Traditional Chinese health promotion and cancer screening practices among older Chinese women

Cannas Kwok
Faculty of Nursing & Midwifery, University of Sydney
cannaskwok@nursing.usyd.edu.au

Abstract:
An essential aspect of the contemporary health promotion paradigm is screening for early detection of disease. On this basis, there has been an increasing emphasis on mammographic screening as a health practice in Australia. Nevertheless, older Chinese-Australian women have been consistently reported as having low participation rates. This qualitative study investigated how older Chinese-Australian women’s concepts of health promotion influence their decisions to participate in cancer screening. In-depth interviews were conducted with 20 Chinese-Australian women. Using thematic data analysis, the findings showed that their health promotion practices lie in devoting attention to preserving and promoting health and overall well-being in everyday life rather than attempting to detect hidden disease by screening. The informants believed that contracting disease, including cancer, is inevitable and there is no way to prevent it. Fatalism appears to be a significant barrier to their participation in cancer screening services. This view formed the basis of behavior in relation to cancer diagnosis in particular toward mammography. If cancer screening is to be developed effectively in the Chinese community, the health workforce needs to include ethnic health workers who are sensitive to their audiences’ health beliefs and health-related behavior.

Introduction
One of the greatest challenges in health promotion in contemporary Western societies is securing compliance with medical recommendations such as the adoption of healthy lifestyles and body screening. Under the current health promotion paradigm based on the biomedical model, individuals are expected to behave in ways that health promotion advocates assume to be the basis of sustained good health. Health education is seen to be one of the most effective means to empower individuals to
make healthy choices and is thus central to health promotion (Bunton & Macdonald, 2002).

Accordingly, regular mammograms are highly recommended for healthy women in their early 50s to ensure that they are free of breast cancer and as a result, undergoing breast cancer screening has become a normative health promotion practice (Kasper & Ferguson, 2000). Although there has been much educational effort to promote breast cancer screening as an effective measure for early detection of cancer and free mammography is widely available, the screening rate is well below national goals and guidelines (Australian Institute of Health and Welfare, 2003). That rate is even lower among women of non-English speaking background. In particular, older Chinese women are 50% less likely to undergo mammographic breast examination than women of the mainstream Western culture (Dollis et al., 1993).

The seriousness of this situation emerges from the fact that breast cancer has the highest incidence of all cancers and is the leading cause of cancer death among Chinese women in Australia (Australian Institute of Health and Welfare, 1999). Not only is the prevalence of breast cancer rising in the settled Chinese population of Australia, but the risk of developing breast cancer by 40% among those Chinese who migrate to Australia (Grulich et al 1995). Since the risk of developing and dying from breast cancer increases with age, it is clear that early detection is highly important for older Chinese women.

The experience of diseases such as cancer cannot be understood without considering the socio-cultural context within which they occur (Lupton, 1995a). Contemporarily, our knowledge of cancer and its prevention is primarily based on bio-medical knowledge, which is depicted as both scientific and professional in origin. While scientific understandings of disease are of great value, the ways in which lay people perceive disease and also biomedical knowledge is socially constructed. It is often the case that lay people have beliefs about cancer and its prevention that do not conform to scientific understandings and it is these beliefs which may underlie resistance to screening procedures such as mammography (Lupton, 1995b).

Culture is fundamental to the concept of health and plays a vital role in determining preventive health behavior, of which cancer screening is one example (Bloomfield & Illinois, 1994). This is particularly true for those older Chinese women whose health
beliefs and practices draw on the type of medicine which has been practiced among Chinese-speaking people for more than 3,000 years (Hoizey, 1993).

Although Australia is a multi-cultural society and equality of access and provision of health care has been emphasized in health promotion (Bunton & McDonald, 2002), surprisingly not a single study exists about cultural influences on the breast cancer screening behaviors of Chinese-Australian women, the largest minority group in the country.

This study examines the extent to which health promotion advice derived from the current health promotion paradigm (e.g. making healthy choices such as participation in body screening) are effective among Chinese-Australian women, whose cultural background varies considerably from that of the dominant Anglo-Celtic culture of Australia.

**Methodology**

This study adopts a social constructionist qualitative approach (Burr, 2003) in which the women interviewed volunteered their views about health promotion particularly in relation to cancer screening practices. This study is designed to provide insights into Chinese-Australian women’s views of breast cancer screening behavior from their own perspectives.

A purposive sample of 20 Chinese-Australian women aged between 50 and 69 who had never been diagnosed with breast cancer, were recruited through personal networks and by using "snowball" techniques. Among the 20 informants, 12 were recruited from a number of Chinese organizations including a church, community centres and a seniors' club, while the remaining eight were introduced by informants and friends.

**Data collection**

Prior to data collection, this study was approved by the Human Ethics Committee of the University of Sydney. In-depth consensual interviews were conducted, using an interview guide which contained both closed- and open-ended questions. In the first, more structured part of the interview, demographic data was collected from the informants. The second part was largely unstructured, guided by only a few general
questions, to focus the discussion on the informants’ views about cancer screening practices. The interviews were from 45 to 90 minutes in duration and were tape-recorded with the consent of informants.

Data analysis

Data analysis involved several steps: transcription, translation, the writing of case summaries, coding and developing matrix tables. The analysis began with open coding of every sentence, looking for patterns and contrasts in the data and identifying themes. Later stages focused on testing and elaborating links established between concepts in order to assess the validity of the propositions (Miles & Huberman, 1994).

Sample

Informant demographics are shown in Table One. All were immigrants from Hong Kong. Their length of stay in Australia varied from three-and-a-half years to fourteen years. Almost all were or had been married, had children, and lived together with family members. More than half had little formal education. It was found that informants' educational level was correlated with their English proficiency. The majority spoke very little or no English. Most were Buddhists; some were not religious, while two were Christians. Many had no employment history in Australia, only two worked full-time, while four were part-time workers.

Table 1. Informant demographics

<table>
<thead>
<tr>
<th>Number of informants (N=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
</tr>
<tr>
<td>50-54</td>
</tr>
<tr>
<td>55-59</td>
</tr>
<tr>
<td>60-64</td>
</tr>
<tr>
<td>65-69</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Widowed</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
</tr>
<tr>
<td>Buddhism</td>
</tr>
<tr>
<td>Christian</td>
</tr>
<tr>
<td>None</td>
</tr>
</tbody>
</table>
Educational level
- None: 3
- Primary: 9
- Secondary: 5
- Tertiary: 3

English proficiency
- None: 11
- Little: 4
- Average: 3
- Good: 2

Years in Australia
- 1-5: 5
- 6-10: 11
- > 10: 4

Findings

Traditional Chinese health promotion

The findings revealed that many older Chinese-Australian women conceptualized health and health promotion as a multi-dimensional paradigm which included the physical, psychological, social and moral aspects of life. The underlying principles of traditional Chinese health promotion practices are based on balancing and harmonizing. Table Two demonstrates the measures many informants believed and practiced to promote health.

Table 2. Health promotion measures among Chinese-Australian women

<table>
<thead>
<tr>
<th>Aspects of health</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health</td>
<td>Healthy diet</td>
</tr>
<tr>
<td></td>
<td>Regular sleep</td>
</tr>
<tr>
<td></td>
<td>Exercise in the morning</td>
</tr>
<tr>
<td>Psychological health</td>
<td>Emotional harmony</td>
</tr>
</tbody>
</table>
Being happy and satisfied
“A satisfied person will always be happy. Illness will also disappear”.

Influence of social life on health
Fulfilling their role of mother
“All goes well (including health) in a harmonious home”.

Influence of moral aspect on health
Doing good to others
Being a good person

Cultural perceptions of “being sick”
Many informants perceived disease as an inevitable part of the suffering that every human has to experience. Disease and illness are regarded not only as part of life and of a natural order, but the women thought that there was no way to prevent them. Illness was regarded as being beyond human control.

Despite acknowledging the effects of lifestyles such as smoking and alcohol consumption on disease prevention, many informants emphasized that such factors were not important because becoming ill was preordained and there was no way to prevent it. Typical comments:

Of course, we get sick because we are human beings. Disease is disease. How can we prevent it? (Mrs Yip, a traditionally minded 68-year-old)

No matter how hard you try to prevent it, there is no way to escape. That’s the natural course. Who won’t get sick? (Mrs Wong, 64)

Fatalism appears to reinforce the belief that disease, particularly cancer, cannot be prevented. The sense of fatalism on this score was the result of the informants' actual experiences and observation of others’ cancer, and most shared stories to support their perception about cancer prevention.

How come some people who always smoke and drink don't get cancer? My husband neither drank nor smoked, and he had a healthy diet…., but he had cancer. You see, what can you say?! (Mrs Lai, a widowed woman in her late 50s)
You know, nuns can get cervical cancer, vegetarians can get bowel cancer, and non-smokers can have lung cancer. Life is like this. If something has to happen, we can do nothing to change it. My dad has been eating salted fish for over 60 years [my informants believed salted fish to be carcinogenic]. But look, he is still alive! Shouldn't he have cancer? So what is prevention? How to prevent? (Ms Po, a nurse working in hospital)

**Culturally appropriate methods of disease prevention**

Even though disease and illness appeared to be unavoidable, some informants believed that negative thinking was likely to promote negative health outcomes since such thinking provoked unnecessary worry and stress. In other words, constant thinking and worry about cancer was likely to cause it to develop. Direct references to cancer were taboo and some considered the use of particular words as inauspicious. When cancer was mentioned in interviews, some women would often add “touch wood”. In their words:

A person shouldn't think too much. As people always say, you should avoid any unpleasant thoughts…. You should not talk about any bad things [including cancer] that haven't happened yet. (Mrs Ng, 63)

We [older people] are very cautious or you can say we are superstitious… Negative thinking has negative outcomes. [Thinking about cancer] is not good. Touch wood! (Mrs Yan, 65 who refused to go for screening)

In asserting that worry about one's health can make one sick, two Chinese platitudes were often quoted: "One shouldn't worry too much", and "Let nature take its course". In the words of Mrs Wan, in her late 60s:

People feel if they don't talk or think about it, it won't happen. The more you think about it, the more chance of it [cancer] happening.

**Discussion**

The Western health promotion paradigm emphasizes the importance of "healthy lifestyles" and “body screening” as the way to achieve well-being. Accordingly, women are recommended to undergo regular mammographic screening in order to achieve early detection of breast cancer. However, this study indicated that such advice was inconsistent with the traditional health beliefs and practices to which my informants subscribed. While acknowledging some of these concepts, they rather conceptualized health promotion practices in terms of a multi-dimensional paradigm related not only to their lifestyles, but also to their bodies, their psychology, their social environment and their morals. These approaches to health maintenance were
established long before they came to Australia, and even after living for many years in the Australian environment, they retained an unquestioning respect for their traditional practices which as far as they were concerned, had served them well in the past.

Thus, rather than following the "New Public Health" approach of attempting to detect hidden disease, many informants were much more attuned to the question: “What you can do to make yourself healthy”. When they talked about health promotion, they focused on health rather than on disease. The concept of detecting hidden or asymptomatic disease by means of medical measures such as screening, does not exist in the traditional Chinese health promotion paradigm. It is these disparities which make Chinese people and Chinese women in particular, less compliant with the disease preventive measures which have been developed by Western medicine. This is confirmed by studies in the USA (Ma, 1999 & 2000) and the United Kingdom (Kwan & Bedody, 2000) which indicate that it is not uncommon for the Chinese community to underuse preventive health care services (Chan & Quine, 1997; Dollis et al., 1993). Even though many Western health professionals regard mammographic screening as a normative health practice, this study indicates that women from some non-Western cultural backgrounds may not share this view. Health promotion, according to the definitions of informants in this study, did not have anything to do with body screening for early detection of diseases.

The biomedical emphasis on body screening in the Western health promotion paradigm in order to determine the health of the individual in the sense of an "absence of disease" or being "disease free", was a foreign concept to many of my informants. These older Chinese-Australian women perceived disease as an inevitable part of the suffering that every human has to experience. Becoming ill is regarded as being beyond human control and not a result of healthy choices, an attitude which contrasts sharply with the notions of health promotion in contemporary Western societies.

Even though seemingly hopeful research findings about cancer prevention and treatment are continuously reported in the media and presented as potential breakthroughs, many older Chinese-Australian women saw this as creating a gap between what they had heard about the control of cancer/breast cancer and their actual
experiences and observations within their personal social networks. Even when there was a reasonably accurate grasp of the range of risk factors for breast cancer among them, this was likely to be offset by a belief that ultimately it is chance or fate that determines whether an individual develops breast cancer or not. It was not a question of making healthy choices. As far as they were concerned, the discourse of “the healthy lifestyles” paradigm failed to explain why some people who did choose healthy lifestyles still got sick, while others who engaged dangerous lifestyles did not. In the case of breast cancer, it was remarked that some women who underwent mammographic screening still died of breast cancer, while some who had not engaged in mammography apparently never contracted the disease and survived. Davison et al. (1991; 1992) state that the notions of "fate" and "destiny” offers answers to what the biomedical paradigm with its emphasis on prevention, failed to explain.

Davison et al. (1991) suggest that fatalism can be a realistic assessment based on actual personal experience and observations and is constantly reinforced through interaction with others sharing the same views. This argument is strongly confirmed by the findings of study.

Contrary to Western thinking about undergoing cancer screening as a preventive measure, some informants saw a refusal to think about cancer as being more effective in cancer prevention. Their method of "preventing" all cancer, including breast cancer, was simply to avoid talking about it or thinking about it when feeling healthy. Instead of actively seeking to detect cancer, they preferred to maintain emotional harmony by avoiding negative thoughts and enjoying the present.

Some of these older women saw knowledge of cancer as something that would spoil their lives and they considered mammography as something that would cause them stress associated with the knowledge of cancer. Accordingly, these informants suggested creative ways of attempting to prevent cancer based on their traditions, but these were never centred on an awareness of body screening, since they believed that these could be actually harmful to their health. Even though many health professionals may dismiss this as nonsense, it is not unreasonable to believe that living under the stress associated with such awareness may be indeed be harmful.
Conclusion

There has been increasing interest over the last decades in how concepts of health and illness are constructed by different communities and how these variations affect their health-related behavior. Despite the dominance of the biomedical model in the Western world and the wide diffusion of health promotion, there is ample evidence that a variety of health epistemologies and health practices co-exist with this model. This study shows that most of the informants in this study still adhere to traditional health practices. They are obviously different from the concepts in the mainstream Western medical paradigm. Very importantly, the women's faith in traditional health practices significantly affects their attitudes toward cancer screening and willingness to participate.

It is important for health authorities to understand the traditional concepts of health promotion held by members of communities in their jurisdictions, since they could account for the low rates of participation in mammographic screening programs. Failure to understand cultural beliefs can reduce the effectiveness of any planned health education activities and health care services provided. If mammographic screening is to be developed effectively in the Chinese community, the breast health workforce needs to include ethnic health workers who are sensitive to their audiences’ health beliefs and health-related behavior. In multicultural societies such as Australia, it is vital that the health system include professionals who are culturally competent in health planning and the provision of health care services to cultural minorities.

References


