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Research paper

Understanding Filipina women's health orientation and the implications for colorectal cancer screening

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What is known on this subject

- Immigrants and less acculturated adults, compared with US-born adults, are less likely to utilise colorectal cancer screening procedures, and thus may be potentially diagnosed at a later stage.
- Health system factors such as access to care and physician recommendation are well-established factors associated with utilisation.
- A fatalistic outlook is understood to be a major barrier to cancer screening among US immigrants and ethnic-minority populations.

What this paper adds

- It provides a qualitative perspective on an understudied ethnic population in the USA, namely older Filipina women.
- It suggests that an interpretation that attributes under-utilisation of cancer screening among immigrants to a fatalistic outlook alone neglects the multi-layered reality of older women's lives.
- The study provides evidence that forgoing a cancer screening test was not so much due to a fatalistic outlook, but more representative of a lack of immediate urgency and consistent with women's health maintenance orientation, which valued balance and stress reduction.

ABSTRACT

This study explored the socio-cultural dimensions of immigrant and US-born Filipina women's orientation toward cancer prevention. In-depth individual interviews were conducted in English or Tagalog with 24 women aged 50–65 years who self-identified as Filipina and resided in the San Francisco Bay Area. The women were recruited from community-based agencies using a direct approach, referral, and snowball sampling. The interviews included questions about lay notions of fate and spirituality and how they infuse Filipina women's health-seeking behaviour and, in turn, their colorectal cancer (CRC) screening practices.

The findings showed that although the women recognised the importance of CRC screening, they did not assign it high priority because they perceived

themselves to be at low risk and they had complex notions of health maintenance which highlighted competing physical and emotional health concerns. A total of 22 women reported having heard of an endoscopic procedure, but only nine reported that they had undergone such a procedure. The women attributed their low perceived risk of CRC to a lack of family history of cancer, the ability to cleanse one's system, and maintaining a well-balanced lifestyle. Their narratives suggested a world view in which fate and personal responsibility coexist seamlessly, physicians were considered to have a valued role as expert advisers, and there was an emphasis on balance and stress reduction. This world view encourages preventive measures when these are needed, but also allows for their deferral.

These older Filipina women's narratives suggested that they had a holistic health orientation that valued maintenance of both emotional and physical health, and that their behaviour was embedded in a complex socio-cultural milieu. Effective interventions to promote CRC screening among Filipinas must be based on understandings of and integration within this context while simultaneously promoting the preventive benefits of CRC screening procedures.

Keywords: Asian Americans, colorectal cancer screening, Filipino Americans, health disparities, immigrant health

Introduction

Colorectal cancer (CRC) is the second leading cause of cancer-related death in the USA (Jemal *et al*, 2008). CRC screening has been shown to effectively reduce mortality and morbidity from CRC as a result of early detection and treatment of cancer itself or of precancerous lesions, and is recommended for all adults aged 50–75 years (Levin *et al*, 2008). Modest improvements in the utilisation of CRC screening procedures have been observed in the past few years in the context of expanding Medicare coverage and increased awareness (Phillips *et al*, 2007; see Box 1). However, compared with non-Latino whites, CRC screening rates remain lower among ethnic minority groups in the USA, especially among Filipino, Vietnamese, Korean and Latino populations (Swan *et al*, 2003; Liang *et al*, 2006; Shih *et al,* 2006; Ananthakrishnan *et al,* 2007; Maxwell and Crespi, 2009; Centers for Disease Control and Prevention, 2010). Furthermore, recent data from the US Centers for Disease Control and Prevention show that under-utilisation persists among lower socio-economic groups (low income and less than high school education) and in the uninsured (Centers for Disease Control and Prevention, 2010).

Immigrants and less acculturated adults, compared with US-born adults, are at even greater risk of under-utilisation (Maxwell *et al*, 2000; Afable-Munsuz *et al*, 2009), and thus may be potentially diagnosed at a later stage. Recent immigrants to the USA face unique barriers to cancer screening use. Language discordance between the patient and clinician, perception of being free of health problems, and a lack of insurance coverage and/or a usual source of care have been associated with under-utilisation of CRC screening among immigrants from Asia and Latin America (Goel *et al*, 2003; Walsh *et al*, 2004; Goodman *et al*, 2006; Kandula *et al,* 2006; Breen *et al*, 2010; Maxwell *et al*, 2010). In a study of Filipino immigrants to the USA, for example, the delivery of care in health systems was deemed unwelcoming and incompatible with their needs and values, and these factors have been shown to affect use (Joseph *et al,* 2009). Physician recommendation, too, seems to play a key role in motivating CRC screening utilisation (Etzioni *et al*, 2004; Wee *et al*, 2005; Klabunde *et al*, 2006). At the same time, advances in medical technology, the multiple options for CRC screening that are available (Levin *et al,* 2008), and the wide range of health information that is accessible to the consumer place an emphasis on patient-focused, informed decision making in healthcare (Rimer *et al*, 2004). This healthcare context demands a more in-depth understanding of the patient's perspective and context, and what motivates him or her to self-advocate for preventive care and to define what factors might facilitate or serve as barriers to navigation of an increasingly complex system.

In addition to factors in health systems, immigrants' low cancer screening rates compared with

Box 1 Definition of Medicare

Medicare is a national health insurance programme in the USA that covers people aged 65 years or older, some disabled people under the age of 65 years, and people of all ages with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant).

US-born adults may be related in part to their having different values and beliefs with regard to health service use (Fernandez *et al*, 2005; Gany *et al*, 2006; Johnson *et al*, 2008). For example, in a large population-based study of Asian Americans in the USA, even after accounting for usual source of care and insurance coverage, under-utilisation of cancer screening tests (lower rates of use compared with white adults) persisted in several national-origin groups, and in Filipinos in particular (Kandula *et al*, 2006). It is notable that, after further adjustment for measures of acculturation, differences in screening rates between Filipino and white adults were attenuated (Kandula *et al*, 2006).

There is a prevailing view that having low perceived control over illness onset, or a fatalistic outlook, is a major deterrent to cancer screening utilisation among diverse ethnic-minority and immigrant groups in the USA, including Latino, African American, Chinese and American Indian populations (Kaur, 1996; Chavez *et al*, 1997; Maxwell *et al*, 1997; Lee, 2000; Shankar *et al*, 2002; Powe and Finnie, 2003; Liang *et al*, 2004; Peek *et al*, 2008; Florez *et al*, 2009). However, with a small number of exceptions, few studies have explored these topics, and fatalistic attitudes in particular, in depth or considered the context of ageing women's general health-seeking orientation. This line of inquiry is needed given the unique life experiences of ageing women and recent US research suggesting that simplistic notions of fatalism do not adequately explain cancer screening under-utilisation in the USA (Abraido-Lanza *et al*, 2007; Florez *et al*, 2009; Pasick *et al*, 2009). Furthermore, international research points to the universality of fate as a belief system, with individuals attributing health or disease to fate to varying degrees and, according to their personal context, challenging the simple dichotomy between fate and personal control (Davison *et al*, 1992; Straughan and Seow, 1998).

This study aimed to identify and explore the cultural dimensions of immigrant and US-born Filipina women's orientation toward cancer prevention. Filipina women belong to the second largest Asian national origin group and the third largest immigrant group in the USA (Barns and Bennett, 2002; Malone *et al*, 2003). Recent data indicate that Filipino adults have much lower rates of CRC screening compared with white adults (Maxwell and Crespi, 2009), and that a low level of acculturation is associated with under-utilisation of CRC screening (Maxwell *et al*, 2000, 2008). Why Filipino adults, especially those who are less acculturated, under-utilise CRC screening tests is not well understood. It is likely that CRC screening behaviour is subject to more complex influences than the common barriers studies suggest. In an intensive inductive study of mammography behaviour and socio-cultural context among Filipinas and Latinas, Pasick *et al* (2009) highlight this point by describing the importance of the meaning that people ascribe to health and health-related phenomena, and the role of culture and social context in creating that meaning. This study drew upon this work, initiating a deeper exploration of how social context and culture, defined as 'the patterned processes of people making sense of their world and the conscious and unconscious assumptions and practices they call on to do so' (Pasick *et al*, 2009, p. 15), influence CRC screening. Central issues that we explored in this study included lay notions of fate, destiny and spirituality and how these infused Filipina women's health-seeking behaviour, including CRC screening practices.

Methods

We conducted 24 in-depth individual interviews with older women residing in the San Francisco (SF) Bay Area, California (CA). Respondents were recruited from several community-based organisations (CBOs) using a non-probability purposive sample design. We worked initially with two main SF CBOs serving low-income, immigrant Filipino families, a population known to be at higher risk for under-utilisation of cancer screening, based on the findings of our literature review. Using referral and snowball sampling strategies, we broadened our recruitment to include Filipina members or participants in other community centres or services in the larger SF metropolitan area, including cities such as San Bruno, Vallejo and Vacaville, and referrals from these women. When recruiting, we also took into consideration age at migration to ensure diversity in acculturation experience. Eligibility criteria were self-identification as Filipina, age 50–65 years, and no previous diagnosis of any cancer.

A semi-structured interview guide was developed containing open and closed questions. The guide was designed to elicit detailed information about the women's perceptions and experiences (see Table 1). Before data collection began, the guide was pre-tested in the field for salience, ability to engender discussion, and duration. The field guide and all study materials were approved by the Committee on Human Research at the University of California, San Francisco.

The primary author (AAM) and a bilingual (Tagalog and English) interviewer, trained in interview techniques, conducted all 24 interviews. Participants were allowed to choose the language that they preferred. In total, 13 of 24 interviews were conducted in Tagalog; 21 of the 24 interviews were conducted in the participants' homes, and the remaining three interviews were conducted in a private work setting or public setting. The women were asked to read and sign consent forms at the beginning of each interview.

Table 1 Interview guide based on the published literature

Topic	Literature
Lifestyle choices	Liang *et al*, 2004
Patient–clinician interaction	Bastani *et al,* 1997; Moskowitz *et al,* 1998
Religious faith and fatalism	Liang *et al,* 2004; Abraido-Lanza *et al*, 2007; Florez *et al*, 2009
Perceptions of cancer risk	Dibble *et al,* 1997; Kim *et al*, 1998; Walter *et al*, 2004

All interviews lasted 1.5–2 hours and were audiotaped with each respondent's consent. Respondents received $40 as compensation for their time. Data were collected from April to November 2007.

The bilingual interviewer translated all Tagalog transcripts into English. Transcripts were further reviewed by the primary author for accuracy and to ensure that translations were meaningful in the context of the study. Phrases and/or words that lost significant meaning in English translation were retained in Tagalog, and their significance and meanings were explained to the research team where necessary. The primary author and another experienced doctoral-level qualitative researcher (KN) independently analysed the content of all 24 English-language transcripts using NVivo 8.0 (NVivo Qualitative Data Analysis Software, 2008). Guided by the study's main research goals, each researcher developed their own coding system, which included identifying a set of search terms, developing salient themes and exploring potential relationships among the themes. During this first stage a total of 18–24 codes were developed. The next stage of coding involved discussion of the initial set of detailed codes and the development of a common set of five themes that informed the analysis, namely faith and religion, personal responsibility, provider trust, stress reduction, and cancer risk perception. Codes were combined into the five final themes that were chosen, firstly based on agreement between the two researchers, secondly, because they were highly relevant to the cancer screening behaviour of the study participants, and thirdly because they addressed the aims of the research study. The findings that emerged were outlined and illustrated with quotes from interviews. These quotes were selected because they characterised the main positions expressed by the women, especially when they seemed to capture a particularly revealing issue.

Findings

Participant characteristics

The mean age of the participants was 57 (±5.1) years. In total, 20 of the 24 women reported having a college degree. Overall, 17 women had private insurance or were enrolled in some form of federal or county-subsidised insurance programme. The remaining seven women reported having no form of health insurance. Three women were born in the USA, five had emigrated to the USA while under 15 years of age, four had emigrated to the USA at the age of 15–25 years, and the remainder had emigrated to the USA when they were over 25 years of age. A detailed description of the sample is provided in Table 2.

Cancer screening test use

Generally, the women discussed the importance of CRC screening, but did not assign it high priority. A total of 22 women reported having heard of faecal occult blood testing (FOBT) or endoscopy, but only eight reported having undergone such a procedure. Of these eight women, six reported that they were screened on recommendation from a physician, two were prompted to do so because of non-specific abdominal symptoms, and two had close relatives who had died of colon cancer. The following sections discuss the ways in which complex understandings of health maintenance and colon cancer disease causation interact to shape women's CRC screening behaviour.

Coexistence of faith and personal responsibility

Although the women articulated the belief that their health and well-being were predetermined by some higher power, this belief did not necessarily conflict

Table 2 Demographics of the interviewed Filipina women by CRC screening use, San Francisco Bay Area, 2007

Variable	Reported CRC use	No reported CRC use	Total sample
Sample size	8	16	24
Mean age (years)	62	55	57
Proportion of college graduates	75% (6)	50% (8)	58% (14)
Insurance[a]			
Private and/or government subsidised	100% (8)	56% (9)	71% (17)
No insurance	0% (0)	44% (7)	29% (7)
Age at migration			
Born in the USA	25% (2)	6% (1)	13% (3)
= 20 years	63% (5)	50% (8)	54% (13)

[a] Any type of insurance will cover age-appropriate colon cancer screening.

with their health-seeking behaviour. Rather, they believed that they were personally responsible for maintaining their health, and at the same time they turned to God for moral support and guidance, especially during times of illness or when medical care fell short of what was needed. This perspective was captured in a common Tagalog saying: '*nasa Diyos ang awa nasa tao ang gawa*' ('It is up to God to have compassion, but to the individual to make things happen'). One woman elaborated on this perspective:

> '[Diseases] can be prevented if the person wants to. Like for example, or what I already said, nothing is impossible if you ask God for help and you don't neglect yourself. It's already written in the palm of your hand, but don't say I got rich with the help of God, no that's not it, '*nasa iyo ang gawa, nasa Diyos ang awa*', your efforts will be blessed. If you're not doing something about it, you're the one who does the work. He blesses you with prolonging your life.'
>
> (Immigrated at the age of 49 years, not screened)

The participants reported that their faith helped them to cope with illness in general. There was a view that medicine alone would not be sufficient to bring about recovery from illness, and in some cases faith played a more central role. The following quotes illustrate how prayer provided guidance and direction to women dealing with illness, and their faith served as a powerful and constant source of hope and strength:

> 'So you really have to pray, medicines are not enough. It doesn't mean when you're taking medicines you're going to get well, but you need to pray. You have to pray what you need to do so God will teach you.'
>
> (Immigrated at the age of 46 years, screened)

> I: 'Where do you go first when it comes to your health conditions?'
>
> R: 'In the church.'
>
> I: 'Why?'
>
> R: 'Because it's like you're talking to the Lord and you're asking him "Lord my children are still young, don't get me yet, cure me, whatever this is help me."'
>
> (Immigrated at the age of 50 years, not screened)

Thus, based on these perspectives, these Filipina women would not forgo a cancer screening test and leave their health to fate alone, as this would be inconsistent with their world view and, more importantly, it would be irresponsible. An interpretation that casts these views simply as fatalistic neglects the multilayered reality of these women's lives. Competing health priorities and women's perceptions of colon cancer disease causation, as the subsequent sections will argue, also combined to influence older Filipina women's cancer screening behaviour, and suggested that the act of forgoing a cancer screening test was not so much irrational, but more representative of a lack of immediate urgency.

Balance and stress reduction

The women's health maintenance philosophy placed value on balance and stress reduction, a finding that has been described in a previous report (Anderson, 1983). This awareness of the mind–body connection was evident in the women's narratives. Faith helped them to cope not only with illness, but also with stressful day-to-day events, and kept them in good

health. The following section shows how stress reduction, as well as rest, exercise, and a diet rich in fruits, vegetables and fish, were essential components of the women's health maintenance philosophy. When asked what it meant to be healthy, one woman answered:

> 'It means they have a peace of mind, of course physically fit to work and not necessarily be fat ... but just that they have this, what do you call it? They have this ability to adjust to people and their surroundings and they can sleep well and are happy. ... Right now I exercise if not every day, every other day, at least 40 minutes to 1 hour. Before I liked to eat meat but now at my age I try to lower that and then more on vegetables, fruits ... and then fish.'
>
> (Immigrated at the age of 48 years, not screened)

Implicit in this quotation was the idea that being in balance with one's surroundings was integral to being happy and healthy, as was an ability to adjust to change or stress. Consistent with this view was a perception that thinking too much about problems had a negative effect on one's health. When asked which health conditions most worried her and her family, one woman responded:

> 'Honestly ... people always have problems, but for me when it comes to problems I just think about it now and if I can't handle it I stop thinking about it because it will make you crazy. That's the antidote for that, you just have to relax your mind, body or what I'm saying is whatever that is good for you, you have to do it so that you'll avoid having distress to your body.'
>
> (Immigrated at the age of 49 years, not screened)

Many of the women cited stress as a primary cause of poor health. They said that they tried to rest more or reduce stress in their life in order to prevent illness, including cancer. According to one woman, being stress free helped her 75-year-old sister to manage diabetes, hypertension and cancer:

> 'And we were all surprised that she got breast cancer and she is in her early seventies now. And it's been like 15 years since they had to remove the breast and I guess she is doing OK ... I would say she is 74 or 75 now and she looks well and she travels you know ... when I talk to her, she tells me it's not so much her diet ... but being stress free ... trying to remain stress free. She said it was one of the coping things for her that helped her keep her diabetes, her high blood pressure and even the cancer at safe levels, if you can call it that.'
>
> (US-native woman, screened)

The notion that stress may cause many diseases, including cancer, has been examined in the epidemiological literature, with mixed evidence (McEwen, 1998; Cohen *et al*, 2007). It is important to consider that although the Filipina women considered CRC screening to be important, sometimes any concern about cancer had to be balanced against more pressing health priorities or concerns, such as diabetes or hypertension, and in a way that was consistent with their stress reduction philosophy. This philosophy was beneficial in terms of viewing stress as contributing to heightened risk of disease (Kelly *et al*, 1997; Cohen *et al*, 2007), but it could also conflict with an orientation that encouraged vigilance and early detection of cancer, especially given the potential anxiety posed by planning for, undergoing and waiting for the results of a CRC screening examination.

Understandings of the risks, causes and prevention of colon cancer

Intertwined with the women's complex notions of health maintenance were a set of beliefs and perceptions about colon cancer that contributed to their understandings of the risks, causes and prevention of this disease. The women discussed a number of factors that they believed caused cancer. Family history, diet and the ability to cleanse one's system were major themes that emerged. When asked to assess their risk of getting cancer, the majority of the participants stated that they did not feel at high risk, and in fact expressed a perceived low risk based on family history. For example:

> 'Cancer is not part of my worry because it's not in my family history.'
>
> (Immigrated at the age of 8 years, not screened)

The few respondents who felt they were at high risk stated that this was because someone in their immediate family (their mother, father, or grandparents) had cancer. According to one woman:

> 'What I understand is family history is [related to] nature. I understand the physical side of it. Family history is a major influence on whether you're going to get it or not, and to a certain extent, what you do might not prevent it, but it can heighten it or diminish it. So I know that I cannot kick it no matter what I do. It's in my genes.'
>
> (Immigrated at the age of 19 years, not screened)

She further elaborated that a diet rich in vegetables and grains could reduce one's risk of getting CRC because it promoted regular bowel movements, which in turn cleansed the system:

> 'especially intestinal colon cancer ... they say that vegetables and whole grains, it cleans you. My mom and dad, they used to say, Filipino food cleans you. Especially when we were sick, they would give us these things, these Filipino foods and these would clean you out.'
>
> (Immigrated at the age of 19 years, not screened)

Other women stated that a diet which included fibre helped to promote regularity of bowel movements, thereby lowering the risk of colon cancer. When asked whether she felt herself to be at risk of colon cancer, one woman responded:

> 'I don't think so because I try to eat vegetables ... fish and vegetables ... you need to eat a lot of fibre, less meat, and drink lots of water for you to have regular bowel movement.'
>
> (Immigrated at the age of 36 years, screened)

The valued role of physicians

Although not the sole source of medical advice and support, physicians and other healthcare professionals were trusted, and played valued roles in women's health maintenance. The women had developed relationships of trust with their physicians over time and through experience. Two women stated that they trusted their physician because they shared the same language and culture, which made it easier to communicate. Feeling comfortable with a clinician was important for developing trust. Some trusted their physician because they respected their authority in medical issues, but they also recognised that physicians were not infallible, so the women would seek out alternative care, especially in complex situations. When asked whether she trusted her doctor, one woman replied:

> 'I don't think it's 100 percent. I would say 95 percent because you know doctors, although they're trained, I have a brother who's a doctor you know, they need advice too, you know you just can't say you have this, you have that, and you read on the paper or watch it on TV and they did misdiagnose this person, and then what now? How could you trust a doctor 100 percent? I would say that the more serious [the] condition you have, the less you trust a doctor because you want to get a second opinion, especially if it's involving, you know, they say you're gonna have this surgery, are you gonna trust just one doctor?'
>
> (Immigrated at the age of 21 years, not screened)

Discussion

This study has revealed that Filipina women engage in complex health-seeking behaviour. In their world view it is necessary to balance fate and personal responsibility, and to reduce stress. Some believe that a lack of family history and a healthy diet protect them against colon cancer, which parallels the scientific evidence on colon cancer causation (Ponz de Leon *et al*, 1987; Fuchs *et al,* 1994*;* Hall *et al,* 1994; Kerber *et al*, 1998). The ability to discern the need for a second medical opinion suggests that the women are health literate, making health-related decisions based on a wide range of information. Their narratives suggest that they have a holistic orientation towards health that encompasses mind, body, the importance of medical intervention and multiple strategies for maintaining good health.

The women also attest to the powerful role of faith, while at the same time acknowledging the role of personal responsibility. Faith played a powerful role in the lives of the women in our study, particularly those who had immigrated. To some, this idea might suggest fatalistic attitudes and the belief that health is beyond one's control, an orientation that is often thought to discourage adherence to recommended cancer screening tests (Otero-Sabogal *et al*, 2003; Powe and Finnie, 2003). For example, in relation to mammography practice, the common Tagalog saying '*bahala na*' ('Whatever will be, will be') has been cited as a reason for the low cancer screening rates among Filipina women (Ko *et al*, 2003). Like Abraido-Lanza *et al* (2007), who caution against attributing Latinos' under-utilisation of cancer screening to fatalism, we argue that this interpretation overlooks the complexity of this Filipino philosophy.

Sociological characterisations of '*bahala na*' emphasise a belief in both human effort and fate (Enriquez, 1988). The circumstances surrounding the expression of '*bahala na*' are usually marked by uncertainty and confrontation:

> '"Bahala na" operates in a situation which is marked by uncertainty and lacking in information. The striking finding is that despite the uncertainty of the situation, very few avoid or run away from the predicament. A person would instead utter "bahala na" and face the situation anyway. Thus, contrary to passive acceptance of fatalism, "bahala na" would be a confrontative attitude. It implies risk-taking in the face of the proverbial cloud of uncertainty and the possibility of failure.'
>
> (Enriquez, 1988, pp. 13–23)

According to this interpretation it would be inappropriate to attribute low levels of cancer screening to this notion of '*bahala na*', which requires both uncertainty and a situation that involves confrontation with something unexpected. First, the women did not appear to be uninformed about the importance of CRC screening, and secondly, no confrontation is involved in delaying a CRC screening test.

Accordingly, the women in this study acted in ways that they perceived to be healthy, but believed that not every aspect of their health was under their control. This finding is consistent with evidence which suggests that individuals rarely embrace a belief system with an exclusively internal or external locus of control with regard to health (Davison *et al*, 1992). This duality of human effort and fate exemplifies the real-life ways of being that can seamlessly blend the so-called rational

with the irrational. This is has been reinforced by Trostle:

> 'Anthropologist E. E. Evans-Pritchard wrote in his classic book *Witchcraft, Oracles and Magic among the Azande* that his African village informants were perfectly capable of explaining that a raised granary collapsed because termites had eaten through the supports (Evans-Pritchard, 1937). But witchcraft explained why that particular granary collapsed just when that particular individual was seated underneath it enjoying the shade.'
>
> (Trostle, 2005, p. 163)

Thus the duality of fate and human effort can be interpreted as a way of coping with and explaining that which is not really understood (Kagawa-Singer *et al*, 2003, 2010).

This interpretation is also supported by Straughan and Seow (1998), who propose that fatalism can be viewed as rational in the absence of information regarding disease causation, and by the work of Davison *et al* (1992), who propose a lay epidemiological framework in which a fatalistic orientation towards disease and death exists in response to the observed randomness with which each of these occurs. Although the attribution of illness to fate would fit logically with the women's lay epidemiological framework, fate in the context of incomplete information about disease causation alone does not explain why the women in our study did not undergo CRC screening for cancer. We argue that maintaining balance and reducing stress were day-to-day health concerns among the Filipina women whom we studied, and therefore the notion of getting screened for a potentially life-threatening disease did not fit coherently within their belief system.

Furthermore, absent from the women's narratives was the idea that health and the onset of illness were beyond their control, and thus the findings do not appear to support the idea that under-utilisation of CRC screening tests was due to fatalistic attitudes. Rather, and more appropriately, the women did not prioritise CRC screening because they believed they were at low risk of developing cancer. This perceived low risk of CRC was attributed to the absence of a family history of cancer, and to being able to 'cleanse one's system.' This belief is consistent with reports that being healthy and asymptomatic are reasons for not getting screened for cancer (Maxwell *et al*, 1997; Borrayo and Jenkins, 2001; Liang *et al*, 2004; Kandula *et al*, 2006). It is also consistent with the findings of Joseph *et al* (2009) who, in their in-depth exploration of culture and mammography screening among Filipinas and Latinas, observed that the concept of perceived benefit was less significant and even antithetical to aspects of social context, again highlighting the complex interplay of meaning and the pitfalls of relying upon simplistic constructs. Finally, it is appropriate to note that the absolute risk of developing CRC in any individual is low, with an average lifetime risk of 5–10% after the age of 50 years (Jemal *et al*, 2010).

Similar to other research, the study reported here points to additional facilitators or barriers to CRC screening, including physician recommendation and a low perceived risk of cancer (Maxwell *et al*, 1997; Wu *et al*, 2005, 2006). Both the US-born and immigrant Filipinas described their respect for and trust in their physicians, explaining that they would undergo screening if this was recommended by their physician. Consequently, interventions targeted at this population might be more successful if clinicians played a more active role in promoting CRC screening procedures. Furthermore, clinicians and educators need to proactively address the beliefs and understandings of CRC described in this study, and to place them in the appropriate context.

Limitations

This is the first qualitative study that has explored CRC screening among older Filipina women. A major strength of this study is its in-depth interview methodology, which revealed insights into women's day-to-day experiences, allowing for a more real-world understanding of Filipina women's CRC screening practices. In qualitative research, sample size is chosen with regard to the data needed to achieve informational redundancy or theoretical saturation, while avoiding such large numbers of interviews that truly in-depth exploration cannot be undertaken (Sandelowski, 1995). In this study this balance was achieved in that the themes which were reported resonated throughout the interviews, and reflect universal concerns about the influence of fate and human responsibility on health behaviours. However, it is acknowledged that the findings cannot be regarded as representative of all US Filipina women. Further quantitative research is needed as a follow-up to this study. Finally, most of the women in this study were college educated, whereas immigrants with less formal education may be more vulnerable and have lower levels of health literacy (American Medical Association, 1999; Schillinger *et al*, 2002).

Conclusion

The Filipina women in this study revealed a complex mix of views and understandings of cancer screening. They attributed a low perceived risk of colon cancer to a lack of family history of cancer, to the ability to cleanse one's system, and to generally maintaining a

well-balanced lifestyle. However, their narratives, particularly those of recent immigrants, also suggest a world view in which fate and personal responsibility coexist and in which balance and stress reduction are valued. Nevertheless, a belief in fate should not be viewed as a barrier to screening. Rather, the women's holistic world view encourages them to take preventive measures when necessary, and helps them to cope with illness and stressful events. Effective CRC screening interventions that target this population should take this world view into consideration, encourage more physician involvement, and provide basic information on CRC prevention. Importantly, given clear evidence of the preventive benefits of CRC screening procedures and the value that the women in this study attached to prevention, we argue that promoting screening as an effective way to prevent cancer could have a significant impact on the CRC screening practices of the Filipina women in this study, and possibly other populations.

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CONFLICTS OF INTEREST

None.

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