

# **CANCER** disparities among **IMMIGRANT** communities in the **United States**

**Author:**  
Pauline Theresa B. Sikat  
M.S., M.P.H.

**Artist:** Staff

**CANCER DETECTION AND TREATMENT HAS IMPROVED OVER THE PAST FEW DECADES, BUT ACCESSIBILITY REMAINS A PROBLEM FOR IMMIGRANT AND ETHNIC COMMUNITIES WITHIN THE U.S.** Improving health access among these groups is hindered by factors that are inherent to their culture and situation. They needlessly suffer more than others. However, there are ways to help them understand their options. Health care providers and community members can take part in providing better information to close the gap.

## Cancer outcomes are improving, but for immigrants too?

According to the World Health Organization, cancer is one of the leading causes of mortality worldwide, accounting for 7.6 million deaths in 2008 and rising<sup>1</sup>. According to the Cancer Trends Progress Report 2011/2012 Update, overall incidence rates for new cancer cases have declined significantly among men from 2000-2007 and for women from 1998-2005, reaching stability in female cancer incidence from 2005-2008<sup>2</sup>. However, cancer is still a major problem as the rates of some cancers such as melanoma, kidney, thyroid, Hodgkin lymphoma, and pancreatic cancers continue to rise<sup>2</sup>. The incidence and mortality rates vary by socioeconomic status, gender, and racial and ethnic groups.

Cancer among ethnic groups calls for attention as the size of immigrant populations in the U.S. increases. According to the 2010 U.S. Census Bureau, the Hispanic population increased by 43 percent, from 35.3 million in 2000 to 50.5 million in 2010, and comprises 16 percent of the total U.S. population of 308.7 million<sup>3</sup>. Blacks or African Americans make up 13% of the total population while individuals who reported their race and ethnicity as 'some other race' alone make up 6 percent of the total, with an increase in population of 29 percent over the last decade<sup>3</sup>. Within that same time frame, people of Asian descent experienced a rapid population growth — the largest

**Table 1. Frequency of Cancer Among Ethnic Groups**

Race/ Ethnicity	Male (per 100,000)	Female (per 100,000)
All Races	542	412
White	543	423
Black	627	398
Asian/Pacific Islander	343	299
American Indian/ Alaska Native	353	314
Hispanic	402	324

of all the racial groups in the last 10 years with a 43 percent increase<sup>3</sup>.

Among these populations, the Cancer Trends Progress Report – 2011/2012 Update indicates that Black males have the highest rate of new cancers. Rates among American Indians/Alaska Natives, Hispanics and Asian/Pacific Islanders are lower<sup>2</sup>. The National Cancer Institute SEER Report describe incident rates from 2005 – 2009 for male and females of various ethnicities<sup>4</sup> (Table 1).

Other studies show that immigrants who have resided in the United States for less than ten years have lower rates of cancer than American-born populations. Newly arrived foreign-born individuals are relatively healthy, but it has been hypothesized that over time acculturation (adapting to the lifestyle of current residency) can cause the health of these immigrant populations

# Five Barriers to Cancer Care

## 1. Socioeconomic Barrier

“It’s too expensive.”

## 2. Health Literacy

“That causes cancer?”

## 3. Language Barrier

“I don’t understand.”

## 4. Knowledge and Attitudes

“I deserve to suffer.”

## 5. Perceptions

“Can doctors be trusted?”

to deteriorate<sup>5</sup>. For example, the 2006 national data showed that newly arrived immigrants in the United States have lower body mass indices (BMI) than American-born individuals. After 10 years of residence, the BMI of female immigrants almost equals their American counterparts and the BMI of male immigrants equals that of American born males after 15 years of residency<sup>5</sup>.

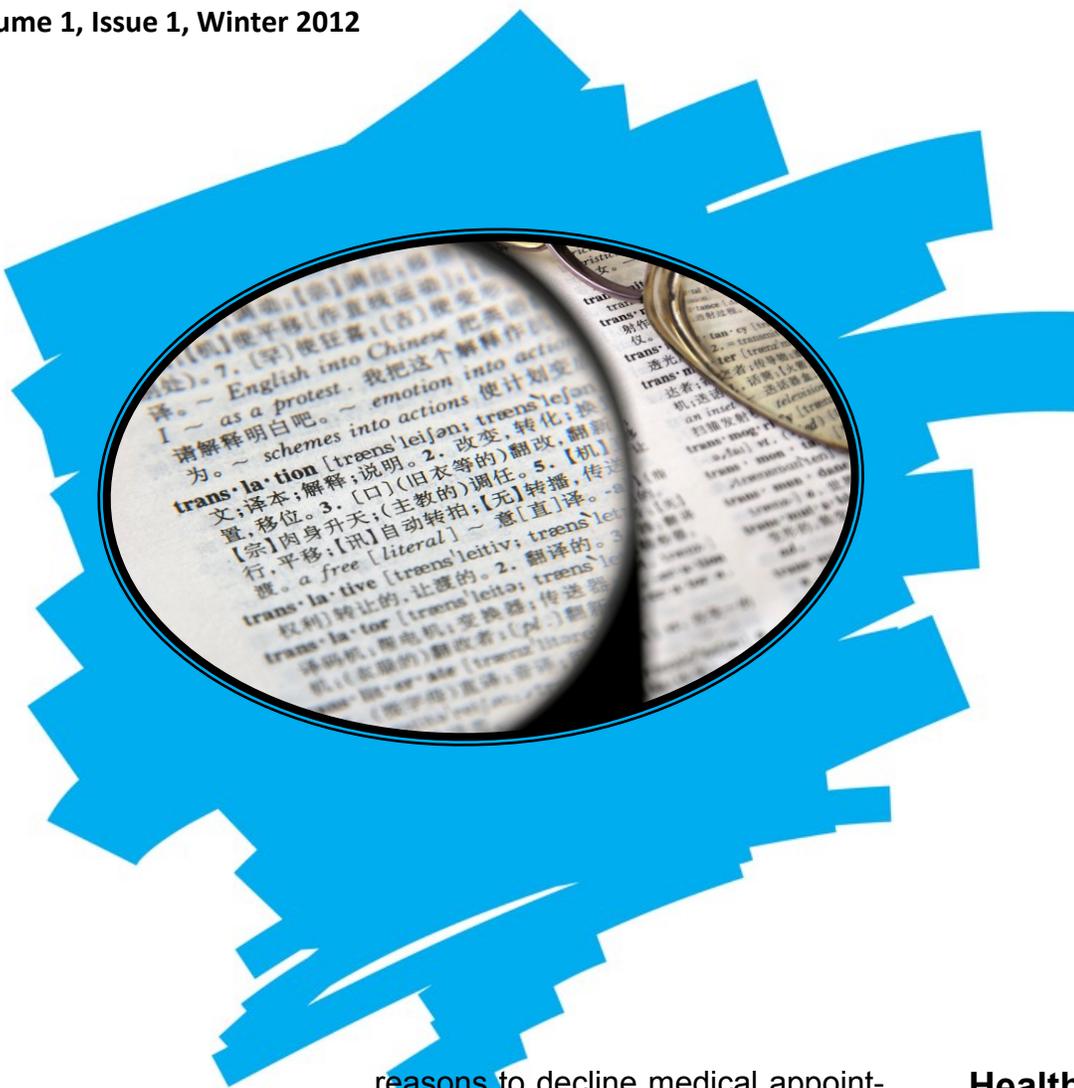
In spite of higher incidences of cancer among immigrant populations who have lived in the U.S. for a while, studies have shown that immigrant populations have low rates of participation in cancer screenings and are least likely to obtain medical care and information about cancer<sup>5</sup>. Some studies claim that low participation in cancer screenings is due to the lack of cancer education and awareness, difficulty in accessing

preventive and screening services, barriers that are related to socioeconomic conditions as well as language and cultural beliefs<sup>6,7,8</sup>.

### Five barriers that prevent people from getting cancer care

#### Socioeconomic Barrier:

Pourat and colleagues describe in his study on Access vs. Acculturation two commonly cited factors that affect access to healthcare and screening services for cancer are the lack of adequate insurance and financial difficulties<sup>7</sup>. Most individuals cite the inability to pay for health services or the reluctance to take time off from work or family obligations as



reasons to decline medical appointments. The author further cites that researchers from the University of California who studied cancer screening rates among Asian Americans concluded that access to care would be limited because medical providers may not accept insurance packages with low reimbursement payments. Public clinics or hospitals received high volumes of patients, but also had limited resources to care for them all. The patients, often immigrants, experienced delayed appointments, long waiting times, and few culturally appropriate services. These negative experiences were enough for individuals from immigrant communities to choose not to seek appropriate cancer services.

**Health Literacy:** A study on cancer information disparities between U.S. born and immigrant populations indicated that foreign-born individuals are less likely to obtain information about cancer or have someone else look for information for them<sup>5</sup>. The study continues to mention that foreign-born respondents to the study expressed frustration, stating that it took much effort to obtain information or that they found it hard to navigate the health system. In cases where information was available, many said they found it hard to understand. The study also found that some foreign-born individuals are more likely to distrust some sources of information such as newspapers, magazines, doctors, the internet, television or radio. For example, foreign-



born Latinos indicated lower trust in health information that came from doctors or health professionals than other ethnicities participating in the study<sup>5</sup>.

**Language Barrier:** Researchers from New York University conducted a qualitative study on immigrant populations' knowledge, attitudes, and behaviors towards cancer screening<sup>6</sup>. The study indicated that immigrants with limited English proficiency had different ways of obtaining medical information. If the information provided was unclear, Chinese and Haitian respondents were likely to turn to family members, friends, social workers at community-based organizations or hospital personnel for clarification or interpretation. Latinos and Caribbean-speaking immigrants would ask nurses to clarify doctor's orders. Respondents also reported that interpretation services at medical settings were poor and often insensitive to patients' cultures<sup>6</sup>.

**Knowledge and Attitudes toward Cancer:** Studies have also shown that many immigrant populations lack knowledge on the causes of cancer and how it spreads. Research shows that immigrants believe that inherited cancers and those caused by environmental factors are least preventable. Knowledge about cancer varies with each ethnic group. One survey done among Chinese immigrants in California showed that 25 percent of the participants believed that cancer is contagious or the result of environmental factors or personal actions such as an immoral behavior<sup>6</sup>. Arab perception from a focus group study viewed cancer as God's punishment and its causes included oversized foods that had been treated with hormones or chemicals, some food preparations, stress and hereditary<sup>8</sup>.

**Perceptions:** Cultural beliefs are one of the major barriers preventing immigrants from accessing cancer ser-

vices. Many feel that health is 'all in the hands of God' and that one should let fate take its course<sup>8</sup>. In addition, many believe that cancer is a private matter that should not be discussed. Chinese respondents in a study about cancer perceptions indicated that they had difficulty talking about cancer because of modesty and privacy issues<sup>6</sup>. In gender-distinct cultures, such as Arab communities, women who are accompanied by male family members to clinics feel uncomfortable discussing women's health issues with men present<sup>8</sup>. Furthermore, cancer is often associated with death in most ethnic cultures resulting in denials and promoting the lack of understanding about the disease.

## Closing the access gap

While cancer is often difficult to face, if detected in its early stages, some tumors can be treated and survivors can live for long periods after treatment. It is important for immigrant communities in the United States to understand the disease and available treatment options so that they can make educated decisions about their health.

Current gaps in access to medical services and information for these communities can be addressed if materials, messages, and public awareness channels are created with cultural considerations in mind and customized to each ethnic community. Additionally, more outreaches and studies need to be done in partnership with local community leaders and key stakeholders within these communities. Furthermore, training health professionals and researchers in cross

cultural communications will help to build trust among immigrant communities about their sources of information. With these efforts, health disparities in cancer among ethnic groups in the United States would eventually decrease and equal access to quality healthcare services will one day be available to all populations.

**Pauline Theresa B. Sikat is a public health professional. She has been involved in public health efforts through New York University Medical Center, non-profit organizations, Memorial Sloan-Kettering Cancer Center, and abroad.**

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