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Growing up in a Vietnamese household, the women talk about everything. From leg pains, headaches, to herbal remedies found online. Despite all these conversations, cancer screenings were never brought up. That silence, I've learned, is not unique to my family. Vietnamese American women face some of the highest rates of cervical cancer in the country, five times that of caucasian women [1], yet remain among the least likely to receive screenings like the PAP test where the rates for Vietnamese Women aged 21 and above is only 53% compared with 85% for non-Hispanic White women [5]. This lack of screenings isn't only present among cervical cancer, but among breast cancer as well, where mammography screening rates among Vietnamese women ranged widely from 26% to 83%, consistently lower than the U.S. national average of 81%, and lower than rates reported in many Asian American subgroups [4]. The question isn't why they aren't asking for help, but why the system was never designed to reach them.

Various factors ranging from socioeconomic to systemic factors prohibit Vietnamese American Women from cancer screenings. The strongest systemic factor that affects them is data invisibility. When health agencies report on Asian American cancer, Vietnamese American women effectively disappear. Federal, state, and institutional data collection practices and analyses involving Asian Americans as a single, aggregated group obscure critical health disparities among the vast diversity of Asian American subpopulations [2]. By grouping Asian Americans, a group spanning over 20 distinct ethnicities with vastly different disease profiles, languages, and healthcare access, it can cause Vietnamese women to fall through the gaps, especially in cancer screening. Furthermore, the grouping together of different subpopulations has resulted in assumptions that all AAPI patients have better survival compared with other racial and ethnic groups. However, it is more likely that each subpopulation experiences distinct outcomes [3]. Data invisibility can cause Vietnamese women to effectively disappear, redirecting funding, policy, and outreach away from them. The silence in my household and the silence in our health data share the same cost: Vietnamese American women don't get screened, and nobody in power notices. If nobody sees the problem then systems won't be built to address it.

Data invisibility is only part of the story. Even when Vietnamese women attempt to seek cancer screenings, cultural and structural barriers block the path. The most frequently perceived psychosocial/cultural barriers to Pap tests were being uncomfortable with doing a Pap test with a stranger (41.0%), believing that one's spouse/partner would be uncomfortable with screening performed by a male doctor (38.8%), [6]. The cultural stigma associated with extramarital sexual activity plays a huge role in cervical screenings where over four in ten women avoid screenings because of concerns their spouse would disapprove of an unknown male provider. While Vietnamese American women have reported similar barriers to screening, studies have identified additional barriers that included unmarried marital status, younger age, lower level of education, living in the United States for less than 15 years, lack of insurance coverage, limited English language proficiency, limited knowledge about cervical cancer and benefits of Pap tests, and lack of female physicians [6]. These barriers prove that individual reluctance isn't the issue behind low cervical screening rates among Vietnamese women but rather, cultural norms surrounding gender roles, knowledge, and marital status. The U.S. health system largely operates under a one-size-fits-all model that fails to account for these differences, expecting patients to conform to

Western ideals of preventive care. This creates ignorance, Vietnamese women may not view screenings as necessary or appropriate, even when services are available. Other systemic factors like language gaps and lack of culturally tailored outreach can further reduce screenings rates, leading to later-stage diagnoses and worse health outcomes.

Addressing low cancer screening rates among Vietnamese American women requires more than encouragement to do better but through systemic change. The most foundational fix is disaggregating the data. By using legislation, Asian Americans can stop being reported all together but through subpopulations which is already happening in California. A problem that isn't seen won't be solved. Furthermore, healthcare systems must meet Vietnamese communities structurally and culturally where they are. That means providing bilingual patient navigators and partnering with trusted community organizations can make screenings more accessible, acknowledged, and accepted. Even social media posts can contribute to higher screening rates where word of mouth between friends and family can advance knowledge of screenings which in turn can lower the cultural stigma associated. Other methods like culturally tailored education, delivered in Vietnamese in churches for instance, have been shown to increase screenings rates.

Vietnamese American women are not hard to reach, they just have never been truly reached for. It must be up to our policymakers to reshape the healthcare system while providing increased, targeted awareness to help them catch up and stay ahead in cancer screening.

References

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