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# ***Community Health Navigators for Breast- and Cervical-Cancer Screening Among Cambodian and Laotian Women: Intervention Strategies and Relationship-Building Processes***

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*In recent years, there has been a growing number of programs employing health navigators to assist underserved individuals in overcoming barriers to obtaining regular and quality health care. This article describes the perspectives and experiences of community-based health navigators in the Cambodian and Laotian communities involved in a REACH 2010 project to reduce health disparities in breast and cervical cancer among Pacific Islander and Southeast Asian communities in California. These community health navigators, who have extensive training and knowledge about the cultural, historical, and structural needs and resources of their communities, are well equipped to build trusting relationships with community members traditionally ignored by the mainstream medical system. By comparing the different social support roles and intervention strategies employed by community health navigators in diverse communities, we can better understand how these valuable change agents of the health workforce are effective in improving health access and healthy behaviors for underserved communities.*

**Keywords:** *breast and cervical cancer screening; cancer prevention and control; community health navigators; community health promotion; advocacy; Cambodians; Laotians; Asian Americans and Pacific Islanders*

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Asian American and Pacific Islander (AAPI) women have the lowest breast- and cervical-cancer screening rates compared to all other ethnic groups (American Cancer Society, 2004). Unfortunately, there is a lack of programs to promote and sustain screening practices for AAPI women despite the fact that they face such structural barriers to screening as lack of health insurance, transportation, child care, language interpretation services, and regular sources of health care (Special Service for Groups, 2001). Culturally mediated knowledge, attitudes, and behaviors regarding cancer etiology and treatment decisions also can act as barriers to cancer screening (Special Service for Groups, 2001). Although many of the structural barriers to cancer screening are universal across cultures, the strategies required to address these barriers vary from group to group. To account for this diversity, programs need to be tailored to the unique needs and resources of communities (Nguyen, Kagawa-Singer, & Kar, 2003; Pasick, D'Onofrio, & Otero-Sabogal, 1996).

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Health navigators are increasingly utilized as a common strategy to assist underserved women to overcome multifaceted barriers in obtaining regular cancer screenings. A growing number of programs employ health navigators who serve as the “insider” health-promotion experts because they are knowledgeable about their communities and are aware of the most effective methods and strategies to reach those who have traditionally been labeled as “hard-to-reach” (Centers for Disease Control and Prevention [CDC], 1994; E. J. Jackson & Parks, 1997; Love, Gardner, & Legion, 1997; Pew Health Professions Commission, 1994; The California Endowment, 2000; Witmer, Seifer, Finocchio, Leslie, & O’Neil, 1995). In fact, President Bush recently signed into law the “Patient Navigator Outreach and Chronic Disease Prevention Act of 2005,” which authorizes appropriations through fiscal year 2010 for the Department of Health and Human Services to establish a competitive grant program. Twenty-five million dollars in grants during 5 years will be allotted to help patients in low-income and rural communities nationwide to access health care services. With this additional federal recognition and funding for health-navigator programs, it will be imperative for the health-promotion field to better understand what makes these programs successful.

Although many studies have defined, described, and evaluated health-navigator programs using a hospital- and clinic-based model (Freeman, Muth, & Kerner, 1995;

Frelix, Rosenblatt, Solomon, & Vikram, 1999), relatively few studies have examined health-navigator programs in community-based settings (Schulz, Israel, Becker, & Hollis, 1997). Such community-based settings are important, however, because community-based organizations sponsor many cancer-education and early detection programs designed to overcome multiple environmental barriers and limitations. It is equally important to describe, understand, and evaluate the experiences and perceptions of these community health navigators (CHNs) so that culturally appropriate and effective cancer-education and screening programs can be designed, implemented, and evaluated to create the most positive changes with the available resources in a community.

In this article, we discuss the experiences of the Cambodian and Laotian CHNs involved in the “Promoting Access to Health for Pacific Islander and Southeast Asian Women” (PATH for Women) project as part of the CDC Racial and Ethnic Approaches to Community Health (REACH 2010) initiative. First, we briefly describe the problem of breast and cervical cancer in the Cambodian and Laotian communities. Next, we explore the history, definitions, and roles of CHNs and discuss their social support functions within their communities. Then we elaborate on the specific intervention applications and accomplishments by our PATH for Women partners, specifically focusing on strategies that our Cambodian and Laotian CHNs enacted to overcome structural constraints and establish trusting community relationships to promote breast- and cervical-cancer screening. Finally, we discuss the lessons that we have learned in working with CHNs and include implications for applying similar health-promotion programs in other communities.

## **► BACKGROUND/ LITERATURE REVIEW**

### ***The PATH for Women Project***

The Cambodian and Laotian (which includes Lao, Hmong, and other ethnic populations from Laos) communities examined in this study are part of the PATH for Women project. PATH for Women was formed in 1999 as part of the CDC’s REACH 2010 project funded through the CDC Foundation, with the generosity of The California Endowment, and is one of only five AAPI-focused REACH 2010 projects nationwide. The PATH for Women project is a community collaboration of seven community-based organizations and two universities (California State University, Fullerton and University of California, Los Angeles). PATH for Women focuses on decreasing disparities in breast and cervical cancer among Cambodian, Chamorro, Laotian, Samoan, Thai, Tongan, and Vietnamese communities in Los Angeles and Orange Counties via a five-pronged community action

plan that includes (a) community education, (b) community training sessions, (c) provider training sessions, (d) breast and cervical screening, and (e) policy advocacy—all facilitated by our community health advocates and navigators. A description of the collaborative process and development of the participatory action research model employed by our project has been detailed elsewhere (Tanjaisiri, Kagawa-Singer, Nguyen, & Foo, 2002).

Long Beach, California has the largest Cambodian community in the United States and a substantial Lao community. The 2000 Census identified 34,032 Cambodians living in Los Angeles and 5,359 living in Orange County, California. In comparison, there were 3,569 Laotians living in Los Angeles and 2,308 living in Orange County (U.S. Bureau of the Census, 2000). Between 1996 and 2000, breast and cervical cancers were the two most common cancers for Cambodian women and the second and third most common cancers for Laotian women in California (American Cancer Society, 2003). Limited information is available on the breast- and cervical-cancer screening practices of Cambodian and Laotian female immigrants in the United States, but studies indicate low rates of screening for both communities (Bailey, Bennett, Hicks, Kemp, & Warren, 1996; J. C. Jackson et al., 2000; Kelly et al., 1996; Special Service for Groups, 2001; Tanjaisiri et al., 2001; Taylor et al., 1999; Yi, 1996; Yi & Prows, 1996).

For this article, we describe the outreach efforts of CHNs in the Cambodian and Laotian communities to highlight the similarities and differences in program strategies and impacts between two Southeast Asian populations from similar geographic and environmental settings. Specifically, we wanted to study the community-based aspects of interpersonal and relationship-building processes experienced by the CHNs and identify the specific qualities and social support roles filled by these women in tailoring breast- and cervical-cancer screening programs and promoting health care access for their communities. Both the Cambodian and Laotian programs are run by staff from a community-based organization called Families in Good Health (FiGH)/St. Mary Medical Center, which is a multilingual, multicultural health and social education agency that provides outreach and education services to the Southeast Asian and Latino communities in L.A. County. FiGH was established in 1987 as a joint venture between the community-based United Cambodian Community, Inc. and St. Mary Medical Center, a Catholic Healthcare West (CHW) hospital in Long Beach, California.

### **Community Health Navigators: History and Definitions**

One of the first models for patient navigation in the hospital setting was described by Harold Freeman and

colleagues in New York in 1995 (Freeman et al., 1995). They looked at the effect that navigators had in helping 1,034 women in Harlem with abnormal breast-cancer screening findings. The patient navigators were trained to provide emotional support and advocacy as they accompanied patients to their follow-up appointments. Although this patient-navigation program was mainly hospital based (with patient navigators assisting those women who had already entered the hospital system and had presented with abnormal screenings), other projects in recent years have used health navigators in different capacities, with some focusing on a more community-based model that seeks to promote access for those who are new to the mainstream medical system (Burhansstipanov et al., 1998; Matsunaga et al., 1996).

Overall, the use of CHNs as “vital links,” “bridges,” and “culture brokers” between a community and available health care services is increasingly gaining recognition (Bird, Otero-Sabogal, Ha, & McPhee, 1996; Eng, Parker, & Harlan, 1997; Landen, 1992; Love et al., 1997; McElroy & Jezewski, 2000). In particular, several studies have found the use of CHNs to be effective in increasing access to breast- and cervical-cancer screenings and health services because CHNs have the necessary knowledge and understanding of the language, cultural values, and structural needs and resources of diverse communities to bridge the gap between community members and the mainstream medical system (Banner et al., 1995; Bird et al., 1996; Bird et al., 1998; Brownstein, Cheal, Ackermann, Bassford, & Campos-Outcalt, 1992; Dignan et al., 1996; Earp & Flax, 1999; Eng & Smith, 1995; Freeman et al., 1995; Frelix et al., 1999; Gotay et al., 2000; Hiatt et al., 2001; Matsunaga et al., 1996; Navarro et al., 1998; Sung et al., 1997).

### **Social Support: Theoretical Concepts Supporting Health Navigator Models**

The theoretical rationale for the involvement of community health navigators stems from the social support and social networks literature that emphasize the important influences of an individual’s and a community’s social networks on health behavior and health decision making (Charles & DeMaio, 1993; Eng, Hatch, & Callan, 1985; Israel & McLeroy, 1985). According to House (1981), social support serves a function in relationships that can be categorized into four broad types of supportive behaviors or acts, as follows:

1. *Affective/emotional support* involves the conveyance of empathy, moral support, love, trust, concern, and caring;
2. *Instrumental support* involves offering tangible aid and services such as labor, money, and time that directly assist a person in need;

3. *Informational support* involves providing advice, suggestions, directives, referrals, and other information that a person can use to address problems; and
4. *Appraisal support* involves giving affirmation and constructive feedback that is useful for self-evaluation purposes.

It is important to note that although these four different kinds of social support are differentiated conceptually, it is often the case that relationships that provide one type of social support usually also provide the other types, thus making it difficult to empirically study and measure them as separate constructs (Heaney & Israel, 2002; House, 1981). Social network theory adds the characteristics of relationships (such as the size/density of communities and the degrees of reciprocal helping or the extent to which support is both given and received) to the understanding of how social support affects relationships and health (Heaney & Israel, 2002; Israel & McLeroy, 1985).

## ► METHODS/STRATEGIES/ INTERVENTION APPLICATIONS

### *PATH for Women Intervention, Evaluation, and Accomplishments*

For our project, we wanted to learn more about the specific processes and strategies employed by the CHNs in tailoring educational and outreach activities to their communities, particularly how CHNs influenced women faced with tremendous barriers to seek and obtain breast and cervical health care. Given the gap in the literature regarding this area, we made both impact and process-evaluation measures a core component of our PATH for Women evaluation plan. For our process evaluation of PATH for Women education, outreach, and navigation activities, all seven of our partner communities submitted monthly reports as well as outreach logs detailing the CHNs' efforts and perspectives in these areas.

Since the inception of the PATH for Women Project 5 years ago, we have consistently worked closely with a total of 18 CHNs (each of our 7 ethnic community partners recruited and employed 2 to 3 CHNs). These CHNs are all bicultural and bilingual and have, on average, 15 years of experience working directly with their respective communities. As part of their training, all of the CHNs attended and organized more than 383 outreach presentations and educational workshops and community training sessions during the past 5 years. The CHN workshops and training included 1- to 2-hour presentations conducted by experienced professionals

throughout the community, including but not limited to physicians, nurses, lawyers, academic researchers, public health advocates, and program directors and staff from community-based organizations. The various topics included in the workshops and training ranged from internal organizational topics, such as developing and reviewing educational materials and community-training curricula, to external relationship-building issues, such as working with the media. Specific breast- and cervical-cancer-related topics included anatomy and physiology; prevention, screening, and treatment options; navigation and case management; setting up mobile screenings in the community; and following up with re-screening exams and referrals. Policy-level topics included working with providers to improve cultural competency and access to screenings and services for their patients, Medi-Cal and Medicare coverage, language access and patient rights, low-cost insurance, and cancer legal issues. Workshops and training also included capacity-building topics such as applying for mini-grants; forming and maintaining community partnerships and coalitions; reading, developing, writing, and reviewing research protocols, community reports, and journal articles; and grant-writing skills to establish sustained funding for continuation of program activities.

During a 4-year time period, the CHNs educated 24,077 community members (22,756 women and 1,321 men) in workshop presentations or one-on-one sessions. The CHNs personally accompanied 1,823 women through the health care system, helping 686 to receive breast exams, 509 to receive cervical exams, and 628 to receive both types of exams. Of these 1,823 women, nearly one third had re-screening exams. The CHNs also organized mobile units to provide a total of 573 mammograms and 45 Pap smears to community women.

### *Study Design*

Although all the PATH for Women CHNs contributed to these accomplishments, we only report in detail on the Cambodian and Laotian process evaluation results for this article. We chose to focus on these two communities because these Southeast Asian health navigators, unlike our other partners, are employed and housed under the same agency (FiGH/St. Mary Medical Center in Long Beach, California) and therefore had similar organizational limitations and resources for their work. Because the organizational contexts were similar for the CHNs from both communities, our evaluation team felt that any differences in their cultural-tailoring strategies could more validly be attributed to

community-based structural factors rather than to differences in organizational capacities to deliver health care for these populations. We had two specific aims for our study: (a) to qualitatively describe the processes that the Cambodian and Laotian CHNs go through in developing strategies to address barriers and resources for breast- and cervical-cancer screening for women in the participating communities and (b) to assess the usefulness of concepts from the social support literature in characterizing the qualities and roles of the CHNs out-reaching to the Cambodian and Laotian communities.

### **Study Measures**

To meet our study aims, we closely reviewed 12 monthly reports and 22 activities logs from the Cambodian CHNs and 12 monthly reports and 20 activities logs from the Laotian CHNs, all submitted between October 2001 and October 2002. The 12 monthly written reports were filled out by the same CHN from each community. The CHNs who organized and carried out the reported activities filled out the activities logs (which mainly included closed-ended questions regarding preparation and implementation for the outreach and education events).

We also conducted in-depth, semistructured qualitative interviews (lasting 1 to 2 hours in length) with 2 Cambodian and 3 Laotian CHNs, all of whom had slightly different responsibilities and experiences in their jobs. Members from our evaluation team conducted separate interviews in English with each CHN but asked similar open-ended questions regarding their work, including topics such as effective recruitment, education, and outreach strategies as well as challenges and barriers that the CHNs encountered in doing their work and how they dealt with these problems. All interviews were audiotaped and transcribed, and at least two members from our evaluation team worked together on content analyses to assess major themes and codes.

To see firsthand the amount of time and efforts required for the work conducted by the CHNs, our evaluation team also shadowed them and conducted observations of their outreach activities as well as their medical appointment navigation sessions with some patients. We followed the CHNs and observed their work on a total of nine occasions (at least 1 to 2 times with each CHN), which varied in length between 1 to 6 hours, depending on the outreach or navigation activities. Interviews and observation sessions were scheduled according to the feasibility, convenience, and permission of the CHNs and patients, following Institutional Review Board-approved guidelines for obtaining informed consent and assurances of confidentiality.

## ► **RESULTS AND DISCUSSION**

### ***Cambodian and Laotian Community Needs and Resources***

The data collected from in-depth interviews, observations, and reports and logs of CHN interventions and advocacy efforts gave our evaluation team valuable, detailed information that helped us to better understand not only *why* but also *how* the CHNs were effective. For instance, the CHNs revealed that because the Cambodian community is much larger than the Laotian community in terms of numbers, the former community has been able to build a stronger infrastructure that includes prominent media channels used as resources for spreading health messages. These differences in resources thus influenced and determined the most effective methods of education and outreach for each community. Both communities, however, similarly faced tremendous economic, social, educational, and political barriers (i.e., high poverty rates, unsafe neighborhoods, high crime and gangs, low-wage jobs with long hours, welfare reform, anti-immigrant policies, etc.). In light of these structural constraints, a summary of the differences and similarities in cultural tailoring processes and strategies between the Cambodian and Laotian communities is presented in Table 1.

### ***Applicability of Social Support Concepts for the Cambodian and Laotian CHNs***

Even though none of our questions in the interviews, reports, and logs were intentionally framed to only elicit the specific terminology or concepts outlined in the social support literature, we found that the CHNs' work fit well with the four categories of social support (informational, instrumental, affective/emotional, and appraisal support) outlined by House (1981).

#### *Informational Social Support—Education and Outreach*

As mentioned earlier, the structural barriers, population difference, and resettlement histories between the two communities affect the infrastructure and acceptability of resources available to support women's screening behaviors and, consequently, the intervention strategies used by the CHNs to fulfill their informational social-support functions (e.g., education, advice, referrals, etc.; see Section A in Table 1). Although the Cambodian community has prominent media channels that the CHNs can use for mass-recruitment and educational-outreach purposes, the Laotian community does not have these resources. Therefore, the

**TABLE 1**  
**Aspects of Cultural Tailoring Processes Between Cambodian and Laotian CHNs**

	<i>Cambodian CHN Strategies</i>	<i>Laotian CHN Strategies</i>
<b>A. Informational support—education and outreach</b>		
Recruitment channels	Utilize media channels (i.e., TV commercial, newspaper ads)	Door-to-door/approach directly
Location/setting for education and outreach	Community organizations/health fairs Religious temples/markets and grocery stores/businesses	Community organizations/health fairs Religious temples/markets and grocery stores/businesses
Delivery method	Mass media	One-on-one, multiple home visits to persuade women to go for screening
Educational materials	Poster of rural Cambodian village with breast and cervical cancer health messages/use of anatomical models	Flip chart featuring Lao women dressed in ethnic clothing/use of anatomical models/brochures on BSE, CBE, mammogram, and cervical education
Promotional/incentive items	Cups, bags, note pads with PATH for Women logo/T-shirt displaying dancing women representing <i>Apsara</i> <sup>a</sup>	Cups, bags, note pads with PATH for Women logo and 12-month calendar with health messages for each month
Timing of education and outreach	Outreach to markets at beginning, middle of month when families get paychecks/attend holiday events and community festivals all year/education in evenings and on weekends	Outreach to markets at beginning, middle of month when families get paychecks/attend holiday events and community festivals all year/education in evenings and on weekends
<b>B. Instrumental support—tangible aid and services</b>		
Navigation through health system	Schedule appointments (preferably with female providers), provide transportation, interpretation, explanations of procedures, fill out medical history paperwork, apply for free/low-cost screening exams	Schedule appointments (preferably with female providers), provide transportation, interpretation, explanations of procedures, fill out medical history paperwork, apply for free/low-cost screening exams
<b>C. Affective/emotional support—interpersonal relationship building</b>		
Message content	“Women’s Health, Family’s Wealth” to emphasize the important role of the woman as family caregiver and address cultural myths and fears about cancer by explaining diseases and importance of screening exams.	“Women’s Health, Family’s Wealth” to emphasize the important role of the woman as family caregiver and address cultural myths and fears about cancer by explaining diseases and importance of screening exams.
Involve men	Acknowledge the importance of the men as household heads and co-decision makers, created brochures for men about women’s and men’s health issues.	Acknowledge the importance of the men as household heads and co-decision makers, created brochures for men about women’s and men’s health issues.
Culturally appropriate greetings/manners of conduct	Polite greetings to show respect to community members: Put hands together and slightly bow head (especially when addressing elders) and say “ <i>Jom reab sor</i> ” (a polite “hi” or “hello”). Ask “ <i>Suksubaysithe?</i> ” (“How are you?”) and “ <i>Junkina?</i> ” (“Where are you going?”). Treat everyone equally with respect regardless of education or knowledge levels.	Always call and make appointment before showing up at women’s houses. Rules of conduct in homes include removing shoes when entering and sharing in offerings of food and refreshments from community women; this shows trust and respect.

*(continued)*

**TABLE 1 (continued)**

	<i>Cambodian CHN Strategies</i>	<i>Laotian CHN Strategies</i>
Involve religious/ community leaders	Speak with nuns and monks. Participate in ceremonies to convey respect, caring involvement, and commitment. Donate money to temples as small token of appreciation for assistance from nuns and monks.	Speak with nuns and monks. Participate in ceremonies to convey respect, caring involvement, and commitment. Donate money to temples as small token of appreciation for assistance from nuns and monks.
Educate providers— cultural sensitivity and competency	Educate providers about history and culture of Cambodian women, including issues about health beliefs, attitudes, practices, experiences with trauma, sexuality, embarrassment, proper conduct between women and providers.	Educate providers about history and culture of Laotian women, including issues about health beliefs, attitudes, practices, experiences with trauma, sexuality, embarrassment, proper conduct between women and providers.
D. Appraisal support— affirmation and constructive feedback	Empower women by explaining each step of navigation process. Follow up with women through phone calls and explain test results and need for re-screening	Empower women by explaining each step of navigation process. Follow up with women through phone calls and explain test results and need for re-screening

NOTE: CHN = community health navigator; BSE = breast self-exam; CBE = clinical breast exam.  
a. A Cambodian mythical symbol of ideal femininity.

Laotian CHNs must conduct their education and outreach door-to-door, face-to-face, and in pairs (for safety precautions because of the high rates of crime and violence in their neighborhoods).

The Cambodian and Laotian CHNs, however, are also very knowledgeable about community resources and would often team up to conduct outreach events at common community locations (e.g., temples, churches, grocery stores and markets, businesses, and community organizations) at appropriate times (e.g., when people cash their paychecks or during holiday events when the CHNs can reach large numbers of people; Sadler, Nguyen, Doan, Au, & Thomas, 1998; Sadler et al., 2000). At the outreach events, the CHNs pass out culturally and linguistically appropriate educational materials and promotional items. In particular, the Cambodian CHNs have found the development of a poster depicting a rural Cambodian village with breast and cervical health messages to be very popular with community members because the poster reminds them of “home,” and they like to hang the poster in their workplaces and houses. Likewise, a T-shirt was developed to encourage timely breast and cervical screenings by incorporating images of a dancing *Apsara*, a mythical prototype of feminine

grace, harmony, and well-being in the Cambodian culture. This imagery is very powerful to the Khmer and has great potential to carry messages about equilibrium and healthy responses to Khmer refugee women and girls (Frye, 1995).

According to the Laotian CHNs, a visual flip chart (with colorful pictures of Lao women in traditional and Western dress) developed to educate women about breast cancer has also been very useful because most of the women they encounter cannot read. Both groups also found the use of anatomical models to be helpful because people can touch and feel for lumps and have a tactile understanding of what the CHNs are explaining.

*Instrumental Support Through Navigation Activities—Tangible Aid and Services*

The instrumental social support functions, processes, and strategies (e.g., transportation, scheduling appointments, interpretation, etc.) provided by both the Cambodian and Laotian CHNs are also very similar (see Section B in Table 1). Because most of the women recruited for screening exams are getting these tests for the first time, the CHNs must navigate or guide them



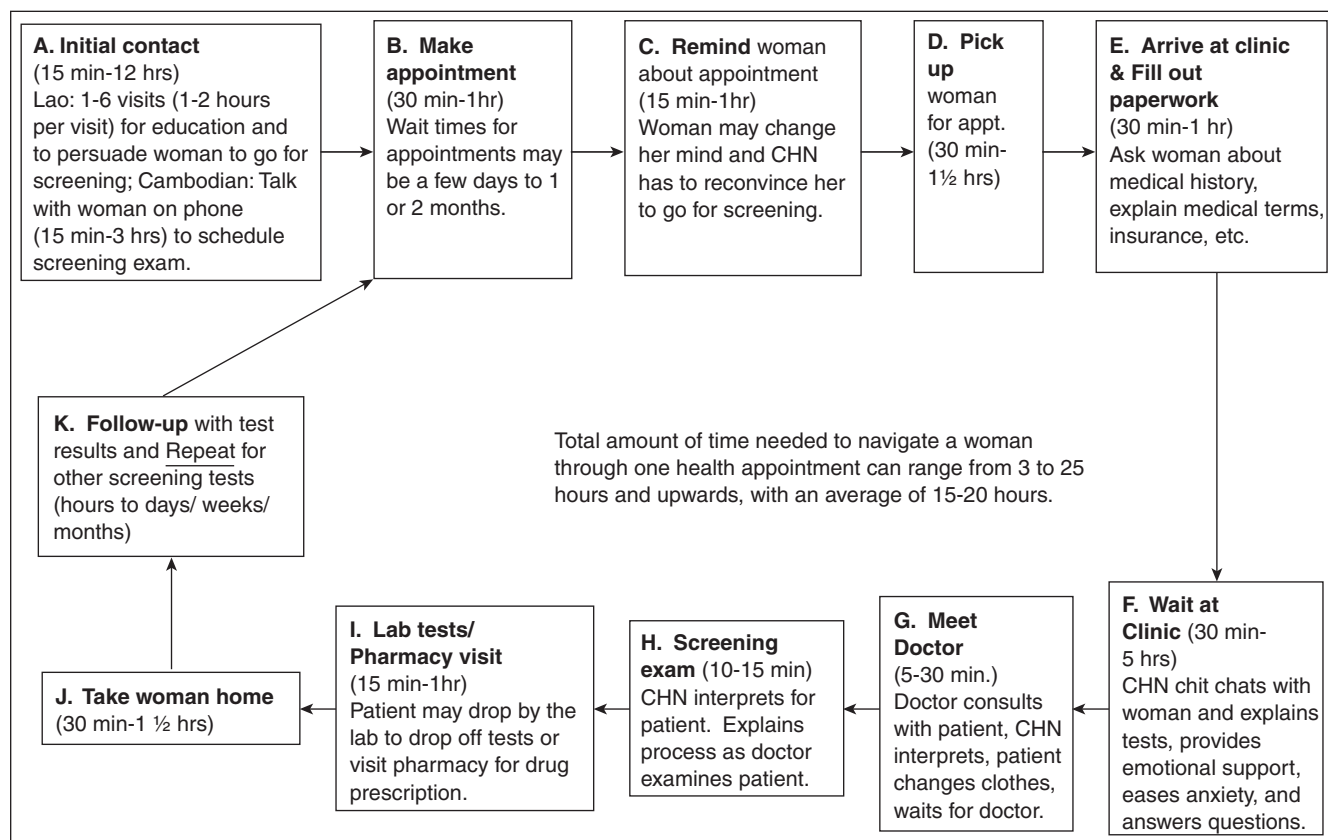


FIGURE 1 Navigation Activities Timeline

through each step of the health-care-seeking process. To give a visual sense of the extensive amount of time it takes for the CHNs to navigate one woman through one health care appointment, we have outlined the steps in a timeline diagram in Figure 1.

The navigation process (see Boxes A-K in Figure 1) begins with the initial contact with the women (see Figure 1A). For the Cambodian community, this process is initiated by the women who call to inquire about the screening tests after seeing the television commercial or newspaper ads developed by the CHNs. The CHNs may spend from a few minutes to 1 to 3 hours (with subsequent phone calls) to inform the women about available services and persuade each of them to make an appointment. For the Laotian CHNs, this initial contact phase takes much longer, as they do not have the community media channels and must go house-to-house to recruit women for the screening exams. The CHNs must make 1 to 6 visits (with an average of 2 to 3 visits) to educate women to make appointments (see Figure 1B). A few days before the appointment, the CHN calls the woman to remind her about the visit (see

Figure 1C). On the day of the appointment, the CHN picks up the woman from her home and drives her to the clinic (traveling 30 to 90 minutes depending on where the client lives; see Figure 1D).

Once they arrive at the clinic, the CHN helps the patient fill out the medical history and insurance paperwork, which takes an average of 30 minutes to 1 hour to complete (see Figure 1E). Then the CHN waits with the patient from 30 minutes (usually for a returning patient) to anywhere from 1 to 5 hours (for a new patient) before the doctor meets with her (see Figure 1F). During the waiting period, the CHN talks with the woman to help ease her anxiety by explaining what she can expect with the tests and answering her questions. Once inside the doctor's office, the doctor consults with the patient about her medical history (for about 5 to 10 minutes). Then the woman is asked to change and wait in a room (5 to 15 minutes; see Figure 1G). For a mammogram, the CHN steps outside the room while the patient gets the test (because of radiation exposure) but many times continues to talk to her from outside the room to provide information, to comfort, and to

build confidence. For a clinical breast exam, cervical Pap smear, and pelvic exams, the CHN stays with the patient and helps to interpret and explain each step as the doctor does the examination while also providing comfort, support, and reassurance about the procedure (see Figure 1H). Once done, the patient may have to go to the laboratory or pharmacy, which may add another 15 minutes to an hour onto the visit (see Figure 1I). When everything is completed, the CHN then drives the patient home (see Figure 1J).

Overall, the amount of time needed to navigate a patient through one appointment can take anywhere from 3 hours (best-case scenario) to 25 hours or more, from the point of initial contact to the completion of the appointment process and receipt of the screening examination. Because many of the recruited women are getting screened for the first time and are monolingual and unfamiliar with the mainstream health services, the CHNs reported that the average number of hours needed to navigate a woman through the system tend to be near the higher end (15 to 20 hours). This does not include the additional time needed to follow up with test results and any abnormal findings (see Figure 1K). Because the different cancer-screening exams are often done separately, the CHNs must often schedule a patient for two to three different appointments before she receives all tests. The additional time for follow-up of test results and additional screening exams may range from hours to days, weeks, or months, depending on the extent of follow-up.

Between 2003 and 2004, the CHNs navigated a total of 166 Cambodian and Laotian women. About a quarter of these women received screening exams for the first time in their lives.

### *Affective/Emotional Support*

In terms of the affective/emotional social support functions (conveyance of empathy, moral support, love, trust, concern, caring, etc.; see Section C in Table 1), the provision of culturally appropriate messages is key in the CHN's role of building relationships and establishing trust with community women and their social networks. By knowing the cultural worldview and backgrounds of their clients (e.g., the cultural customs, the health beliefs and attitudes about cancer, the proper modes of conduct and communication with community members), the CHNs were able to tailor their messages in culturally acceptable and salient ways that connected them emotionally with the community. One CHN described how cultural issues are important in her work in the following quote:

Well, cultural issues with Lao people, they are sensitive just like any other people. So if you go to

them, you have to know their culture a little bit. Even though, let's say, like a bunch of American people, they don't know anything about Lao, in order for them to make their work *work*, they have to learn a little bit of Lao culture before you go to them. But even if you speak the same language, but you go to them, and you don't respect their culture, then of course, you know, they don't like you, and they're not going to cooperate with you to do your work. So culture, it's a lot of sensitive things that you need to learn and you need to know. For example, let's say you go to temple, right, you're not going to wear your shoes in the temple. If you do that, people will look down on you and they are not going to welcome you in next time, and things like that. If you see the older people, for the Hmong people, you have to know that you have to bow to them, you have to say hello for the old people, you have to respect them in a cultural way, in order for them to welcome you and for you to do your work. So culture is one of the main important things that you need—to understand the culture. It's everything.

As this wise CHN stated, understanding the culture is essential. This understanding includes respect, trust, and appreciation of the clients and their worldviews, because knowledge of the culture alone is necessary but not sufficient in working with the community. The building of trust and respect in health education and outreach involves the use of culturally appropriate greetings and manners of conduct. For instance, the CHNs from both communities used the motto, "Women's Health, Family's Wealth" to emphasize the important role of the woman as family caregiver. The message being conveyed is that if the woman takes care of her own health, she would better be able to take care of her family.

The CHNs also made efforts to involve the men in their educational outreach by creating brochures about breast and cervical cancer as well as men's health issues so that they could better support the women in their lives and learn about their own health needs. Similarly, the CHNs showed the same kind of respect and inclusiveness for community and religious leaders in the Cambodian and Laotian communities. In building relationships with these leaders, the CHNs conveyed commitment, caring involvement, and respect by communicating and sitting with the monks and nuns in ceremonies and donating to the temples and churches. For many Southeast Asian groups like Laotians and Cambodians, the practice of medicine is inseparable from religion. Sickness is often believed to come from the will of the gods or as a matter of karma (Muecke, 1983; Taylor et al., 1999). Therefore, the CHNs involved

the religious leaders to encourage women to get screened to bring the Buddhist tenets of “good karma” and equilibrium to their health (Frye, 1990, 1995; Frye & McGill, 1993).

Because of the lack of Khmer- and Laotian-speaking providers, the CHNs also served as patient advocates and informally educated medical providers during patient visits about the history and cultures of the Cambodian and Laotian women to increase their cultural sensitivity in delivering care for these communities.

### *Appraisal Social Support*

The area of appraisal social support (giving affirmation and constructive feedback that is useful for self-evaluation purposes; see Section D in Table 1) was not emphasized as strongly by the CHNs as the other types of social support. All of the CHNs did mention, however, that they made sure to follow up with all the women they navigated through the health system to explain test results and affirm the need for re-screening exams. The CHNs also made a point to educate community women not only about breast and cervical cancer but also about the process of getting care and being their own health advocates. The Cambodian and Laotian CHNs would transfer their wealth of knowledge to the women as they guided them through the appointments, showing them where to go for exams, the easiest route to the clinic, the reasons for the medical procedures, and so on. The CHNs realized that the more that community members learned to access these services themselves, the more that they could teach their relatives, friends, and neighbors in their social networks to do the same. It is also important to note that the CHNs became such trusted confidantes that community women and their families would often seek their advice for topics beyond breast and cervical cancer (e.g., citizenship and immigration issues, work-related issues, social services for their families, etc.). This usually resulted in the CHNs devoting personal, unpaid time outside of regular work hours to help those in need in their communities.

## ► CONCLUSION

In a review of 17 studies that used social support or social network interventions to effect change in health behavior or health status, Cwikel and Israel (1987) found that 11 studies reported beneficial results, with evidence suggesting that more positive outcomes resulted from the use of affective support, particularly when coupled with either instrumental or information support. The findings from our exploratory study suggest

a similar conclusion for the work of the Cambodian and Laotian CHNs. Although the CHNs noted the importance of the informational and instrumental support functions in their advocacy and navigation work, it appears that these types of assistance were effective in getting women screened because the CHNs also provided the affective and emotional aspects of support necessary to convey empathy and respect and to establish trust with community members. In addition, the CHNs were aware of policy and environmental issues affecting the community (i.e., need to transition off welfare, increase of violent deaths in the area, deportation of immigrants, etc.) and how to work around these barriers to continue navigating the women through the health care system. Because the CHNs live and work in the same neighborhoods as the women they serve, they have an intimate understanding and empathetic insight into many of the problems affecting their communities and are personally invested in helping to find solutions. Perhaps this compassionate advocacy and credibility provided by CHNs is the crucial link motivating individuals to turn knowledge into health behavior.

We should note, however, that a major limitation of our study is the small sample size. We describe the activities of only 5 Cambodian and Laotian CHNs, all of whom had slightly different responsibilities and experiences in their jobs as health navigators. Therefore, although the findings from this study are not generalizable to the work of CHNs in other communities, the findings were consistent with the other 13 CHNs in our project and may be transferable to other communities with similar backgrounds.

### ***Recommendations and Implications for Health-Promotion Research and Practice***

Despite the limitations, this is the first study, to our knowledge, that has explored the perspectives of Cambodian and Laotian CHNs regarding their own experiences in tailoring breast- and cervical-cancer programs for their communities. Results from our study reveal that women from these Southeast Asian communities have many unmet needs regarding cancer that might potentially be met through the assistance of CHNs. Our findings suggest that future programs with underserved ethnic communities should involve more of the participatory and collaborative research principles proposed by the REACH 2010 projects, especially allowing community members to play critical roles in developing, implementing, and evaluating strategies and solutions to their health problems. In particular, employing CHNs and paying close attention to community social support networks, environmental needs

and resources, and interpersonal relationship-building aspects of health education programs may provide the key emotional connections and community buy-ins often necessary for effective health-promotion programs.

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