, but had worked with the Hmong community in a community health center in the United States; the maintenance of field notes by the researcher and her ongoing reflection of her impact on the focus groups; the use of a Hmong nurse as a co-facilitator; convening the focus groups in a Hmong neighborhood; and involving the participants in the first stage of the analysis by their sanction of the data as it was recorded.
The study met the criteria of transferability by documenting specific information about the focus group method and recording of the data, thus enabling another researcher to apply a similar process with another population with limited English language abilities. The dependability of the study was supported by keeping an audit trail of the process (Rodgers & Cowles, 1993), which included documentation of the initial interview questions and their advance disclosure with the participants, maintenance of field notes, and discussion and recording of decisions regarding the research design with a nurse from the Hmong community. The dependability was also supported by offering focus groups in English or Hmong, comprised of women of varying ages. In this way, "multiple realities" and perspectives were reflected in the focus groups. The inclusion of a registered nurse of Hmong descent on the research team and the involvement of the participants in the early analysis of the data, as well as the credibility, transferability, and dependability all contributed to the confirmability of the study.

The study had several limitations. Interviewees provided their perceptions of specific issues at hand and offered potential solutions that may or may not be applicable to similar situations in other refugee/immigrant communities. Group dynamics can be negatively impacted by an insufficiently prepared group facilitator in a number of regards: the facilitator may not be adept at managing group process and thus unable to ensure that all group members have an opportunity to participate; the facilitator may undermine data collection by cutting off discourse too early and/or misinterpreting ideas as they are generated and analyzed. Furthermore, when conducting multilingual research, accurate capture and identification of concepts is a perennial data collection concern. These limitations were addressed by the inclusion of the Hmong nurse to help facilitate the focus groups and the researcher’s strong background in conducting community focus groups.

**Participants**

The focus group participants included a purposive sample of women who were recruited by staff of the UWM College of Nursing at community events and health fairs, and the sample met eligibility criteria of the approved Human Subjects Review Board protocol which was that women had to be Hmong and at least 35 years of age. (Women have to be at least 35 years of age to participate in the Wisconsin Well Woman Program.) Interestingly, many of the women talked about choosing their birth dates, as without written records, their age was approximate.

**Instrument**

An interview guideline (Table 1) was developed by the researcher in partnership with the Hmong nurse on the research team. Participants were asked questions from the interview guideline and were also encouraged to address additional topics that they believed should be included in the discussion.

**Data collection**

Two focus groups were conducted, each lasting approximately 2 hours: one in English with four participants and one in Hmong with 10 participants. Participants chose the focus group based on the language they preferred to use.

To promote the comfort of the participants and to diminish the influence of the European-American researcher, focus groups were conducted at a restaurant.

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**Table 1**

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<tr>
<th>Initial Interview Guideline</th>
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<tr>
<td>What do Hmong people say about cancer? What are their fears?</td>
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<tr>
<td>What do Hmong people do when they are sick?</td>
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<tr>
<td>We know that many kinds of cancer can be treated if caught early. What should the messages say?</td>
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<tr>
<td>How do you think being Hmong has had an impact on the health care services you have received?</td>
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<tr>
<td>What are your suggestions for making health care services better for Hmong families?</td>
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owned by a Hmong family and located in an area with a high density of Hmong households. The Hmong nurse who co-facilitated the focus groups also assisted with translation and analysis of the participants’ responses.

Responses were summarized in English by the researcher and displayed. Both the researcher and the Hmong facilitator encouraged participants to discuss and revise the summaries, allowing the women to self-edit the data, clarifying and expanding upon ideas among themselves. Both the reflexivity and transparency of this data collection process served to enhance accuracy and increase the participants’ sense of ownership in the process.

The decision was made to forego audiotaping the discussions because of the possible impact the recording process itself might have had on both the researcher and the participants. By discussing and analyzing the responses of the participants as they were being written down, the participants were better assured that their voices and ideas would be captured and it gave the researcher the opportunity to ask additional probing questions.

The synergy that develops in focus groups allows for one member’s response to spark additional ideas among other members, and increase the depth of the exploration of any one idea. In this study, it provided an opportunity for the women to think more deeply about their experiences with cancer in their community and treatment in the United States.

**Analysis**

The first stage of the analysis occurred during the focus group. The reflexive approach for capturing the data allowed participants to engage in the initial stages of analysis, as ideas were translated into English words. The Hmong women’s discussion regarding translated concepts was important, given the fundamental cultural differences reflected in Hmong and English. The dialogue among participants allowed time for the focus group members to reach consensus about the meaning of an idea and to stimulate more discussion about the issue being considered. By displaying the summaries during each of the focus groups, bilingual/English-speaking participants, as well as the Hmong nurse, could continuously check to ensure the accuracy of the translation as the summary of ideas was being written.

In the second stage of the analysis, the summarized data were typed and reviewed, first for the content related to the research question and then inductively for additional themes that arose from the data. Major thematic categories were identified and refined through a discussion process with the research team members.

**RESULTS**

Field notes indicated that participants in the focus group conducted in Hmong were older in age and less formally educated than the English-speaking group. The younger group included two women educated as teachers and one licensed practical nurse completing an Associates Degree in Nursing. The professional backgrounds of these women were consistent with the researcher’s assumption that the English-speaking group would be more assimilated. Having a focus group in each language allowed for the inclusion of a broader range of perspectives and experiences among interviewees. The participating Hmong women expressed beliefs that issues of culture, language, and history lead to many misconceptions about cancer. Themes that emerged from the focus group discussions included: “fatalistic and ‘black and white’ thinking”, “valuing rumors rather than scientific information”, “strong adherence to traditional medicine”, “male leaders controlling health care decisions”, “embarrassment discussing women’s bodies”, and “preferred strategies in addressing cancer”. During the note-taking process, the participants approved the data as it was written in their collective voice, rather than as individual quotes. In some cases, an individual’s remarks were accepted as the group’s thinking.

**Fatalistic and “black and white” thinking**

Focus group participants reported that “there is no word for cancer in the Hmong language”; the translation of the word they use for cancer means “death”. 
They described Hmong people as “fatalistic”, believing that “if you are diagnosed with cancer, you will die, but that is your destiny or fate”. One group member stated that “you could not go against the clan”; her clan leaders had denied that her husband had cancer after it was diagnosed. She said that they believed that by denying the cancer’s existence, it would not be present.

The younger women reported that “Hmong people see things very black and white”. They stated that when treated by a health provider, the Hmong person wants “a 100% guaranteed outcome that they will recover” from the illness/disease and may take the prognosis very literally. One younger woman said that mistrust may develop when a health care provider reports that a patient “has 2 months (to live), but they live for 6”. The older women suggested that health care providers use “gentle” explanations such as, “If you do not follow the directions, you will not live long with your family.”

The participants reported that when Hmong individuals contract cancer, they may delay seeking Western health care until they can no longer bear their pain. “They want to die due to too much pain… They don’t seek help until too late.” An older participant reported that her husband had died of cancer after traditional Hmong healers made unsuccessful attempts to cure him. Another reported that by the time her aunt was diagnosed, the cancer had spread throughout her body. The often late diagnosis of the disease reinforces Hmong people’s fatalistic attitudes, as death becomes more closely associated with the diagnosis of cancer.

Valuing rumors rather than scientific information
Many of the women, first generation refugees, had learned to trust Americans over time. They had to first overcome fearsome rumors about life in the United States, such as suggestions that Hmong women would be abused or as one said, “People heard that Americans were the giants who eat people.” The older women believed that many misunderstandings occurred because of inadequate translations. The women reported that misunderstandings also led to Hmong perceptions of discriminatory health practices by Western health providers. On the other hand, misunderstandings on the part of the health care providers led to frustration on their part and culturally insensitive health care. Several of the women shared stories of “angry” American nurses and doctors.

Strong adherence to traditional medicine
Older women in the focus groups reported that while living in Laos, family members took on the role of healers as there were no physicians available to them. The younger women judged Fadiman’s (1997) account in The Spirit Catches You and You Fall Down as an accurate portrayal of Hmong history and beliefs, and spiritual and herbal remedies.

The women discussed the use of common herbal remedies that Hmong people learned through their oral tradition. Both groups reported that because the plants used for these medicines are shipped from Southeast Asia, they “can be expensive”. Both groups of women reported that Hmong families use herbal medicines either prior to taking prescribed Western medicines or to supplement Western medicines with herbal remedies. Interestingly, they reported that they have learned that “American health care works for children”.

Women in both groups described various traditional healing practices including: blood letting; “cupping” (a cup is heated and placed on the affected area of the body); use of “tiger balm” or other creams; and dietary remedies. For example, “If it’s believed that a food caused an illness, that food is burned, mixed with water, and used as a medicine.” Eggs are often used in treatment for conditions such as skin rashes. Copper bracelets are used “for moods and to keep bad spirits away”. The women reported that when the individual’s health improves after the treatment, Hmong people continue to believe that these health practices work.

Male leaders controlling health care decisions
While believing in scientific approaches to medical care, the younger women reported frustration with the need to seek permission for treatment from older, male family members who often believe in more traditional health practices. Out of necessity, the older
Perspectives of Hmong Women About Cancer

Women had developed long-standing alliances with male family members for promoting the health and welfare of their families.

Women in both groups described instances in which clan leaders refused to obtain Western health services for their family members. One described her husband’s diagnosis of appendicitis. The clan leaders refused Western treatment for this man, preferring that the Hmong shaman perform a traditional healing ceremony. Fortunately, he recovered from this illness without the surgery recommended by the American physician, thus reinforcing distrust in Western medicine. One of the younger women said she was able to persuade her husband to get cancer treatment after discussing his needs with his older brother. The women advised that because “the Hmong still respect the wishes of their elders”, cancer detection messages might be disseminated to and through family elders.

Women in both groups reported that family leaders respected educated people, particularly those within their own families. They suggested that this respect afforded opportunities for these individuals to serve as health care advocates who could help to promote early screening for cancer. The women reported that in general, health care decisions are made by men, with older men holding more power than younger men.

Embarrassment discussing women’s bodies

The women reported that Hmong women are very modest about their bodies. The older women reported that breast and cervical cancer prevention are “embarrassing subjects” and suggested that practitioners be straightforward with their messages. In the focus group with the younger women, the researcher reported that one of her patients had told her that she could more easily discuss family planning issues in the English language as it was much more embarrassing to speak about these issues in Hmong. The younger women agreed with this statement and reported that there were more English words for the language of anatomy and physiology and using English—their non-native language—provides them more distance from the intimacy of discussions about reproductive health. They further described the difficulty of showing body parts to a male practitioner and the need to be assigned to a female health care practitioner.

Preferred strategies in addressing cancer

The participants described health care access issues related to language. They reported avoiding clinic receptionists who were unwilling and/or unable to accommodate their language and culture. The women talked about the importance of developing a trusting relationship with the health care provider. They also suggested that health providers use professional interpreters rather than relying on clients’ children to perform this function, as well as employing interpreters of the same gender as the client. The women reported that they preferred interpreters who were better educated, understood the illness, and were able to explain it in descriptive language.

The women suggested having an adult son or daughter coordinate care for their elderly family members. They cautioned, “If it is a woman who coordinates care and there is a poor outcome, the woman may be blamed for the result and may become an outcast of the clan.” Some participants suggested that home visits were a good strategy for identifying family members who could assist with care coordination.

Participants recommended that providers should strive to effectively communicate their messages to the Hmong family males/elders who most directly influence clan/family health care perceptions and behaviors. Younger women described the importance of identifying supportive, male family members who would advocate for Western medical practices.

Participants had specific suggestions for using culturally appropriate communication channels for health education and early cancer detection. The women suggested disseminating messages at places offering programs for Hmong elders and inviting well-respected individuals to assist with health education events held within their communities. They reported that Hmong radio is an important media source for “Hmong elders who do not speak much English and do not read”. The women suggested that respected community members provide radio testimonials concerning the health promotion message.
The women stated that “Hmong are very visual”. They suggested using diagrams, visual aids, and even X-rays to teach people about their illnesses. They reported that many Hmong people “walk away with false impressions” when health explanations are not clear and that videotapes should feature Hmong actors speaking Hmong.

DISCUSSION

The increased incidence and invasiveness of cervical cancer among Hmong women in the U.S.—and the potential for increasing rates of cancers related to North American lifestyles—demands culturally appropriate health care interventions that will better serve one of the United States’ fastest-growing population groups. Nurses working in women’s health arenas are in an ideal position to facilitate interventions that are empowering to Hmong women.

There are a number of culture-related challenges in promoting health education regarding cancer and early cancer detection. An initial challenge is the lack of a specific word for cancer in the Hmong language. Consistent with the reports of the focus group participants, an instructor for the Asian American Network for Cancer Awareness, Research and Training (AANCART) described how few North American medical terms have counterparts in Hmong language (University of California Davis Health System, 2008). This supports the use of clear messages with more visual, diagrammatic health education materials to improve women’s knowledge of anatomy and physiology. This information is important for Hmong women’s increasing understanding of their own bodies, women’s health issues, and the resources that are available to them to better care for themselves and their families.

It is important for nurses to balance their efforts to work within the patriarchal culture with efforts to empower Hmong women to advocate for optimal health care for themselves and their families. To be culturally sensitive to those Hmong women who adhere to the traditional practice of male leaders controlling health care decisions, nurses must identify particularly supportive male elders or educated sons who can advocate for the recommended therapy. This can be thought of as an expansion of current best practices that incorporate the client and family in the development of a treatment plan. Reaching influential Hmong elders is a primary strategy for promoting health messages in this community.

Important to the early detection of cancer in this population, the women recommended the use of multimedia strategies for disseminating health promotion and early detection methods. These strategies can be targeted to elder Hmong groups through testimonials from educated members of their community over their local, Hmong language radio stations. Because Hmong people value education, educated Hmong women, particularly Hmong nurses, may gain status and power if used as spokespeople for health messages. Development of videotapes that feature Hmong men and women advocating for scientific approaches to health care can be an effective means of reaching multiple Hmong generations. Because cancer may not have symptoms in its early stages, it may be difficult to persuade some Hmong patients and/or their family members to acknowledge that the condition even exists and these public communication strategies could help to promote earlier detection. These strategies may work as well with other new immigrant or refugee groups who are attempting to address acculturation issues while maintaining their cultural identity.

The women participants reinforced the importance of well-trained interpreters. This is consistent with the U.S. National Standards on Culturally and Linguistically Appropriate Services (The Office of Minority Health, U.S. Department of Health & Human Services, 2007) in which standards for language access services require that programs receiving federal funds provide a competent interpreter without charge. The women in the study further specified that, for the Hmong culture, the interpreter should be the same gender as the client. Women interpreters may empower Hmong women to discuss their health concerns more accurately and to seek needed treatment. The women also reinforced the need for good translation services throughout
the health care encounter, from registration to discharge.

They reported that Hmong people acknowledge that health care providers do not understand the nuances of their language and traditions, but they appreciate providers’ attempts to learn more about their culture. They especially appreciate when providers acknowledge instances of inadvertent cultural insensitivity made during health care encounters. Campinha-Bacote (1999) wrote of the need for “obtaining cultural knowledge about the client’s health-related beliefs and values... The client’s world view will explain how he/she interprets his/her illness and how it guides his thinking, doing, being” (p. 182). This respect and sensitivity are requisite for culturally competent health care for any “other” group (Burcham, 2002; Campinha-Bacote; Canales & Bowers, 2001). Nurses can engender respect as they encourage women to give voice to their health concerns.

The results of this study indicate that Hmong women are able to maintain their strong cultural traditions within North America. They blend traditional Hmong treatments with Western medical practices as they feel are needed. Health care providers must acknowledge that prescribed treatment plans for Hmong family members may be supplemented with traditional remedies. A comprehensive assessment of the family’s traditional healing practices is required, as well as an awareness that some individuals may not disclose their use of these practices.

The results of this study were validated by the consistency of the responses of both groups with each other. While little information regarding Hmong beliefs about cancer is available, participant responses concerning Hmong health care practices were highly consistent with other such reports in the literature (Culhane-Pera & Xiong, 2003; Fadiman, 1997; Jambunathan & Stewart, 1995; Olson, 1999). Furthermore, participant reports in this study were similar to those of other minority cultural groups (Geiger, 2003; Shambley-Ebron & Boyle, 2004) and women from developing countries (Mkandawire-Valhmu & Stevens, 2007; Shrestha, 2003).

IMPLICATIONS FOR NURSING PRACTICE, POLICY, EDUCATION AND RESEARCH

This study has implications for practitioners, policymakers, educators and researchers developing or expanding services for early cancer detection and treatment. Outreach as an intervention means that the onus is on the health care provider to “reach out” to vulnerable populations. The women participating in this study reaffirmed that the health care professionals who are developing screening programs must understand that a client’s contact with any representative of the health care system, from office receptionist to billing clerk, is just as important in promoting access to health care as contact with the health care provider. Each step in accessing a health program or service must be carefully assessed to identify areas that may foster mistrust or misconceptions. For example, if language barriers occur at the first phone call or initial face-to-face contact, or if gender is not considered in scheduling appointments with providers, there is an increased risk that the Hmong person seeking health services will discontinue efforts to access care.

Issues of gender and patriarchal clan structures significantly impact the health care obtained by members of the Hmong community. Practitioners must consider these issues when providing health education and assisting Hmong families with health care. Recognition that respect for elders and education are strong cultural traditions can be helpful in advocating for improved health care services within Hmong families. Community health nurses have the opportunity to support the continued education of Hmong women and to support them in voicing their concerns while empowering them to make choices about health care that are beneficial to their wellbeing.

One notable finding of this study is the need for further research to study the differences between health care obtained for Hmong children versus adults in the United States. The women in the focus groups alluded to their beliefs that American pediatric care has been beneficial for their children. They implied that Western health care is an important
source of health care for young Hmong family members even when more traditional methods are used by that family’s adults. The rationale for these differences needs further elucidation which will help nurses support women in their decision-making about their children. This information, along with other findings of this study, may provide greater insight into the development of strategies for building trust between American health care providers and Hmong clan members who practice more traditional health care.

Finally, we must continue to support the development of cultural sensitivity and competence in students in the health professions and expand efforts to recruit and retain Hmong health professionals. The Hmong people’s respect for education supports the potential for a growing cadre of Hmong health professionals who will be able to not only serve their own community, but could enlighten other health professionals and students about the health needs of their own and other vulnerable populations. As Hmong women assume important and visible roles in the health care system, they will gain more power within their community to make decisions about the health care for themselves and their children.

ACKNOWLEDGMENTS

This project was funded in part by the Wisconsin Well Woman Program. The Well Woman Program is supported by a cooperative agreement (#U55\CCU52109) with the Centers for Disease Control and Prevention Early Detection Program.

REFERENCES


