Social Construction of Cervical Cancer Screening Among
Women in Panama City, Panama

by

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of the requirements for the degree of
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DEDICATION

To all the Latinas who endured too many sacrifices to reach their dreams. To my mother and father who have always been concerned with my education and to my brothers who showed me how to be tough. To MamaMerce, my dear grandma, always guiding and watching over me, I still miss you. To all the women in my life, who helped mold me into who I am today.
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Arlene Calvo

ABSTRACT

To learn how to address health issues specific to Hispanic cultures in an effort to address health disparities, learning from cultural aspects that affect health from the countries of origin would be most useful. Community programs built on rigorous and systematic research prove to be more powerful than ad-hoc programs. Qualitative research techniques offer powerful alternatives for public health professionals to develop adequate and directed programs at the community level, especially among underserved communities and those represented by oral/spoken traditions. The study was conducted among 132 working class single and married Mestizo women between the ages of 20-40 living in Panama City, Panama. This group of women has the highest incidence of HPV in Panama so are at the highest risk of cervical cancer. Using social construction as the theoretical framework, this study uses four different qualitative research techniques: free listing, pile sorting, individual semi-structured, and group interviews. Key findings include the importance of religion and family, women’s understandings of the relationship between sexuality and health, influence of media, other women, and husbands help construct screening knowledge among women in the study. Culturally relevant health education interventions and programs delivered in a group format at the community level in a participatory mode would be most effective in reaching women in Panama and other Hispanic populations. Future quantitative studies and influences of social networks are suggested.
CHAPTER I-STATEMENT OF THE PROBLEM

Reaching the public health goal of health for all can only be accomplished if specific research and programs aimed at decreasing the unequal burden of disease are developed. In 2001, Dr. George Alleyne, Director of the Pan American Health Organization, stated that the search for equity in health is a vital concern for the Region of the Americas, particularly in Latin America and the Caribbean, which display the most inequitable income distribution in the world. Therefore, public health efforts to decrease health disparities should be addressed at an international level as well as within the United States (American Public Health Association, 2001; Bauer, 2000; Hawe & Shiell, 2000; Mathews, Manor & Power, 1999).

One of the public health goals in the United States is to decrease health disparities among diverse, at-risk and medically underserved populations. The Healthy People 2010 document cites eliminating health disparities as one of the primary health goals for the nation (U.S. Department of Health and Human Services, 2000a). In late 1999, the Institute of Medicine (IOM) released a document, titled The Unequal Burden of Cancer, which presents the status, issues, and recommendations regarding the unequal distribution of cancer in the population of the U.S. Despite scientific gains, not all segments of the population have benefited to the fullest extent from advances in the understanding of cancer, mainly among ethnic minority groups (IOM, 1999). Moreover, this unequal distribution of disease is experienced globally (Northridge & Wilcox, 2001).
Worldwide, cervical cancer is a public health problem, particularly in developing countries. Cervical cancer kills over 200,000 women in developing countries each year (National Cervical Cancer Coalition, 2001). The highest rates of cervical cancer are found in Central America, followed by sub-Saharan Africa. Panama is a small Central American country, both in size (75,517 km2) and in population (approximately 3.0 million inhabitants) (Contraloría General de la República, 2001) (Appendix A-World Facts and Map of Panama). Although Panama is a small country, it experiences one of the highest reported rates of cervical cancer in the world (72/100,000) (Reeves, Gary, Johnson, Icenogle, Brenes, de Britton, Dobbins, & Schmid, 1994; Reeves, Brinton, Brenes, Quiroz, Rawls, & De Britton, 1985). Within Panama, the incidence of cervical cancer in Herrera Province exceeds any other reported world rate (79/100,000) (Reeves, et al., 1985; Barés, 2001). Cancer continues to be the most common cause of death in Panama, cervical cancer being the first cause of cancer mortality among women (Contraloría General de la República, Dirección de Estadística y Censo, República de Panamá, 1997; Contraloría General de la República, Dirección de Estadística y Censo, República de Panamá, 1998; Contraloría General de la República, Dirección de Estadística y Censo, República de Panamá, 2001; Barés, 2001). During the first six months of 2004, the main cause of death reported at the National Oncology Institute in Panama continues to be cervical cancer (N=265). Breast cancer holds the second place in the list (N=242) (National Oncology Institute, 2004).

Several clinical and epidemiological studies on cervical cancer causation and risk factors were conducted in Panama during the 1980s and early 1990s under the auspices of the Centers for Disease Control and Prevention, the National Institutes of Health’s
National Cancer Institute and the National Cancer Institute of Canada. Results show that one of the main causal factors associated with cervical cancer is the human papillomavirus (HPV). In Panama, the incidence of HPV among the female population is 52% and most commonly found in working class (lower, middle, upper) Mestizo (people of mixed race in Latin America) women between 20-40 years of age (Veltmeyer & Petras, 1998). Several studies conducted in Panama found an association between HPV and cervical cancer (Garrido, 1996a; Garrido, 1996b; Reeves et al., 1994; De Britton, Hildesheim, De Lao, Brinton, Sathya, & Reeves, 1993; Acs, Hildesheim, Reeves, Brenes, Brinton, Lavery, de la Guardia, Godoy & Rawls, 1989; Garrido, 1988; Brenes, de Lao, Gomez & Reeves, 1988; Reeves, Caussy, Brinton, Brenes, Montalvan, Gomez, de Britton, Morice, Gaitan, de Lao, et al., 1987).

Some studies looked at probable causes for the high incidence of cervical cancer in Panama. Some of the causal factors associated with cervical cancer studied in Panama include: parity (De Britton et al., 1993; Brinton, Reeves, Brenes, Herrero, de Britton, Gaitan, Tenorio, Garcia & Rawls, 1989a); injectable contraceptives (Herrero, Brinton, Reeves, Brenes, de Britton, Tenorio & Gaitan, 1990a); oral contraceptives (Brinton, Reeves, Brenes, Herrero, de Britton, Gaitan, Tenorio, Garcia & Rawls, 1990a); combination of multiple risk factors (e.g., early age at first coitus, multiple pregnancies, non-participation in Pap smear screening programs and educational level) (Herrero, Brinton, Reeves, Brenes, Tenorio, de Britton, Gaitan, Montalvan, Garcia & Rawls, 1990b; Acs et al, 1989); herpes simplex virus type 2 (Rawls, Lavery, Marret, Clarke, Adam, Melnick, Best, Kraiselburd, Benedet, Brenes et al., 1986); and, cigarette smoking (Prakash, Reeves, Sisson, Brenes, Godoy, Bacchetti, de Britton, & Rawls, 1985).
In addition, different population subgroups were studied in Panama regarding HPV infection and cervical cancer. Some of the populations studied include: men (Brinton, Reeves, Brenes, Herrero, Gaitan, Tenorio, de Britton, Garcia, & Rawls, 1989b); prostitutes—housed in a specific location (Arosemena, Guerrero, Caussy, Cuevas, de Lao, & Reeves, 1988); and, bar girls, cabaret entertainers and streetwalkers (Reeves & Quiróz, 1987).

In a case control study of adult women under 70 years of age, 50% of cervical cancer cases and 29% of controls reported never having been screened (Herrero, Brinton, Reeves, Brenes, de Britton, Gaitán, & Tenorio, 1992). Preventive and screening services for cervical cancer that are adapted to regional (rural, urban) characteristics are recommended in Panama (Herrero et al., 1990b; Herrero et al., 1992). In addition, common structural denominators (e.g., screening, treatment) along with poverty and low socioeconomic status associated with cervical cancer risk factors in Panama and other Latin American countries are poorly understood (Herrero et al., 1990b).

A study conducted by Purnell (1999), the only social and behavioral study available in the literature regarding health education and promotion in Panama, focuses on development of effective and efficient health promotion interventions in Panama. Purnell (1999) recommends a thorough understanding of persons’ beliefs and values when planning health care and promotion interventions that are culturally acceptable, respectful and appropriate in this country. However, a dearth of information and literature exists regarding the social and behavioral aspects of cervical cancer in Panama.

Prevention and early detection of cervical cancer through screening efforts are effective tools to control this disease (Pan American Health Organization, 2001).
Preliminary data suggests that Panamanian women do not seek screening services even when these services are available (Calvo, 2001). This study attempted to address this issue and the existing lack of research and information by looking at the social construction of cervical cancer screening among Panamanian women. Through the study, an understanding of cervical cancer screening among Panamanian women was sought by using social constructionism as the theoretical framework and following a qualitative research approach. This study provided information on cervical cancer screening knowledge, sources of social influence, cultural beliefs and attitudes, experiences with cervical cancer screening, reasons for not screening, and reaction to local media information on cervical cancer. This study contributes the observation of construction of meaning among groups of women as they react to information on cervical cancer from local print media.

Global Aspects

Cervical cancer is the leading cause of cancer deaths among women in developing countries, and a study of global distribution may help define determinants of fatal cancers or at least suggest the right questions to ask (Basch, 1999). Globalization, economic, social and cultural aspects, communications, and travel, contribute to the evolution of multiculturalism and affect health care delivery systems worldwide (Briggance & Burke, 2002). “The world is getting smaller” (Petersen & Lupton, 1996, pg. 22). Events that occur in one part of the world have an impact in another, and our health is now connected to social processes occurring in areas remote from where we live (Petersen & Lupton, 1996). In the 21st century, an emphasis on public health efforts to improve health exists as they relate to closing the gap within and among countries (World Health Organization
Cross-national or transnational (international) studies of women’s health are recommended to support and understand women’s health status as a multidimensional concept (Williamson & Boehmner, 1997). Understanding the multidimensional aspects of diverse and minority women’s (e.g., Hispanics) health in the United States can be enhanced by studying the inception of these concepts (e.g., in Latin America).

Approximately 32.8 million Hispanics reside in the United States, representing 12% of the total population (U.S. Department of Commerce, Census Bureau, 2001). Hispanics are the fastest growing minority group in the U.S. (U.S. Department of Commerce, Census Bureau, 2001). Minority women, in general, experience a disproportionate high burden of cervical cancer (Giuliano, Papenfuss, Scheider, Nour & Hatch, 1999), and Hispanic women have the highest incidence of cervical cancer than any other racial or ethnic group in the United States (American Cancer Society, 2001).

Eight U.S. studies have simultaneously examined cervical cancer incidence in relation to social class and race/ethnicity; and all, except one, included only African-American and White Americans in the study (Krieger, Quesenberry, Peng, Hoen-Ross, Stewart, Brown, et al., 1999). Mass screening for cervical cancer has considerably reduced invasive cancer rates; however, Hispanic Americans have not benefited from these screenings (Howe, Delfino, Taylor, & Anton-Culver, 1998). In addition, new Hispanic immigrants are less likely to seek cervical cancer screening services, potentially due to low levels of acculturation, income and access (Lazcano-Ponce, Moss, Cruz-Valdés, de Ruiz, Cásares-Queralt, Martínez-León, & Hernández-Avila, 1999a). New immigrant women represent a diverse group who often face multiple cultural, linguistic and systemic barriers. More research is needed on the relevancy and applicability of
commonly used health promotion approaches to this group (Hyman & Guruge, 2002).
Since Panama has one of the highest recorded rates of cervical cancer in the world,
studying Panamanian women’s social construction of cervical cancer screening will offer
valuable information on the screening seeking behaviors of some Hispanic women
groups in the United States, mainly those with Caribbean influences. It is anticipated that
results from this study will provide information that will assist in development of
appropriate health education and service delivery interventions in Panama, other Latin
American countries and among Hispanic women in the United States. Ultimately, results
of this study will assist in guiding future research and practice to help decrease the
disproportionate burden of high morbidity and mortality due to cervical cancer among
Hispanic women.

Overview of the Panamanian Health Care System

Panama has a universal health care system. By means of La Caja de Seguro
Social or Social Security Fund as well as the Ministry of Health, comprehensive health
services are provided to the citizens of Panama. The mission of the Social Security Fund
is based on the principles of universality, solidarity, integrity and fairness with quality
and efficiency, within the framework of a philosophy of social enterprise. Although some
might debate that the mission of the Social Security Fund is not reached due to unstable
political, economic and social infrastructure, ultimately most Panamanians have access to
some form of health care (Caja del Seguro Social, 2000).

La Caja del Seguro Social or La Caja, as it is commonly called by Panamanians,
has a two-fold service delivery goal. First, it provides health care services to its
beneficiaries (all working men and women and their beneficiaries). Second, it provides
funding assistance for retired persons, disability recipients, maternity leave for new mothers, and other forms of financial support. *La Caja* was founded under President Dr. Arnulfo Arias Madrid through government legislature in March 1941. President Madrid’s vision was to mirror the German health care system, where he attended medical school, which offers universal coverage. One of the fundamental policies enacted, was the assistance to workers in relation to work-related accidents. Before this fund began, policies regarding benefits for workers, both in the public and private sector, were not guaranteed. Since 1941, these benefits have been guaranteed (Caja del Seguro Social, 2000).

The Panamanian Constitution declares that all Panamanians have the right to health care. The Constitution establishes that safeguarding the health of the Republic’s population is an essential function of the State. Since public health in Panama is regulated by the public sector, lower income Panamanians are eligible to receive health care provided to them by the government. It is estimated that 90% of health care delivery to the population is covered by *La Caja del Seguro Social* and another 40% by the Ministry of Health, so the services overlap. The Ministry of Health is the steering entity of the national health system and it formulates policy, regulates activity, and exercises the function of health authority (Pan American Health Organization, 2001). Services provided by the Social Security Fund include primary health care and prevention, and treatment, mostly trauma care. The Panamanian Ministry of Health also oversees health education and health promotion efforts at a national level. These two governmental agencies offer services free of charge or at very low cost. Hence, most Panamanians should have access to universal health care services and health education and promotion.
Panama’s national health plan recommends health education and promotion programs for specific demographic groups, and promotes individual responsibility for a better quality of life. The Panamanian national plan also calls for promoting health research and dissemination of scientific knowledge (PAHO, 1999a; PAHO, 1999b). Nonetheless, a gap in the literature exists where community-based research is used to determine screening barriers, racial, socioeconomic and cultural factors, and health education needs of Panamanians.

Theoretical Tenets

Social constructionism provided the theoretical framework for this study. Social constructionism refers to the ways people develop, through their experiences and social interactions, knowledge, attitudes, perceptions and behaviors about a topic, in this case cervical cancer screening (Loseke, 1999; Wood, Jewkes, & Abraham, 1997). An important component of social constructionism is the context of social problems and the premise that reality and the phenomena of daily life are socially constructed (Berger & Luckman, 1996; Brown, 1995).

Two constructs that are substantial in this theoretical framework are culture and society. Culture refers to the shared and learned knowledge, beliefs, values, attitudes and behaviors that people within a society share. Society consists of people bound together by social and cultural commonalities. A society also includes people within a geographical location that interact with each other guided by their culture (Loustauanau & Sobo, 1997). Culture is a pluralized concept; the social basis of health differs widely across groups, nations and continents (Morris, 2000).
Social constructionism facilitates our understanding of the process by which individuals attempt to adapt personal experiences to pre-existing cultural models, modify such models in the light of new information, and confront conflict in their own interpretations of illness (Mathews, Lannin, & Mitchell, 1994). Therefore, the purpose of the study was to understand Panamanian women’s construction of their beliefs, values, attitudes, meanings, and perceptions about cervical cancer screening based on their experiences with the healthcare system, social interactions and local media. This study differs from a knowledge, attitude and belief (KAB) study in that it focuses on the social influences and construction of the meaning of cervical cancer and cervical cancer screening rather than reporting on existing knowledge, attitudes and beliefs.

Preliminary data on professional aspects using key informant interviews were explored during the summer of 2001 (Calvo, 2001). Preliminary data suggests that Panamanian women tend to self-medicate, since many of the medications (e.g., antibiotics, analgesics, oral contraceptives, etc.) are available over the counter. Similarly, the use of religion and home remedies passed through generations or learned from the media are also practiced among women in Panama (Calvo, 2001). Preliminary data suggest a need to further explore sociocultural factors, such as folk knowledge and social influences, which affect cervical cancer screening among Panamanian women. This study focused on the socio-cultural aspects rather than structural aspects of health care.

Another factor to consider is folk medicine. Folk medicine refers to the “unofficial” non-Western medicine. According to Hufford (1992) and Loustaunau and Sobo (1997), people usually derive their attitudes, values, and decisions about medical care from folk medicine. Similarly, popular perceptions of medicine are important to
discuss. Popular and folk medicine derives from knowledge constructed through social networks, as well as, discourse and information provided through local media and social influences. Folk medicine, as seen in this study, is the practice of self-medication, vaginal cleansing and entire system of beliefs commonly observed in Panama. Panamanian women’s perceptions constructed from personal and community experience of the illness was determined through an ethnographic approach consisting of semi-structured individual and group interviews (Wood, et al., 1997).

Purpose of the Study

Cervical cancer is a disease that can be controlled through early detection (PAHO, 2001). As indicated in available literature regarding cervical cancer in Panama, this specific type of cancer is a public health problem and structural factors do not seem to be barriers to screening. Since structural factors (e.g., access, cost) do not seem to be fundamental factors deterring women from seeking screening services, therefore sociocultural factors were studied.

In general, biomedical or public health education messages in Latin America are not widely developed. This is also true for Panama. Individual and population approaches to health, such as prevention and early detection may assist in addressing the cervical cancer problem in Panama, which could be accomplished partially through health education and health promotion. Although several clinical and epidemiological studies have been conducted on cervical cancer and HPV in Panama, social and behavioral studies or health education interventions are not evident in the literature, in preliminary data, or in communications with key health personnel in Panama (Calvo, 2001).
Media (e.g., television, radio, newspapers, billboards, magazines, etc.) plays an important role in the construction of meanings in our daily lives and of popular beliefs about health (Lantz & Booth, 1998; Loseke, 1999). Media or mass media refers to the major channels of communication—self-contained audio, visual or print distribution systems that can simultaneously reach large numbers of people with the same message (Israel & Nagano, 1997). Young adults in developing countries are vulnerable to socio-cultural variables, such as social networks and media that shape their reproductive health practices (Israel & Nagano, 1997). Sources of information affect the use of cancer screening exams. People who use popular media as a primary source of health information are more likely to have heard of cancer screening procedures than those who rely exclusively on other sources (Meissner, Potosky, & Convissor, 1992).

News coverage can have a strong influence on how the public responds to social issues (Woodruff, 2001). Portrayal of cancer on popular media can affect behaviors and choices women make about their health, including screening practices (Lantz & Boothe, 1998). Alcalay and Mendoza (2000) conducted a study for the Pan-American Health Organization (PAHO), titled *A Comparative Study of Health-Related Messages in Latin America Media*. Results show that the majority of media messages in Panama (57.8%), Argentina (49.1%), Bolivia (72.4%), the Dominican Republic (57.6%), and Venezuela (59%) do not recommend healthy behaviors. And less than 0.2% of media offers female health programming. Nonetheless, health service utilization messages are highest in Panama (n=155), which account for 26.8% of health messages in the country.

The Panamanian National Secretariat for Science, Technology and Innovation (SENACYT) (2001) reports that Panamanians show interest with respect to science
information provided to them in the media. This report on the use of media in Panama shows that 86% of study participants watch television, 67% listen regularly to the radio, over 50% read the newspapers, 90% use the telephone, and 40% use computers. Regarding the use of print media and science information, 33% of respondents said that they read one or more science and technology related articles in the week preceding the survey. Thus, Panamanians obtain science-related information from local print media (e.g., local newspapers).

To develop culturally and socially relevant cancer control messages for women in Panama, an understanding of social construction of cervical cancer screening was proposed in this study. A worldview dichotomy of the medicocentric (medical model view) and the popular and folk view was evident from preliminary data (Calvo, 2001). Illness is culturally shaped in the sense that how we perceive, experience, and cope with disease is based on our explanations of sickness, explanations specific to the social positions we occupy, and systems of meaning we employ (Kleinman, 1975; Kleinman, Eisenberg, & Good, 1978). Individuals tend to adapt personal experiences to cultural models, modify the cultural models when exposed to new information and confront conflicts in their own interpretations of the meaning of illness (Mathews et al., 1994). Understanding the social construction of illness can contribute to the development and implementation of health policy by illuminating the effects of class, race, gender, language, technology, culture, political economy, institutional structure, and professional norms that constrain or influence the possibilities for intervention (Brown, 1995). Considering women’s social construction of cervical cancer screening could assist Panamanian and other Latin American health care officials and ultimately U.S. health
care providers in addressing the disproportionate burden of cervical cancer among Hispanic women and among nations by addressing behavior change within pre-existing understandings.

To effectively address these constructs, qualitative research methodologies were used following studies conducted in South Africa by Wood, Jewkes, and Abrahams (1997) and in eastern North Carolina by Mathews et al. (1994) on cervical and breast cancer, respectively. Working class single and married Mestizo women between the ages of 20-40 were interviewed, the highest risk group for cervical cancer (higher HPV rate, 52%). The dependent variables are regularly screened, not regularly screened and unscreened women. Individual and group interviews were conducted at different sites throughout Panama City, including women’s homes, clinics, health centers, restaurants and the local public university. All interviews were conducted in Spanish, tape-recorded, transcribed, coded using Ethnograph (Scolari, Sage Publications Software, 1997) and analyzed manually as well as through the coded transcripts. In this study, semi-structured individual interviews among 117 women in Panama City were conducted to gain an understanding of the meaning of cervical cancer screening and its relationship with family, religion, social influences, experiences with health care system and media. Individual interviews were led by a semi-structured interview guide. In selected interviews, free listing and pile sorting provided additional data on cultural domains, categorization and meanings of cervical screening or preventive behavior. Observations during four group (N=13) interviews provided insight to women’s reaction to local print media information on cervical cancer. Quantitative data were analyzed using the
statistical analysis software SPSS as well as the Microsoft Office Excel computer program.

Research Questions

Research objectives guided the research questions to explore how Panamanian women understand the meaning of cervical cancer and cervical cancer screening.

**Objective 1:** To understand the meaning of cancer, cervical cancer, and cervical cancer screening constructed by Panamanian women.

**Research Questions:**

a. How do women think about cervical cancer screening?

b. What are women’s perceptions about cervical cancer screening?

c. What factors encourage or deter (e.g., family, religion, culture, etc.) women from seeking screening services?

d. How do women perceive preventive care?

e. How do women perceive cancer?

f. What relationship, if any, do women make between sexuality, health and cervical cancer?

**Objective 2:** To understand social influence on Panamanian women regarding cervical cancer screening.

**Research Questions:**

a. What social norms affect women’s understanding of cervical cancer screening?

b. To what extent do others’ opinions influence women’s attitudes regarding cervical cancer screening?

c. Who or what influences women’s communications about health and medicine?
d. Whose opinions most highly influence women’s attitudes regarding cervical cancer screening?

**Objective 3:** To observe the impact of cervical cancer and cervical cancer screening information transmitted by local media.

**Research Questions:**

a. What are women’s perspectives about health information in the media?

b. How do women react to health information presented to them in local print media?

For future health education endeavors [not part of theoretical framework]:

**Objective 4:** To identify Panamanian women’s learning preferences of health messages.

a. Where do women receive their health information?

b. What information channels would be more engaging for women?

**Delimitations**

1. This study is limited to Panamanian Mestizo women who live in Panama City, Panama.

2. This study is also limited to women who have lived in Panama City, Panama all their lives.

3. This study includes Panamanian women from 20-40 years of age residing in Panama City, Panama.

4. This study is limited to working class (lower, middle, higher) Panamanian women in Panama City, Panama.

5. Only Panamanian women who voluntarily agreed to participate in this study were included.
Limitations

1. Women in the study are not representative of all women in urban areas of Panama or Latin America.

2. Results of the study might not be generalizable to all populations, nor to all Hispanic American women. Nonetheless, a theoretical framework can offer a platform for the generalization or transferability of information gained from qualitative data that can be applied to similar persons in similar situations (Grbich, 1999; Malterud, 2001; Morse, 1999). Ethnographic studies of cervical cancer beliefs among Latina women might be generalizable to other Latina women (Chavez, McMullin, Mishra, & Hubbell, 2001).

3. The study is based on self-reported data from Panamanian women included in the study.

4. Women who agreed to participate in the study may be different from Panamanian women who did not agree to participate in the study.

5. Women were recruited following a sample of convenience (grab sampling method) and snowball sampling.

6. Women who participated in interviews at clinic settings might be different from women who participate in interviews at home settings.
Definitions

1. **Acculturation**: giving up most traits of the original culture to adopt those traits of the dominant group (Locke, 1992).

2. **Categorizations**: names that we attach to objects in our world become labels for types of things or types of people; we see similarities among diversity. Categories and their contents are socially constructed (Loseke, 1999). Each culture establishes its own rules for placing boundaries around categories: thus what an individual knows (process of cognition) is influenced by what the individual is taught to filter out of what comes in through the senses (process of perception). These culturally defined boundaries on our cognitive capacities are set by the criterion of relative importance (Crane & Angrosino, 1984).

3. **Cultural Competence**: the ability of an individual to understand and respect values, attitudes, beliefs, and mores that differ across cultures, and to consider and respond appropriately to these differences in planning, implementing and evaluating programs and interventions (Joint Committee on Health Education and Promotion Terminology, 2001).

4. **Culture**: shared and learned knowledge, beliefs, attitudes and behaviors that people in a society or members of a group hold (Galanti, 1991; Loustaunau & Sobo, 1997).

5. **Disease**: abnormalities in the structure and function of body organs and systems; within the biomedical model, modern physicians diagnose and treat diseases (Kleinman et al., 1978).

6. **Illness**: experiences of devalued changes in states of being and in social function; the human experience of sickness (Kleinman et al., 1978).
7. *Matriarchal (matriarchate)*: a tradition in which community power lies with the eldest mother of a community. A social system in which the mother is the head of the family (American Heritage Dictionary of the English Language, 2004).

8. *Mestizo*: person of mixed race; particularly, in Mexico, Central and South America; a person of European (Spanish or Portuguese) and indigenous descent. Mestizos constitute a large part of the population in several Latin American countries (Columbia Encyclopedia, 2001; Veltmeyer & Petras, 1998).

9. *Social Construction*: influences of human interaction on development (construction) of meaning that affect knowledge, attitudes, values, and behaviors (Loustaunau & Sobo, 1997). Social forces shape or construct our perceptions of health, illness, and healing (Lupton, 1994). Constructionist perspectives encourage us to take words seriously because even the simplest words are categories for entire systems of meaning (Loseke, 1999).

10. *Social Structure*: organized patterns of relationships between individuals and groups within a society, which orders their behavior in a predictable fashion and influences their interactions (Loustaunau & Sobo, 1997).

11. *Values*: the things individuals hold as important, each culture promotes different values (e.g., money, freedom, independence, privacy, reputation, family) (Galanti, 1991).

12. *Worldview*: basic assumptions about the nature of reality, these become the foundation for all actions and interpretations. For example, religion largely defines the worldview of people who are devoutly religious (Galanti, 1991).
CHAPTER II-LITERATURE REVIEW

Chapter II offers information on current literature available regarding cervical cancer, cervical cancer screening, screening barriers and motivators, cervical cancer in Panama, the Panamanian health care system, culture and health, and Latinas and cervical cancer screening. In addition, social constructionism is presented as the theoretical tenet that drives this research study. Social constructionism helps support the application of qualitative research methods in the form of in-depth semi-structured and group interviews in the study. Although Hispanics in the United States and Latin America comprise a heterogeneous group, for the purposes of this study the terms Hispanic and Latino(a) will be used interchangeably in this proposal.

The implication that social constructionism shapes health care practices, in this instance cervical cancer screening, among women in Panama is a tenet that drives this research study. According to preliminary data (Calvo, 2001) and literature available, structural factors (e.g., cost, transportation, location) as related to access to screening services are favorable to Panamanian women. Nonetheless, socio-cultural construction coupled with scarcity of information available to Panamanian women, are factors that deter women from seeking screening services.

Studying social construction of cervical cancer screening in Panama is relevant to the United States due to the excess mortality due to cervical cancer experienced by Latino women in the U.S. (ACS, 2001). This study provides information on socio-cultural and cognitive factors that deter Hispanic/Latino women from seeking screening services
(Morris, 2000), and help learn health care and illness construction from women who experience one of the highest reported rates of cervical cancer in the world (Petersen & Benishek, 2001; Reeves et al., 1994). Exploring social constructionism among Panamanian women might assist public health practitioners and scholars who work with Hispanic women in addressing socio-cultural factors that deter women in similar situations from seeking cervical cancer screening services, even when available. In this manner, the burden of cervical cancer in Panama can be addressed through relevant interventions and future research studies. From a global perspective, health disparities regarding the unequal burden of cancer among ethnic minorities in the United States and other developed countries, namely Hispanics/Latinos in similar situations, can be addressed.

Globalization and Public Health

“It really boils down to this: That all life is interrelated. We are all caught in an inescapable network of mutuality, tied into a single garment of destiny. Whatever affects one directly, affects all indirectly.”

--Martin Luther King, Jr.

Globalization has forced North America to confront directly the problems of Latin America; it is also changing the nature of health challenges facing people all over the world (Frenk & Gómez-Dantes, 2002). The diversity of today’s multicultural society has encouraged governments to think about the needs and histories of their mixed populations (Bateman, 2002). Developed nations can gain significant benefits from participation in world health efforts (Fidler, 2001). Engagement in world health activities protects citizens, permits surveillance of disease threats, allows collaborative research and sustains expanding markets for trade (Howson, Fineberg, & Bloom, 1998). A world
health framework that encompasses an additional investment of $22 billion per year by 2007 for essential health services in low to middle income countries would yield $360 billion annually by 2020, and save 8 million lives per year 2010 (Sachs, 2001).

The process of increasing globalization is dominated by market influences that often have a negative effect on public health in less developed countries (Wilson, Cawthorne, Ford, & Aongsonwang, 1999). The globalization of public health poses problems to health, such as development of unforeseen chronic diseases due to behavior in developing countries, but also presents important opportunities for research (Cornia, 2001). Globalization has resulted in the need to emphasize transnational public health approaches, including transnational research, to take advantage of the positive aspects of global change and to minimize the negative ones (Yach & Bettcher, 1998). Research efforts attempt to bridge the gap between the world’s haves and have-nots and to instill a sense of social and environmental responsibility (World Economic Forum, 1999).

Dramatic changes in global social, political and environmental factors including accelerating growth in international travel, trade and commerce, and changes in environmental conditions and disease etiology, are creating areas of convergence and international interdependence in public health (Taylor, 1999). Further, a framework is needed to ensure that benefits of technological advances in the sciences, such as the Human Genome Project and chronic disease research, are available worldwide and used in a manner that will promote national and international health (Taylor, 1999). Researchers need to recognize interdependence and a global perspective where no issue will ever again be fully local (Huddleston, 2000) and the inequality of access to care needs to be addressed (Sitthi-Amorn, Somrongthong, & Janjaroen, 2001).
Bettcher and Lee (2002) propose a set of cognitive dimensions of globalization as it relates to public health. In this set, concerns in changes to the creation, exchange and application of knowledge, ideas, norms, beliefs, values, cultural identities and other thought processes are affected as a consequence of globalization. Information across national boundaries through mass media affects public health, mostly promoting unhealthy lifestyles (e.g., diet, smoking) and health seeking behaviors (Bettcher & Lee, 2002).

Doyal (2002) examines the effects of globalization in public health, namely on women’s health. A lack of research and international consensus exists regarding measures of women’s health and well-being. The author analyzes experiences of women in different social settings and concludes that gender and sex have formed women’s experiences worldwide in a manner which is hazardous to the health of this vulnerable population.

A context of consideration from Western nations helping poorer ones include encouraging research into the most efficient and effective ways of improving health; improving education, primary health, and health promotion; and, research from academic and other research institutions should focus on methods to achieve health improvements (Avery, Segall, Evans, Tandon, Murray, Lauer, & Bonneux, 2002). A need exists to recognize issues of interdependence that include whether wealthy nations spread the benefits and reduce the burdens of the modern world; on whether poor nations enact the changes necessary to make progress possible; and, on whether we all can develop a level of consciousness high enough to understand our obligations and responsibilities to each other (Smith & Richards, 2002). A health-centered process of globalization can be
achieved only by ensuring that the interests of developing countries and vulnerable populations are fully represented in international decision-making forums (Woodward, Drager, Beaglehole, & Lipson, 2001).

The Panamanian Health Care System

Within all the issues that traditionally affect public health in Latin America, Panama, in comparison, was historically influenced favorably by the construction of the Panama Canal undertaken by the U.S. government, which provided a legacy of health (Bock & Gans, 1993; Centers for Disease Control and Prevention (CDC), 1995; Schamel, Potter, & West, 2000). One of the aims during the construction of the Panama Canal was to protect workers against disease, particularly infectious diseases, such as, malaria and yellow fever. These types of communicable diseases had affected the completion of the construction of the Canal by the French before the U.S. government continued the construction efforts.

President Theodore Roosevelt appointed Colonel William Crawford Gorgas as Sanitary Officer for the Canal. Gorgas’ overarching goal was to eradicate mosquitoes and prevent them from breeding. At the time, doubts in the scientific community about mosquito transmittal of disease, including malaria, were common. Due to Gorgas’ efforts, it was determined that malaria indeed was transmitted by mosquitoes, providing a significant contribution to scientific knowledge at the time. Dr. Gorgas was later appointed Surgeon General of the United States. Between 1906 and 1914, the year the Panama Canal was completed, the number of malaria cases was reduced by 90% (CDC, 1995).
Panama is a relatively small country, with an area of 75,517 km² and is divided into 9 provinces, 67 districts or municipalities, 3 indigenous regions and 512 mayoral jurisdictions (Contraloria General de la Republica, 2001). According to the 2000 Panamanian National Population and Housing Census, the population consisting of approximately 2,839,177 inhabitants is made up of non-indigenous groups (91%), which include Hispanics mestizos (majority), descendants of African slaves, or African slaves from the West Indies. The remainder of the population is indigenous Native American (9%) (Contraloría General de la República, 2001).

PAHO reports that of the total $3,789 (U.S.) million in public expenditures in Panama in 1995, almost half was allocated to social services. Spending on health and education in Panama is equivalent to 12.8% of the Gross National Product (GNP), or approximately $317 per capita. In 1995, it was estimated that 40% of the population lived in poverty. From a public health perspective, health disparities are observed among the poorest sectors of a population, so this high percentage of poverty could perhaps be translated into adverse health effects for the population.

The leading causes of death are malignant tumors/cancer, accidental injuries and violence, cerebrovascular disease, myocardial infarction and other ischemic heart diseases, respectively (PAHO, 1996). So, we can observe a transition from the infectious communicable diseases to more chronic lifestyle related diseases, which mirrors the health status of industrialized countries.

Some of the current efforts set forth by the current Ministry of Health include: strengthening leadership of the Ministry; establishing environmental health programs, promoting health programs for specific demographic groups; strengthening societal
participation in health promotion; decentralization of the health care sector, among other policies (PAHO, 1996; Panamanian Ministry of Health, 2002).

Panama has a universal health care system. By means of the Caja de Seguro Social or Social Security Fund, comprehensive health services are provided to beneficiaries. The mission of the Social Security Fund is based on the principles of universality, solidarity, integrity and fairness with quality and efficiency, within the framework of a philosophy of social enterprise. Although some might debate that the mission of the Fund is not achieved due to volatile political, economic and social infrastructure, ultimately most Panamanians have access to some form of health care (Mayes, 2000).

The Caja de Seguro Social (La Caja) has a two-fold service delivery goal. First, it provides health care services to its beneficiaries. Second, it provides funding assistance for retired persons, disability recipients, maternity leave for new mothers, and other forms of financial support. President Madrid’s vision was to mirror the German health care system, where he attended medical school, which offers universal coverage. One of the fundamental policies enacted was the assistance to workers in relation to work related accidents. Before this fund began, policies regarding benefits to workers, both in the public and private sector, were not guaranteed.

Financial constraints faced by La Caja, include low sources of funds, increased number of unanticipated retirees and elimination of the thirteen-month segments (annual bonus payment of a month worth of salary—hence, the thirteenth month) as source of funding. So, in 1991, facing a probable complete elimination of the current system, then President Guillermo Endara Galimany influenced a change in policy. The new policy
stated that, as of 1995, the retirement age would increase by 2 years, to 57 years of age for women and to 62 years of age for men. In addition, two-percent of salary will be reimbursed every 12 months to persons after reaching retirement age. Recent directors of La Caja have vowed to increase technological advances, including computer networks, for administrative purposes and to increase quality of health care services provided to beneficiaries, by means of enhanced resources and scientific equipment (Caja de Seguro Social, 2000).

From a health standpoint, Panama is divided into 13 health regions (PAHO, 1998). Social policy management is the responsibility of the public institutions that are part of the social Cabinet of the Executive Branch (Ministry of Health, Ministry of Education, Ministry of Housing, Ministry of Labor, Ministry of Youth, Women, Childhood and the Family, Ministry of Public Works, and Ministry of Planning). Currently, health sector reform is underway. Three laws have facilitated the separation of functions, the strengthening of intrasectoral work, and community participation to constitute the legal framework for the sectoral reform (PAHO, 1998; Panamanian Ministry of Health, 2002).

A new model for family, community, and environmental care is planned, which includes classification by levels of care and implementation of a referral and back-referral system between the community level and the primary and secondary levels of care. A pilot of the model is currently being conducted in the San Miguelito (urban), Metropolitan (urban) and Coclé (rural) Health Regions. In these three health regions, implementation, responsibilities, competencies and resources are being transferred gradually and progressively. The Ministry of Health has been drawing management
agreements between the national and regional levels, and between regional and local levels. Accreditation of health facilities and quality assurance processes, including technology assessment and regulation of devices and equipment, is currently being designed. Although health sector reform is in its early stages, PAHO is conducting an evaluation at this time. In this manner, PAHO provides technical support to the Panamanian health care sector, while financial support is provided through loans from the World Bank and the Inter-American Development Bank (Echeverria-Cota, 1998; PAHO, 1998; Panamanian Ministry of Health, 2002).

In 1998, the World Bank approved a seventeen-year health services modernization project for Panama. The modernization project is funded in part by the World Bank ($4.3 million) and the Panamanian government ($1.43 million). The purpose of the project is the integration of the Ministry of Health and the Social Security Fund in key strategic areas. Integration of the two main service delivery institutions includes: the implementation of a national health plan and a national investment plan; implementation of a new primary health care model; and, the development and implementation of new management techniques and information systems at the central, regional and provider levels (Echeverria-Cota, 1998). Overall, the project aims at increasing the efficiency and effectiveness of the health system while achieving equity of access and utilization of health services for all population groups, particularly the poor (Echeverria-Cota, 1998).

Panama’s public health sector does not function in isolation from the rest of Central America. Within the framework of the Central American Health Initiative and the Fronteras Solidarias or Shared Borders Program, activities were developed to promote health and prevent diarrheal diseases, cholera, malaria, dengue and AIDS. These diseases
are infectious communicable diseases that can pass across countries’ borders; so international efforts to address these health issues exist (Sibrián & Aburto, 1992; Stanziola, Chong Ho, Ramirez, & Mulet Cerezo, 1993; Tejada del Cid, 1982).

In this same fashion, the Instituto de Nutrición de Centro América y Panamá (Institute of Nutrition of Central America and Panama-INCAP) was established in 1946 by the ministries of health from Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. The purpose of this institute is to conduct research regarding the public health nutritional problems affecting diverse populations in the region and to identify possible solutions. Since its inception, 77 clinical and epidemiological studies have been conducted in Panama (Stanziola, Chong Ho, Ramirez, & Mulet Cerezo, 1993). Nutrition is closely related to health, and within developing countries, nutrition efforts constitute a focal point (Insel, Turner, & Ross, 2002).

Cervical Cancer

*Cervical Cancer Epidemiology*

Cervical cancer is the most common type of cancer among women worldwide (Liu, Wang, Waterbor, Weiss, & Soong, 1998). Annually, there are approximately 466,000 new cases of cervical cancer globally, with 80% occurring in developing countries (John Hopkins PIEGO Corporation, Reproline, 2001; Muir, 1990; PAHO, 2001). Ninety-five percent of women in developing countries have no access to cervical cancer screening tests (Joseph, 1999). Cervical cancer is the leading cause of female cancer deaths in certain areas of Africa, Asia, and Latin America, killing approximately 231,000 women annually (Joseph, 1999; PAHO, 2001). Cervical cancer leads to about
100,000 potential years of life lost and an average of 23 years of life lost per death worldwide (Muir, 1990).

**Cervical Cancer, Human Papillomavirus, and Associated Risks**

Cervical cancer is a complex disease, which by its association with the human papillomavirus (HPV), has elicited research in a broad range of areas, such as diagnostic, clinical and behavioral studies (Crum, 2000). Cervical cancer is caused by a change in the cells that line the wall of the cervix—the lower part of the uterus. The cells follow normal development and gradually change to pre-cancerous cells, which appear as lesions on the cervical wall. The cells eventually become cancerous. Fortunately, in 50% of women with pre-cancerous lesions, the cells remain benign (pre-cancerous). Cervical cancer exhibits no symptoms in its early stages, for this reason, it is frequently not detected until it becomes severe (Muñoz & Bosch, 1997; Program for Appropriate Technology in Health (PATH), 2000; Pan American Health Organization (PAHO), 2001).

The most common risk factor associated with cervical cancer is sexual transmission of certain strains of the Human Papillomavirus (HPV) (Burk, 1999; Muñoz & Bosch, 1997; Pisani et al., 1999a; Pisani et al., 1999b; Robles 2000). HPV is responsible for *condyloma acuminata* and venereal flat warts, commonly referred to as genital warts (Fox, 1992). There are numerous types of HPV, all of which are referred to in a numerical typology (Fox, 1992). HPV 15 to HPV 20 are the HPV strains most commonly associated with cervical cancer, of these HPV 16 and 18 are the types most closely linked to cervical cancer (Anon, 1995; Crum, 2000; Ho, Bierman, Beardsley, Chang, & Burk, 1998; Fox, 1992; Robles, 2000; Woodman, Collins, Winter, Bailey, Ellis, Prior, Yates, Rollason, & Young, 2001).
HPV is an etiologic agent of cervical cancer and the most common sexually transmitted infection (STI) in women, which may or may not present symptoms; hence, the infection can be asymptomatic and undetected for long periods (Cuzick, 2000; Muñoz & Bosch, 1997; Qu, Jiang, Cruz, Chang, Ho, Klein, & Burk, 1997). HPV has been clearly established as the primary cause of cervical cancer in nearly all cases, found in at least 93% of invasive cervical cancers worldwide (Cuzick, 2000; Walboomers, Jacobs, Manos, Bosch, Kummer, Shah, Snijders, Peto, Meijer, & Muñoz, 1999). Walboomers et al. (1999) concluded that the worldwide HPV prevalence in cervical carcinoma is 99.7 percent. This is also the current percentage officially reported by international organizations (JHPIEGO Corporation, Reproline, 2001)

Bosch et al. (1995) conducted a study attempting to ascertain the prevalence and type of HPV associated with cervical cancer worldwide. The study confirmed an extensive, global association between human papillomavirus infection and cervical cancer. Researchers in the study collected more than 1,000 specimens from cervical cancer patients in 22 countries with recorded high incidence of cervical cancer. Results show that HPV 16 was present in 50 percent and HPV 18 was present in 14 percent of all specimens. Thus, once again ascertaining the relationship between HPV, mostly types 16 and 18, and cervical cancer.

Factors that increase HPV prevalence include: never been married, divorced, or separated status; more than three lifetime sexual partners; more than one partner in the previous year; cigarette smoking; and, current use of oral contraceptives (Brinton, 1992; Sellors, Mahony et al., 2000; World Health Organization, 1985). In addition to HPV, other risk factors associated with cervical cancer are summarized in Table 1.
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Initiation of sexual relations at a young age</td>
</tr>
<tr>
<td></td>
<td>Age group: ages 25-60 are at higher risk</td>
</tr>
<tr>
<td></td>
<td>Risk increases with age</td>
</tr>
<tr>
<td>Behavior</td>
<td>Not having regular screening</td>
</tr>
<tr>
<td></td>
<td>Having multiple sexual partners, or having sex with someone who has multiple partners</td>
</tr>
<tr>
<td></td>
<td>Smoking</td>
</tr>
<tr>
<td></td>
<td>Use of oral contraceptives</td>
</tr>
<tr>
<td></td>
<td>Nutritional deficiencies</td>
</tr>
<tr>
<td>Ethnicity/Race (in the U.S.)</td>
<td>Being African American, Hispanic, or American Indian</td>
</tr>
<tr>
<td>Genetics</td>
<td>Family history of cervical cancer</td>
</tr>
<tr>
<td>Sexually Transmitted Infections (STI) or other Diseases</td>
<td>HPV infection</td>
</tr>
<tr>
<td></td>
<td>Exposure to other sexually transmitted infections (STI), e.g., herpes simplex virus type II</td>
</tr>
<tr>
<td></td>
<td>Being HIV positive-weakens a woman’s immune system and increases vulnerability to HPV infection</td>
</tr>
<tr>
<td>Socio-Economic Status (SES)</td>
<td>Lack of access to health care</td>
</tr>
<tr>
<td></td>
<td>Low income and educational levels</td>
</tr>
</tbody>
</table>

Sources: Crum, 2000; Fox, 1992; Lawson, Kenson, Bobo & Kaeser, 2000; PAHO, 2001.

Cervical cancer is considered one of the most detectable and preventable forms of cancer because, in general, it develops gradually. Hence, regular screening increases the likelihood of detection and treatment before the disease spreads. In addition, cervical cancer can be diagnosed easily due to its visibility (Brown, 1996; Fox, 1992). Other forms of cancer, such as breast or prostate cancers, are observed through special equipment (e.g., mammogram) or tests (e.g., Prostate Specific Antigen-PSA). In contrast, a gynecologist can observe cervical cancer cells under a microscope without the need for expensive technology (PAHO, 2001). Hence, it is a fairly simple disease to diagnose.
Cervical Cancer in Latin America and the Caribbean

Developing countries experience a disproportionate impact of cancer (Jones, 1999). Scarce resources, limited infrastructure and competing health priorities prevent most developing countries’ health systems from implementing successful programs (Bishop et al., 1995). Lack of access to adequate screening and treatment services indicate that one of the most easily preventable, detectable, and treatable forms of cancer has become a significant cause of mortality among women, especially poor women (PAHO, 2001).

In 1990, more than 371,000 new cases of cervical cancer were identified among women worldwide. Nearly 290,000 of these cases are estimated to have occurred in developing countries (Parkin, et al., 1999). The highest age-standardized incidences of cervical cancer in 1990 were reported in southern Africa, Central America, and Melanesia, where the rates were over 40 per 100,000 women. Rates of more than 30 per 100,000 were reported in eastern Africa, the Caribbean and tropical South America (Parkin, et al., 1999). Further, an estimated 470,606 incident cases and 233,372 deaths due to malignant neoplasm of the cervix occurred among women globally in the year 2000 (Globocan, 2000). At the turn of the twenty-first century, cervical cancer remains a significant public health problem in Latin America and the Caribbean (PAHO, 2002a), where nearly 200 women are diagnosed with cervical cancer every day (Robles, 2000) and 25,000 die annually (PAHO, 2002b).

Although cervical cancer in Canada, the United States and other established market economies has declined over the last forty years, mainly due to the introduction of the Pap test, most Latin American and Caribbean countries with available data,
experience constant or increasing levels of cervical cancer morbidity and mortality (PAHO, 2002a; Robles et al., 1996). For example, cancer registries in Costa Rica, Colombia, Perú and Brazil consistently report high annual age-standardized incidence rates in excess of 20.0 cases per 100,000 women between 1978 and 1992 (PAHO, 2002a). Cervical cancer remains the largest cause of cancer death among women in developing countries with an estimated 77,291 cases and 30,570 deaths as of 2001 (PAHO, 2002a; Pisani et al., 1999a; Pisani et al., 1999b). A comparative view of cervical cancer incidence and mortality rates by region reveals that Latin America and the Caribbean are surpassed only by East Africa and Melanesia. Within Latin America, Central America has the highest incidence rate (Table 2).

<table>
<thead>
<tr>
<th>Region</th>
<th>Incidence Rate</th>
<th>Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Africa</td>
<td>44.32</td>
<td>24.24</td>
</tr>
<tr>
<td>Middle Africa</td>
<td>25.08</td>
<td>14.16</td>
</tr>
<tr>
<td>Northern Africa</td>
<td>16.77</td>
<td>9.08</td>
</tr>
<tr>
<td>Southern Africa</td>
<td>30.32</td>
<td>16.45</td>
</tr>
<tr>
<td>Western Africa</td>
<td>20.28</td>
<td>10.87</td>
</tr>
<tr>
<td>Caribbean</td>
<td>35.78</td>
<td>16.84</td>
</tr>
<tr>
<td>Central America</td>
<td>40.28</td>
<td>17.03</td>
</tr>
<tr>
<td>South America</td>
<td>30.92</td>
<td>11.97</td>
</tr>
<tr>
<td>North America</td>
<td>7.88</td>
<td>3.23</td>
</tr>
<tr>
<td>Eastern Asia</td>
<td>6.44</td>
<td>3.19</td>
</tr>
<tr>
<td>S. Eastern Asia</td>
<td>18.26</td>
<td>9.65</td>
</tr>
<tr>
<td>S. Central Asia</td>
<td>26.47</td>
<td>14.95</td>
</tr>
<tr>
<td>Western Asia</td>
<td>4.77</td>
<td>2.50</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>16.81</td>
<td>6.20</td>
</tr>
<tr>
<td>North Europe</td>
<td>9.84</td>
<td>4.00</td>
</tr>
<tr>
<td>South Europe</td>
<td>10.18</td>
<td>3.25</td>
</tr>
<tr>
<td>Western Europe</td>
<td>10.43</td>
<td>3.74</td>
</tr>
<tr>
<td>Australia</td>
<td>7.72</td>
<td>2.66</td>
</tr>
<tr>
<td>Melanesia</td>
<td>43.81</td>
<td>23.78</td>
</tr>
<tr>
<td>Micronesia</td>
<td>12.31</td>
<td>6.16</td>
</tr>
<tr>
<td>Polynesia</td>
<td>28.98</td>
<td>15.20</td>
</tr>
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</table>
Some data are available for specific countries in Latin America and the Caribbean, but data are not widely accessible. Among the data available, the incidence rates for selected countries include: Brazil (37.1); Colombia (34.4); Costa Rica (24.5); Perú (53.5); and Puerto Rico (9.8) (1988-1992, age standardized per 100,000 population) (PAHO, 2002a). Mortality rates are more scarcely available in selected countries. Some mortality rates available, include: El Salvador (11.65); Mexico (8.52); and, Nicaragua (11.73) (1999, age standardized mortality rate per 100,000 population) (PAHO, 2002c). Nonetheless, these are higher rates than those experienced by developed countries of the industrialized world.

Further, human papillomavirus (HPV) represents an increased risk factor for cervical cancer in Latin America. In Mexico, Hernández-Acial et al. (1997) determined that HPV, types 16 and 18, are associated with cervical cancer in that country. In Brazil, Roteli-Martins et al. (1998) found that both smoking and HPV were significantly associated with cervical cancer among Brazilian women. In Costa Rica, a large population-based randomized study (N=11,742) determined that a majority of women with cervical cancer had been infected with HPV 16/18 (Schiffman, Herrero, Hildesheim, Sherman, Bratti, Wacholder, Alfaro, Hutchinson, Morales, Greenberg, & Lorincz, 2000).

Screening services in Latin America are linked to family planning and prenatal care services, usually offered to women under 30 years of age, and have not appropriately targeted other women at-risk (PAHO, 2002a; Robles et al., 1996). For example, mortality data indicates that women between 35 and 54 years of age, repeatedly account for the greatest proportion of annual deaths (PAHO, 2002a) with 60% of invasive cases
occurring among women under the age of 60 (PAHO, 2002b). Although still under research, it is suggested that development of vaccines and low-technology approaches for detection offer the best promise for controlling cervical cancer in the developing world (Coursaget & Muñóz, 1999; Duggan-Keen et al., 1998; Galloway, 1998; Jones, 1999).

Schiffman et al., (2000) suggests that HPV screening is an effective tool to detect cervical cancer early in Latin America. However, cervical cancer screening in Latin America is purely opportunistic and not within an organized program including quality control, follow-up and treatment (Robles, 2000). In 1986, the World Health Organization (WHO) recommended that women in developing countries, where infrastructure for regular screening and follow-up is not available, be screened at least once during their lifetime. Following the WHO recommendation, Sherlaw-Johnson et al. (1997) concluded that blanket screening for women 30-59 years of age, with the aim of screening all women once in their lifetime, could reduce the incidence of invasive cancer by up to 30 percent.

During the last two decades, cervical cancer represents an appreciable public health problem in Mexico. Cervical cancer is the most frequently found cancer in the country and it is also responsible for approximately 36% of cases of all types of cancers among women (Escandón-Romero, Benítez-Martínez, Navarrete-Espinosa, Vázquez-Martínez, Martínez-Montañez, & Escobedo-De La Peña, 1992; Cortés Gutiérrez, Leal Elizondo & Leal Garza, 2000). A total of 3,711 annual cases of cervical cancer are recorded in the Federal District (Mexico City) and 1,093 in the state of Nuevo León, occupying first and second place in number of annual cases, respectively (Gutiérrez et al., 2000). In a case-control study conducted by Hernández-Avila et al. (1998) in Mexico, the
authors concluded that women with cervical cancer in Mexico seek Papanicolaou testing only if they have symptoms. Moreover, Lazcano-Ponce (1999a) reported that low Pap quality, women screening only if symptomatic, preference for female providers, perception that public services are impersonal and lack privacy, and women’s apprehension about disapproval from their sexual partners for seeking testing are factors that augment the cervical cancer problem in Mexico. In addition, the same author confirmed in 1997 that low coverage of screening programs is an important problem in Mexico (Lazcano Ponce et al., 1997).

In Chile, cervical cancer is one of the leading causes of mortality in women over the age of 35. Public health efforts to control cervical cancer began in Chile in the 1960s; but it was not until the 1990s that a coordinated program with monitoring and evaluation began. Similarly, cervical cancer remains a serious health problem in Colombia and Costa Rica. Despite efforts to increase accessibility to screening, social, and cultural issues need to be addressed in local and medical communities to influence program success (Salmerón-Castro, Franco-Marina, Salazar-Martínes, Lazcano-Ponce, 1997). Although a need for socio-cultural research regarding cervical cancer is evident, most of the research conducted in these and other Latin American countries has been of a clinical or epidemiological nature (PATH, 2000; Salmerón-Castro, et al., 1997).

A case control study conducted in Costa Rica identified the following risk factors: number of sexual partners; age at first sexual intercourse; number of live births; presence of type 16/18 human papillomavirus DNA; sexually transmitted infections; Pap smear history; and, socioeconomic status. The authors conclude that although screening quality might play a factor in cervical cancer incidence, the observed issues reflect behavioral
more than screening factors (Herrero, Brinton, Hartge, Reeves, Brenes, Urcuyo, Pacheco, Fuster, & Sierra, 1993).

Male behavior was also addressed to determine if it affects the etiology of invasive cervical cancer. In a case-control study among adult husbands of cervical cancer patients and controls conducted in Panama, Costa Rica, Colombia and Mexico, HPV infection in men with multiple sexual partners were compared to those who reported one lifetime sexual partner. Results determined the need for further behavioral studies regarding health behavior, including genital hygiene among men (Brinton, Reeves, Brenes, Herrero, Gaitán, Tenorio, de Britton, García, & Rawls, 1989).

Current literature shows a dearth of qualitative studies exploring social and behavioral aspects (e.g., knowledge, attitudes, beliefs, perceptions, etc.) of cervical cancer in Latin America. Mexico is the source of some of the research found in this area. Lazcano-Ponce et al. (1999b) conducted four focus groups to identify certain barriers to early detection of cervical cancer in Mexico. Among the barriers identified were: lack of knowledge about cervical cancer etiology; lack of information on the Pap test; perception that cancer is an inevitably fatal disease; problems with client-provider relationships; giving priority to unmet needs related to extreme poverty; opposition by male sexual partner; rejection of the pelvic examination; long waits for sample collection and results; and, perceived high cost of care. In addition, the author identified the following communication strategies to promote the Pap test in Mexico: promotion during contacts between health personnel and women; distribution of information by radio, posters, and pamphlets; promotion through community groups; and, incorporating promotion of cervical cancer prevention into existing health programs. Similarly, PAHO (2001)
recommends that a new approach emphasizing prevention and positive aspects of screening and early detection accompanied with a gender-focused analysis (e.g., understanding a woman’s place in society) of the situation is necessary to fully understand the incidence of cervical cancer in the Americas. Nonetheless, proposed solutions should fit in with individual social realities and public health capabilities (Robles, 2000).

Although PAHO (2001) identified prevention as the best tool in the fight against cancer in Latin America, important challenges to accomplish prevention are also identified. Such challenges include: lack of access to free or affordable health services to poor and rural women; children’s health is a priority to women, over their own health; fear of male partner, who may refuse to allow gynecological visits; lack of women’s control over their own sexual relations in some societies; negative experiences with physicians or health workers; linking screening programs to family planning programs reaching women under 30 years of age; and, lack of information about screening and fear of results. The present study explores some of these challenges among women in Panama. Robles (2000) understands that development of cervical cancer prevention programs in Latin America do not occur in a vacuum, they evolve and are reflected in social constructs that influence the success of programs. These findings can assist researchers in Latin America and researchers in the United States working with new Hispanic immigrants in similar situations.

Screening and Cervical Cancer Control

Cervical cancer is described as an ideal disease for which to implement mass population-based screening. A prolonged asymptomatic phase permits early detection of
pre-invasive disease that is potentially 100% curable, making invasive cervical cancer theoretically a completely preventable disease (Brown, 1996). Morbidity and mortality rates of cervical cancer have decreased in the United States in recent decades due, in part, to widespread cervical cancer screening and successful treatment of cervical abnormalities (Fox, 1992; Lawson et al., 2000). Studies conducted in Europe and Canada indicate that screening for cervical cancer can decrease the incidence and mortality due to cervical cancer by as much as 60%-90% (Brown, 1996; Eddy, 1990). To illustrate, cervical cancer used to be one of the most common causes of cancer death for women in the United States. Between 1955 and 1992 mortality due to cervical cancer declined by 74% mostly due to the use of the Pap test for screening (ACS, 2000).

Prevention and early detection are effective tools to control cervical cancer morbidity and mortality (PAHO, 2001a; PAHO, 2001a). Eradication of HPV by vaccination is gaining ground as an effective manner to control cervical cancer (Cuzick, 2000; Galloway, 1998). However, technical and practical issues remain before a safe, effective, inexpensive HPV vaccine can be produced for mass use (Coursaget & Muñoz, 1999). Furthermore, testing for HPV in addition to or instead of cervical cytology (Papanicolaou/Pap Test) is also recommended as a control measure (Bollen et al., 1997; Cuzick, 2000; Kiviat, Koutsky, Critchlow, Galloway, Vernon, Peterson McElhose, Pendras, Stevens & Holmes, 1990; Lowy & Schiller, 1998; Walboomers et al., 1999). HPV-positive women are at significantly greater risk than HPV-negative women for developing cervical neoplasia (cervical cancer); this test remains the most sensitive (Crum, 1998; Crum, 2000), but is highly dependent on the existing health care infrastructure (Cuzick, 2000). Hillemanns et al. (1999) found that self-sampling for HPV
in Germany is a reliable, useful and satisfactory method for HPV screening. The vinegar test (acetic acid) is another option, which has been suggested for use in developing countries; it is a cost effective and efficient test that can be performed easily by midwives (Joseph, 1999). Nonetheless, HPV and vinegar testing as alternatives to the Pap test remain in controversy (Crum, 2000).

Optimal delivery of the Papanicolaou (Pap) to at-risk women is the most widely supported and recommended form of cervical cancer screening today (Casper & Clarke, 1998; Crum, 2000; Jennings-Dozier & Lawrence, 2000). The incidence and mortality for invasive cervical cancer in the United States declined steadily since the introduction of the Pap smear for screening in 1945 (Brown, 1996; Lawson, et al., 2000). However, the rate of decline in invasive cervical cancer slowed since the early 1980s in the United States and appears to have stabilized in recent years (Lawson et al., 2000). Effective control of cervical cancer depends primarily on early detection of precancerous lesions through the use of Papanicolaou screening, followed by timely evaluation and treatment (Lawson et al., 2000).

The American Cancer Society (2000) determined that the 5-year survival rate for early invasive cancer of the cervix is 91%. The overall 5-year survival rate, for all stages combined, is about 70%. For pre-invasive cervical cancer, the 5-year survival rate is nearly 100%. Thus, early detection of cervical cancer could help decrease mortality due to this treatable disease (De Britton, 1980).

The cost of early detection is also lower than treatment of the disease. It costs approximately $100 U.S. dollars to screen a woman for cervical cancer every five years.
In comparison, it costs approximately $2,600 dollars to treat a woman with cervical cancer (Program for Appropriate Technology in Health-PATH, 2000).

Prevention of cervical cancer through health education and screening are recommended as effective control interventions. This includes education on the use of barrier type methods of contraception (e.g., latex prophylactic/condom use) and following screening guidelines. The American College of Obstetricians and Gynecologists (Fox, 1992; Schiffman, Brinton, Devesa & Fraumeni, 1996), the American Cancer Society (2001), and the National Cancer Institute (2001) recommend annual Pap smears beginning at the time of sexual activity is initiated or at age 18, and continuing throughout the woman’s life. Early detection by Pap smears prevents at least 70% of potential cervical cancers (Alexander, LaRosa, & Bader, 2001). Community interventions, where inclusion of the intended audience along with community partnerships as central points of the educational program, are effective and efficient manners to develop relevant cervical cancer control endeavors (Busch, Wooldriege, Foster, Shaw & Brown, 1999; Kretzmann & Mcknight, 1993; Mamon, Shediaic, Crosby, Celentano, Sanders & Matanoski, 1991; Meade & Calvo, 2001). Increased effort is needed in the U.S. to purposely focus on groups with large proportions of unscreened or rarely screened women, including women residing in rural areas; minorities (African-, Hispanic-, Asian- and Native-American); and, recent immigrants who have different attitudes, knowledge, and behaviors regarding disease prevention and health promotion (Lawson et al., 2000). Screening for cervical cancer among these groups of women could further reduce the unequal burden of disease due to cervical cancer. Cervical cancer
continues to be a major public health problem worldwide and control measures can assist in reducing morbidity and mortality associated with this disease (Lawson et al., 2000).

Cervical Cancer in Panama

Panama has an effective public health system, which operates hospitals and clinics in every province, even in isolated rural communities, since the 1960s (Britton, Reeves, Valdes, Joplin & Brenes, 1980; Escala, 2000; PAHO, 1999a; Panamanian Ministry of Health, 2002). Currently, there is approximately one physician per 790 persons and one nurse per 869 persons in Panama. In Panama City, this number is reduced to 547 persons for each physician and 661 per nurse (Contraloría General de la República, 2001). Consequently, classic infectious diseases and infant and maternal mortality have been reduced dramatically. Nonetheless, cancer remains among the three leading causes of death since 1968 (Britton et al., 1980; Contraloría General de la República, 2001). In 1974, the National Oncology Institute (Instituto Oncológico Nacional) of Panama began a cancer registry. Since then, it has been clear that cervical cancer is overwhelmingly the most frequent form of cancer in Panama and the age adjusted cervical cancer incidence is among the highest reported in the world (Britton et al., 1980; Contraloría General de la República, 2001).

Notwithstanding appreciable modernization in delivery of public services, including education and health services, health concerns continue to be observed in Panama. Problems remain regarding inequity of access to health services and disparities concerning quality of life relate to poverty, socioeconomic and structural issues regarding the Panamanian economy (Panamanian Ministry of Health, 2002). Although some economically disadvantaged groups face the burden of infectious diseases, chronic
diseases represent the predominant health problems in Panama. These chronic problems
are mostly associated with behavior and lifestyles, along with environmental and
modernization aspects of the country (Panamanian Ministry of Health, 2002). Previous
studies have linked modernization to cancer and other chronic disease (Goyan Kittler &
Sucher, 2001).

Chronic and lifestyle associated diseases are currently the number one cause of
death in Panama. Within chronic diseases, cancer represents the most common cause of
death (1,796;15.6 per 100,000 for all types of cancer). Malignant tumors are followed by
accidents, unintentional injuries and other violent injuries (1,401;12.9 per 100,000) as the
second cause of death. Cerebrovascular diseases (e.g., stroke) (1,193;11.0 per 100,000)
and cardiovascular disease (1,081;9.9 per 100,000) are the third and fourth leading causes
of death, respectively (Contraloría General de la República, 2001).

Since the early 1980s international attention has focused on the high incidence
and mortality due to cervical cancer in Panama. This international interest began when
researchers determined that women from the Herrera province in Panama presented the
highest reported age adjusted annual incidence rate (79/100,000) of cervical cancer in the
world (Reeves, Valdes, Brenes, de Britton, & Joplin, 1982; Reeves, Brenes, de Britton,
Valdes, & Joplin, 1984; Reeves et al., 1985). Several epidemiological and clinical studies
were conducted in Panama in the 1980s and early 1990s regarding cervical cancer by a
group of researchers funded by the Centers for Disease Control and Prevention, the U.S.
National Institutes of Health-National Cancer Institute and the National Cancer Institute
of Canada (Acs, et al., 1989; Brenes et al., 1988; De Britton, et al., 1993; Garrido, 1988;
Garrido, 1996a; Garrido, 1996b; Prakash, Sisson, Godoy, Rawls, Reeves, Brenes,
Bachetti & Britton, 1985; Reeves et al., 1987; Reeves, Brinton, García, Brenes, Herrero, Gaitán, Tenorio, De Britton, & Rawls, 1989; Reeves et al., 1994). Today, cervical cancer continues to be the number one cause of death among women, reaching rates of up to 72 per 100,000 for women over 15 years of age (Contraloría General de la República, 2001; Escala, 2000).

Human papillomavirus (HPV) is also a strong causal factor associated with cervical cancer in Panama (Britton, et al., 1980; Escala, 2000; Prakash, et al., 1985; Reeves, et al., 1989). It is estimated that over 50% of the population is infected with HPV types 16 and 18 (Reeves et al., 1989). Several studies have identified the following risk factors for HPV infection and cervical cancer among Panamanian women: number of sexual partners (4 or more); use of oral contraceptives; deficient sexual hygiene of partner; high risk partner (promiscuous male partner); parity (number of live births); age at first intercourse (under age 16); previous sexually transmitted infection (e.g., herpes simplex type 2); history of abortion; nutrition (e.g., low vitamins A & C, carotenoids, fruits and vegetables); and, smoking (De Leon, Kant, & Navarro, 1995; Herrero, Potischman, Brinton, Reeves, Brenes, Tenorio, de Britton, & Gaitán, 1991; Prakash et al., 1985; Reeves et al., 1985).

Reeves et al. (1985) found that women with cervical cancer in Panama are more likely to be under 40 years of age, mestizo (mixed European and Indian ethnicity), have monthly income of $200 or less, have an elementary school education, and reside in urban areas (even if they are originally from rural areas). This group of researchers also theorizes that Panamanian women initiate stable sexual relationships at a young age and that those who have multiple partners have serial monogamous relationships. Similarly,
male associated risk factors coupled with low socioeconomic status increase the occurrence of cervical cancer in Latin America (Skegg, Corwin, Paul, & Doll, 1982; Reeves et al., 1985).

Literature and preliminary data suggest that researchers and health care practitioners in Panama agree that early detection through regular screening would enhance cervical cancer control (De Britton, 1980; Brinton et al., 1980; Calvo, 2001; Panamanian Ministry of Health, 2002). From a structural perspective, access to screening (by cost and geographical location) is available to women, as shown in Table 3.

<table>
<thead>
<tr>
<th>Location</th>
<th>Cost</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Fund hospitals and clinics</td>
<td>Free of charge</td>
<td>Available free of charge in all areas of the country, including rural communities.</td>
</tr>
<tr>
<td>Public health centers, Ministry of Health</td>
<td>$0.50 cents for the gynecological visit</td>
<td>Patient purchases the speculum herself at the health center. Service available in all areas of the country.</td>
</tr>
<tr>
<td>Asociación de Planificación Familiar (APLADA)—Association for Family Planning</td>
<td>$14.00 donation</td>
<td>A donation is recommended, but it is offered at lower cost according to monthly salary. Available in Panama City.</td>
</tr>
<tr>
<td>Private health insurance—HNA Panama, S.A.*</td>
<td>50% Co-Pay for annual Pap test</td>
<td>Only one private insurance company offers coverage of screening services. The cost of premium varies, but on average it is approximately $34/month.</td>
</tr>
<tr>
<td>Out of pocket, private physician</td>
<td>$10-$15</td>
<td>The amount varies according to the lab where the sample is sent. Available in all areas of the country.</td>
</tr>
</tbody>
</table>

(Source: Calvo, 2001; Ceniceros, 2000)

HNA Panama S.A. administers a self-funded health care plan financed by the U.S. government for 23,000 individuals, most of whom are retirees of the Panama Canal and their beneficiaries. HNA is a joint venture of Health Network America based in West
Long Branch, New Jersey and the Panamanian health insurer *International de Seguros.* The company imported certain U.S. managed care tools such as the concept of a primary care physician and emphasis on health improvements (quality of care and of lifestyle) along with cost reductions (Ceniceros, 2000).

Other structural factors to consider are transportation and childcare. Studies among high cancer risk populations observe the importance of these two structural factors when seeking screening services. Panama offers affordable ($0.25 cents for a bus ride and $1.00-$1.25 for a taxi ride) and practical transportation. Transportation access to hospitals and clinics is readily available. It is an accepted practice that women bring their children to doctors’ visits or have a family member or friend help with child care. Hence, transportation and child care should not act as barriers to care in Panama. Nevertheless, socio-cultural factors might act as barriers to cervical cancer screening in Panama (Calvo, 2001) and it is the intent of this study to explore the social construction of these factors. Similarly, lack of an organized national culturally relevant health education campaign to address the problem of cervical cancer might also be a factor to explore in future studies.

*Cervical Cancer Screening among Latinas*

Cervical cancer is a curable disease if diagnosed and treated early (Ries, Hankey, & Edwards, 1990). Improved screening and early detection could increase survival rates and lower mortality rates (Harlan, Bernstein, Kessler, 1991; Hiatt, 1997). Hispanic women are less likely to seek a Pap test (Harlan et al., 1991; Suarez, Goldman, & Weiss, 1995). Research suggests that a decreased rate of early detection results in delays in cervical cancer treatment and poor prognoses among Latinas (Frank-Stromborg, Wassner, Nelson, Chilton, & Wholeben, 1998).
Several factors deter and motivate Hispanic women from seeking cervical cancer early detection and screening services. Latinas face economic, institutional, social, and cultural factors that affect access to health care (Ramirez, McAlister, Gallion, & Villarreal, 1995; Salazar, 1996). Hispanic women are less likely to get a Pap test and less likely to receive information about cancer screening and warning signs (Elder, Castro, De Moor, Mayer, Candelaria, Campbell, Talavera, & Ware, 1991). Latinas present more misconceptions about causes of cancer and the effectiveness of treatment than other ethnic groups (Balcazar, Castro, & Krull, 1995). In addition, Hispanic women who subjectively and cognitively feel healthy and have no evidence of illness according to their cultural health beliefs are unlikely to seek cancer screening services (Borrayo & Rae Jenkins, 2001). A multi-dimensional strategy (Harlan et al., 1991) addressing language, cultural aspects, community, inclusion of family members, respect for patients, awareness of cultural variations and interpretations (e.g., inclusion of religious aspects, environmental exposures), and forming rapport (e.g., interpersonal relationships), among other relevant interventions can increase cervical cancer screening among Hispanic women (Blume, 1999; Cheney, 1996; Curtis, 1994; Love, 1998; Moses, 1989; Phillips, 1996; USDHHS, 2000; Wells, 1993; Zahm & Blair, 1993).

Cervical Cancer Screening: Deterring Factors

Cervical cancer is commonly associated with low socioeconomic status and less access to health care. This is usually true for Hispanic women (Farley & Flannery, 1989). Social and cultural factors also influence the decision of Hispanic women and other ethnic minority women to participate in cancer screening programs (Rajaram & Rashidi, 1998). For example, sociocultural factors associated with Hispanic women’s health
protective attitudes and behaviors relative to cancer include social class and acculturation (Harmon, Castro, & Coe, 1996).

Borrayo and Rae Jenkins (2001) conducted a qualitative study using focus groups (N=34) among Hispanic women in Texas to determine cognitive and sociocultural factors that affect cancer screening practices. The authors conclude that according to study participants, there is no reason to participate in cancer screening if they are “feeling healthy” (Borrayo and Rae Jenkins, 2001, pg. 815). Feeling healthy involves the women’s subjective feelings of wellbeing and a cognitive perception that they are not at risk for the development of cancer, in this case breast cancer. Thus, screening is a detection strategy women use when they are cognitively aware of the possibility of not being healthy. If a woman does not follow cultural preventive strategies, such as avoiding nicotine, caffeine, and blows (golpes), she is more likely to consider cancer detection strategies. Similarly, Chavez, Hubbell, McMullin, Martinez, and Mishra (1995b) identified a Latina model of beliefs about breast cancer risk factors that emphasizes breast trauma and bad behaviors, including drinking alcohol, and using illegal drugs. Additional beliefs of cancer causation among Latinos include the use of sugar substitutes, microwave ovens, pork meat, spicy foods and antibiotics (Perez-Stable, Sabogal, Otero-Sabogal, Hiatt, & McPhee, 1992).

Borrayo and Rae Jenkins (2001) also examine the women’s strong religious Catholic background and the related belief of divine predestination. In this belief (fatalismo), God’s fate or will destines certain individuals to develop an illness such as cancer. This belief prevents women across social classes from seeking screening services.
because cancer is beyond their control. Fatalismo reinforces the beliefs that cancer is a death sentence, something to avoid talking about, and a form of punishment from God (Perez-Stable, et al., 1992). The authors also reveal that beliefs such as cancer being a symptomatic and fatal illness influence women’s decision to avoid screening.

Hunt (1998) explored moral reasoning and the meaning of cancer in Southern Mexico by focusing on perceptions of history, course and control of illness. In this ethnographic study, oncology physicians and patients (N=43) discussed concepts of moral order and expressed their notions of what constitutes right and wrong behaviors. Causal explanations of cancer include physical trauma (golpe/blow), strong emotions (stress, nerves, anger), heredity (born with it, latent), failure to reproduce (no children, abortion), excessive reproduction (too many children), sexuality (having too much or too little sex), husband’s infidelity, environmental (pollution), lifestyle (smoking, alcohol), excess work, diet, age, hormones, and traditional beliefs (aire/air, susto/fright, hot/cold).

Generally in Latin America, an emphasis in monogamy among women and permissible promiscuity among men exists (Frank-Stromborg et al., 1998). Women might feel that they are being unfaithful to their husbands when showing their private parts, even to a doctor (Salazar, 1996). In Hunt’s study, respondents made moral judgments about social class, ignorance and promiscuity as they relate to cervical cancer. Men might not allow their partner to be tested or treated because of “machismo or ignorance” (Hunt, 1998, pg. 305). In this study, local culture and social hierarch influence biomedical concepts.

Similarly, Chavez et al. (2001) observed the influence of normative and nonnormative behaviors regarding cervical cancer among Latinas in California, including
beliefs about morality and virtue. Using ethnographic approaches (interviews, free listing, ranking) and survey analysis, results of the study show that Latinas associate having multiple sexual partners with risky behavior (bad, immoral). Vaginal infections come from their own risky behavior or from their partners. Unmarried women do not seek screening services because they are not expected to be sexually active before marriage; and seeking a Pap test denotes being sexually active. The latter is a similar observation made during preliminary data gathered in Panama City, Panama (Calvo, 2001). Chavez, et al. (2001) also noticed a lack of knowledge about HPV among Latinas, which is a strong causal factor for cervical cancer presented in the biomedical model.

Pérez-Stable, Otero-Sabogal, Sabogal & Napoles-Springer (1996) report on the traditional gender roles observed among Hispanics and how this might affect cervical cancer screening. The authors affirm that Latinos characterize women as submissive and with little influence in decision making. In contrast, men are dominant and in control of situations (machismo). According to the authors, machismo could be a barrier for women to access early detection tests, since Latino men may need to approve of their partners obtaining cancer screening examinations. The authors suggest that interventions should anticipate machismo and prepare women to respond to situations in a culturally appropriate manner.

Women might also avoid cervical cancer screening due to embarrassment, discomfort, forgetting, feeling healthy, older age, and not being recommended by physician (Savage & Clarke, 2001). Jennings (1997) reports barriers to cervical cancer screening among Latinas as access to a doctor, doctor’s gender, lack of symptoms or
problems, time schedule, fear of the examination, discomfort from Pap test, cost, and transportation. The author also mentions as deterring factors, Latinas’ embarrassment of invasive procedures or the exposure of body parts during an examination, as well as, believing that cold or unclean speculums are used during Pap tests.

Literacy skills, knowledge and attitudes are also associated with women participating in screening behaviors (Boffetta, Stellman, & Garfinkel, 1989; Davis, Arnold, Berkel, Nandy, Jackson, & Glass, 1996; Hiatt, Pasick, Pérez-Stable, & McPhee, 1996). According to Davis et al. (1996), limited literacy skills and lack of knowledge about screening services contributes to the underutilization of early detection services in low-income women. Lack of knowledge and information regarding the causes of cancer, its prevention, early detection and treatment reflects in strong fatalistic attitudes toward this disease (Lantz, Dupuis, Reding, Krauska, & Lappe, 1994; Peragallo, Fox, & Alba, 1998).

Access to care also affects utilization of services. Hispanic groups with restricted access to health services due to language and culture (e.g., patriarchal—men play dominant role and might not agree with their wives being tested), low-income levels, and limited political power are less likely to seek screening services (Bechtel, Shepherd, & Rogers, 1995; Blair, Mustafa, & Heineman, 1993). Masood (1999) published an editorial on the reasons why women still die from cervical cancer in the U.S. and how to address these issues. Some of the reasons determined by Masood included the lack of effective screening programs, especially for medically underserved women (ethnic minorities) and the ongoing debate on the Pap test (e.g., guidelines, frequency). The author indicated that increasing health education and access to care for all women regardless of age, race,
ethnic background, and socioeconomic status as prime methods for addressing the problem of cervical cancer in the United States.

Lack of insurance coverage and other factors are deterrents to access (JCPES, 2001). An important determinant of access to health care includes having a regular health care provider (Orton, 1994). Systems of care should also be socioculturally competent (Wells, 2000). The ability to develop public/private and academic/community partnerships to assure access to health care is needed (Meade & Calvo, 2001). Sole government involvement at all levels, local, state and federal, does not guarantee access to care (Orton, 1994); it should also address social, economic, and cultural factors (Gordon, 1999).

**Cervical Cancer Screening: Motivating Factors**

Cognitive factors that motivate Hispanic women to participate in cancer screening services include previous behavior (e.g., smoking, diet) that is culturally associated with increasing risk of developing the disease (Balcazar, Castro, & Krull, 1995; Borrayo and Rae Jenkins, 2001; Kowalski, 1999; Parkin & Khlat, 1996). Women feel that having practiced these behaviors increases their risk of cancer and makes them seek screening services. Addressing barriers such as lack of knowledge, concerns about cost, radiation and fear of the results can predict future screening behaviors (Hiatt, 1997). Motivating factors for cervical cancer screening among Latinas also include receiving financial assistance/free Pap smears, access to transportation, being reminded of annual exam and approval from a significant person (Jennings, 1997). Jennings (1997) reports children, friends, spouse, sister, doctor, family, mother and father as significant figures that will motivate Latinas to seek screening services.
Balcazar and colleagues (1995) recommend that health education and promotion interventions for cancer control and cancer risk reduction for Hispanics present: a group or familial orientation, rather than an individualistic orientation; cultural emphasis on harmony in interpersonal relationships; avoidance of confrontation and conflict in relationships; strong loyalty, solidarity, and attachment with nuclear and extended family members; values of respect and obedience for authority figures; preference for closeness in interpersonal space reflected in warm social relations; present time orientation with focus on here-and-now activities; and strong gender roles, including clear distinctions for behaviors among men and women. The authors also mention the need to address issues of accessibility to health services including communication barriers, social isolation, and inability to develop rapport with target audiences.

Social networks present positive influences on cervical cancer screening among Latinas. Suarez, Lloyd, Weiss, Rainbolt and Pulley (1994) explored the effects of social networks on cancer screening practices among low-income older Mexican-American women (N=450) in the U.S.-Mexico border. In this study, the authors used a survey to ascertain a social network score based on number of confidants, number of close friends, number of close relatives, frequency of contact with these close friends or relatives per month, church membership and church attendance. Women with the highest social network scores were more likely to have been screened within the past 2 years. The number of close friends was the most important predictor of having a mammography and a Pap smear. Women may rely on social networks for information, transportation, money, role modeling (observational learning), reinforcement and emotional support. The authors
conclude that social networks are an important determinant of cancer screening behavior among Hispanic women.

Hispanics’ willingness to participate in cancer control programs also depends on receptivity of health messages and screening interventions, methods of program delivery, and the audience’s preparedness to participate in healthy behavior change (Balcazar et al., 1995). For example, the use of lay outreach workers (e.g., *comadres*), mobile vans, health fairs, and media-based public health campaigns using role models to present health messages are attractive interventions designed for Hispanic populations (Hiatt, 1997; McCoy, Nielsen, Trapido, Zavertnik, & Khouri, 1991; Olsen & Frank-Stromborg, 1993; Patton, 1995; Peragallo et al., 1998; Ramirez, McAlister, Gallion, Ramirez, Garza, Stamm, de la Torre, & Chalela, 1995). A more personal contact or personalized care and proactive follow-up might also have positive measurable effects on cancer screening among Latinas (McAlister, Fernandez-Esquer, Ramirez, Trevino, Gallion, Villarreal, Pulley, Hu, Torres, & Zhang, 1995; Zabora, Morrison, Olsen, & Ashley, 1997).

As public health professionals, we need to remember that the possibility of a condition that may cause illness or death many years from now is of less importance to Latinas than obtaining food, clothing and shelter today (Zabora et al., 1997). Involving community members in the process of developing chronic disease messages and programs might help address socio-cultural attitudes among Hispanic women that might deter them from seeking screening services (AMC Cancer Research Center, 1994; Mein, 1998). Addressing cultural competence in screening programs increases accuracy of care, effectiveness, efficiency and success of acceptable programs (Kagawa-Singer, 1997; Lambert, 1995; Poss & Meeks, 1994; Ward, Bertera, & Hoge, 1997; White, Begg,
Fishman, Guthrie, & Fagan, 1993). In a similar realm, incorporating literacy and health literacy into key health messages (e.g., use of photo novellas or audiovisual media) also enhance cancer control interventions (Sissle & Drew Hohn, 1996; Velazquez, 1996; Wang & Burris, 1994; Williams, Baker, Parker, & Nurss, 1998; Yancey & Walden, 1994). In Latin America and the Caribbean, women’s groups advocating for female cancers’ control follow some of the above suggested factors to encourage women to seek early detection services (Shallat, 1995).

In summary, factors that affect Latino women’s seeking behaviors are complex. These factors also need further understanding. Without negating structural factors, sociocultural factors play a principal role in Latinas cervical cancer screening behavior. Beliefs do matter. Latina women negotiate the cultural knowledge about disease and prevention, the predominant popular cultural knowledge and the knowledge promoted by physicians (Chavez et al., 2001). This is similar to the model observed among African American women in North Carolina by Mathews et al. (1994). The latter study shows that women gather cancer information from indigenous, popular and particular biomedical conceptions about cancer and treatment (Mathews et al., 1994). Chavez et al. (2001) emphasize that we should not view structural and cultural explanations as competing or mutually exclusive. However, consistent observations in beliefs about cervical cancer risk factors across Latina women subgroups suggest generalizability of ethnographic findings on beliefs to larger populations (Chavez et al., 2001). Latinas’ embedded beliefs about cervical cancer fall within a larger context of social relationships and normative behavior (Chavez et al., 2001). Beliefs matter; and utilizing ethnographic approaches to understand these beliefs offer important research contributions.
Culture, Health, and Cultural Competence

Culture refers to the expected behavior, beliefs, values, practices and customs that define an integrated pattern of human behavior including thought, communication, ways of interacting, roles and relationships (Denboba, Bragdon, Epstein, Garthright, & McCann Goldman, 1998; Taylor, García, & Kingson, 2001). Culture dictates social behavior and norms, determine what is acceptable and what is not acceptable (Bracey, 2001). Each culture has a unique outlook on life, called worldview (Goyan Kittler & Sucher, 2001). Culture along with its worldview define how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given (Office of Minority Health, 2000). Hence, culture influences: how health, illness and disability are perceived; attitudes toward health care providers, facilities, and how health information is communicated; help seeking behaviors; preferences for traditional versus non-traditional approaches to health care; and, perceptions regarding the role of family in health care (Denboba et al., 1998).

Globalization, war, and worldwide poverty are responsible for increasing migration of individuals and families (including physicians) among all nations and continents. As physicians are trained in technology, their worldview becomes more compartmentalized and dehumanized. But the mindset of the patient is different. Issues about how individuals view their bodies, themselves, and their relationships to past, present, and future members of their communities must be considered for each patient [and community]. Furthermore, how individuals interact with the local ecology and the world has profound effects on notions of health and the causes of and cures of illness (Fennelly, 2001).

In today’s society of multiculturalism, delivery of culturally relevant health messages is an important component of health education and health promotion (Stoy,
Leininger (1989) defines *cultural competence* as the in-depth awareness of different cultures so that the provider can be knowledgeable about the client’s cultural background in order to provide culture specific care or some universal (common human) care needs. Cultural competency includes understanding all barriers to care that a population faces by going beyond *lack of knowledge* (Holland & Courtney, 1998). Regarding cancer control, health care professionals should treat seriously the lay knowledge of their patients and families (Boston, 1999). *Cultural relativity* is taking cultural competence a step further by understanding a culture within the context of that culture, avoiding the biases of one’s own culture (Goyan Kittler & Sucher, 2001).

Culture affects perception of causal understanding of illness. For example, rural Indian women attribute causes of cancer to metaphysical beliefs such as, God’s will, fate, and karma, than to other factors (Kohli & Dalal, 1998). There is growing recognition among health professionals that being familiar with the culture of a particular group and developing effective partnerships to involve group members in the production of their own health messages are essential strategies to promote health (Holland & Courtney, 1998; Meade & Calvo, 2001). This includes the development of health education interventions, such as printed materials that are culturally (Guidry & Walker, 1999) and linguistically tailored (Juarez, Ferrell, & Borneman, 1999). For Hispanic populations, the availability of materials in Spanish and in accessible format, such as in video or audiotape are imperative in cancer education (Juarez et al., 1999; Meade, Calvo, & Cuthbertson, 2002). Cultural competence of health care providers can foster care seeking and adherence to treatment (Schilder, Kennedy, Goldsten, Ogden, Hogg, & O’Shaughnessy, 2001). Inclusion of members of the intended audience through the
development of materials and programs also enhances the relevancy of the message and future utilization will most likely occur (Brookins-Fischer, 1998; Nazzar, 1995).

**Hispanic Culture and the Meanings of Health**

Current literature on Hispanic health presents certain cultural characteristics that are observed among certain Hispanics. These cultural characteristics although important might not be observed among all Latinos. Nonetheless, to serve Latinos effectively, it is important to gain a clearer understanding of their health status and cultural values that guide Latino health (Molina & Aguirre-Molina, 1994). First, social interactions are guided by *personalismo*, which is the trust and rapport that must be established with others by developing warm, friendly and personal relationships. In health care delivery *personalismo* is an important component of reaching the Latino community effectively (National Alliance for Hispanic Health, 2001). The western health care delivery system is commonly exemplified by a time limited direct to–the-point encounter. This differs from the Latino expectation of establishing a friendly relationship with the health care provider whether professional (e.g., medical doctor) or folk (e.g., *curandero*) (Molina, Zambrana, & Aguirre-Molina, 1994).

Second, in Latino culture, the self is defined by the family (including extended family members) and the group. This family orientation or *familismo* represents family connectedness or interdependence of family members (Prewitt Diaz, 1999) Latinos tend to include members of the family, both immediate and extended, in the health care communication process. This process is known as the *family health culture*. A person's decision and attitude for treatment is typically shaped by those of other family members. The tendency of the industrialized world to accentuate individualism moves away from
family inclusion. Following the western model of care deters many Latinos from seeking health care services (Molina et al., 1994).

Third, culture influences health and outcomes, such as folk health beliefs and traditional health practices, and can cause miscommunication with biomedical practitioners. Folk illnesses, those for which orthodox western medicine lacks understanding and competence in treating, further influences lack of trust in health care providers. For example, common folk illnesses in Latino culture include: *mal de ojo* (dangerous imbalances in social relationships, such as when a person wishes something bad to happen to another), *empacho* (upset stomach), *ataque de nervios* (attack of the nerves), *susto* (fright, soul loss) and *caída de mollera* (fallen fontanel). All of these illnesses or Latino disease categories come from the notion of an imbalance in physical, emotional and social wellbeing.

Folk healers (e.g., *curanderos, espiritistas, santeros*) play an important role in health by providing health advice and folk treatments (Aguirre-Molina & Molina, 1994; National Alliance for Hispanic Health, 2001). Mexicans refers to healers as *curanderos*, Puerto Ricans call them *espiritistas*, and Cubans call them *santeros*. Curanderos provide health advice and folk treatment. Espiritistas focus more on illnesses caused by intentional acts of God or other supernatural forces (Molina, Zambrana, Aguirre-Molina, 1994). Santeros practice a synthesis of African religious beliefs brought to America by African slaves and Christianity from White ruling classes. Santería is used to better health, emotional, and financial afflictions (Canizares, 1999).

Limited physical activity, increase in infectious and chronic diseases, and poor nutritional status represent many some the current health concerns for Latinos.
Consequently, emerging health issues include cancer, heart disease, diabetes, HIV/AIDS, alcohol abuse, drug abuse and mental health. The 1982-1984 Hispanic Health and Nutrition Examinations Survey (HHANES) was the first special population survey conducted by the National Center for Health Statistics (NCHS, 1985; Delgado, Johnson, Roy, & Trevino, 1990). The information was collected among the three largest Latino groups in the U.S.: Mexicans (Texas, New Mexico, Colorado, Arizona and California), Cubans (Dade County, Florida) and Puerto Ricans (New York, New Jersey). This survey provides baseline data Latino health (Molina & Aguirre-Molina, 1994). For example, obesity and overweight are common afflictions among Mexican populations (Aldrich & Variyam, 2000; Pérez-Escamilla et al., 2000; Trevino, 1999; Russell, 1998; Zive, 1998). Obesity is associated with diabetes, hypertension and cardiovascular disease (Molina & Aguirre-Molina, 1994).

In contrast, Hispanics also present positive health outcomes as compared to other racial or ethnic groups. Although at greater risk for a number of chronic illnesses and diseases, Hispanics have lower mortality rates. In addition, Hispanic populations exhibit a number of positive health indicators in terms of diet, low levels of smoking and illicit drug use, and strong family structure (National Alliance for Hispanic Health, 2001).

The National Council of La Raza introduced two concepts of Latino culture, respeto and fatalismo. Fatalismo (fatalism) is when illness is thought to be caused by God's will, punishment or fate, while unnatural illnesses originate from evil done to one another. In this concept, the person feels like he/she has no control over the illness and avoids seeking treatment, such as the case of Hispanic migrant and seasonal farmworkers and their views of cancer (Lantz, Dupuis, Reding, Krauska, & Lappe, 1994; Meade &
Calvo, 2001). Cancer presents a good example of fatalismo among Latinos. Latinos agree that cancer is synonymous with death, cancer is God's punishment, and that there is very little one can do to prevent getting cancer or to treat it successfully. Preliminary data suggests this is also true for Panamanian women (Calvo, 2001).

*Respeto* (respect) in the Latino community health care experience is viewed in a holistic manner. The patient respects the physician's opinion as he/she would the opinion of a priest. Conversely, Latinos expect to be treated with respect by health care providers (Sennot-Miller, 1994). Latinos place a high value on interpersonal relationships. Respect plays a strong part in the Latino worldview. *Respeto* is demonstrated by using formal Spanish language, being tactful, listening attentively, showing compassion to patients and courteous body language (National Council of La Raza (NCLR, 1998).

A common belief among Latinos is the caliente/hot and frío/cold or mojado/wet and seco/dry concept (Fennelly, 2001; Spector, 1996). This is an important part of the indigenous folk ethnomedical system which affects food consumption, the hot-cold classification, a humoral equilibrium model (Cosminsky, 1975, Foster, 1987). Foods, beverages, herbs, plants, medicines and illnesses are classified according to the qualities of hot/caliente and cold/frío (Cosminsky, 1975; Messer, 1981; Foster, 1987). The classification is not usually determined by observable characteristics or the physical temperature of the substance (although temperature could sometimes be a factor); but, it is determined by innate intrinsic qualities possessed by the substance in question (Cosminsky, 1975; Messer, 1981; Messer, 1987). For example, chili is hot because it produces a burning sensation in the body and pork is cold (Cosminsky, 1975; Messer, 1981). Many people also accept the idea that certain foods maintain health and prevent
illness (Cosminskey, 1975). Thus, the holt-cold idiom is a guide to behavior, diet and medication (Messer, 1981). For example, women during pregnancy might avoid hot foods and during postpartum avoid cool foods and medicines, or a hot person must not drink cold water, as it could cause colic (Spector, 2001). This is an important cultural classification that affects health behaviors, such as Hispanic women who avoid receiving a Pap smear due to the belief of the use of a cold speculum during examination (Jennings, 1997).

Theoretical Tenet: Social Constructionism

Social constructionism rests on the belief that reality is socially constructed and emphasizes language as an important means by which we interpret experience (DeLamater & Hyde, 1998). Social constructionism posits the idea that human reality is formed by and has its being in discourse (Baillie & Corrie, 1996). People try to adapt personal experience to pre-existing cultural models, modify such models in the light of new information, and confront/resolve conflicts in their own interpretations of the meaning of a single episode of illness (Mathews et al., 1994). Social constructionism is an expansive framework for understanding that reflects the combination of ideological, literary and rhetorical, and social critiques, of the prevailing knowledge establishment with emphasis on the social aspects of human life and its tendency to question existing knowledge structures (Witkin, 1999). Constructionists or constructivists, used interchangeably, assume that all epistemological systems are socially constructed and (in)formed through sociopolitical, economic, and historical context and processes.

Constructionist perspectives suggest that through this theoretical framework we can understand how people become what they are and explain problems (Craib, 1997;
Loseke, 1999). Constructivism can also be used to examine how individuals come together to form a shared reality of their group experience (Brower, 1996). Social constructionism has been used to understand aspects such as: human sexuality and gender roles (Bockting, 1997; Money, 1995); social work approaches (Dean & Rhodes, 1998); environmental issues (Burningham, 1998); media impact on culture and society (Newton, 1998); history of ideas (Bevir, 1997); criminal justice (Travers, 1997); psychotherapy (Baillie & Corrie, 1996; Gilmartin, 1997); need of multiculturalism in health care professions (Briggance & Burke, 2002); general practitioners’ perceptions of health (Thompson, Cupples, Sibbett, Skan, & Bradley, 2001); cultural competency (Taylor-Brown, García, & Kingson, 2001); societal sensibility to cognitively disabled persons (Watson, 1996); adoption (Miall, 1996); family relations and family dynamics (Gray, 1997; Mailick & Vigilante, 1997; Miller, 1991; Weiss, Marvin, & Pianta, 1997); pain and aging (Encandela, 1997); attention deficit hyperactivity disorder (Levine, 1997); addiction and alcoholism (Smith, 1993; Sonnenstuhl & Trice, 1987; Truan, 1993); stress, depression and tiredness among women (Walters & Denton, 1997); bulimia (Brooks, LeCouteur, & Hepworth, 1998); crack babies (Lyons & Rittner, 1998); and, HIV/AIDS (Grove, Kelly, & Liu, 1997; Lawless, Kippax, & Crawford, 1996; Pollock, Lilie, & Vittes, 1993) among other issues.

Gegeo & Watson-Gegeo (2001) studied indigenous epistemology among Kwaraae rural villagers in the Solomon Islands, where villagers themselves explored how they construct knowledge—instead of being the subject of outside research. In this constructionist study, a focus on the process through which knowledge is constructed and validated by a cultural group and the role of that process in shaping thinking and behavior
took place (Gegeo & Watson-Gegeo, 2001). The authors were able to ascertain the cultural group’s ways of thinking and of creating, reformulating, and theorizing about knowledge via traditional discourses and media of communication, anchoring the truth of the discourse in culture. Results of the study recognize that culture is variable (dynamic), an ongoing conversation embody conflict and change, shaped by the dialectic of structure and agency, inherently ideological, and prone to manipulation by powerful interests (e.g., political and health care systems, etc.) (Gegeo & Watson-Gegeo, 2001). The focus is on why claims or rhetoric (verbal, visual or behavioral statements that try to convince audiences to take a condition seriously) emerge at a particular time, the form in which they are organized, and how they are maintained (Burningham, 1998; Loseke, 1999).

Constructionist perspectives encourage us to take words seriously because even the most simple words (particularly the most simple words) are categories for entire systems of meaning (Loseke, 1999). Subjectivity itself is a discursive product (Hekman, 1999). Hence, a key feature of social constructionism is the idea that human reality is created and has its being in discourse (e.g., language, metaphor, text), that is: “everyday conversation in general, and storytelling in particular” (Baillie & Corrie, 1996, pg. 295).

Witkin (1999) ascertains that social constructionism is a defining feature of the postmodern era as a broad theoretical framework for understanding. According to the author, in constructionism, the relationship between language and things in the world is indeterminate: that is there is no necessary connection between objects, actions, and states, and what they are called. “Rather than reflecting the world, language generates it” (Witkin, 1999, pg. 44). Constructivist stances emphasize the formative function of language and its inseparability from human actions. So, Witkin argues that language and
meaning are the products of human interchange—language as a tool. This discourse allows for inclusion of marginalized forms of knowledge and discourse, for new approaches to inquiry and practice as an alternative voice to the hegemony of the prevailing knowledge establishment. Witkin also offers the notion that instead of trying to decide whose representation of reality is closer to truth, we must decide how to choose between competing interpretations. Critically different kinds of constructions (stories) support different kinds of practical action. Stories then are consequential. So, rather than asking which story is “true” (an impossible task) we can ask what actions different constructions support.

Denzin and Lincoln (1994) define constructionism as a paradigm in which individual constructions of ‘social reality’ are the focus. Taking this definition, Grbich (1999) asserts that this paradigm fits the qualitative tradition. Social constructionism stresses the process as well as the content, emphasizes social relations (e.g., family) understanding and participation, and converts data gathering into an empowering process of discovery within the context of culture and community (Mailick & Vigilante, 1997). Social constructionism evokes large cultural messages that influence individual meaning-making (Levine, 1997).

Social groups, at various levels of complexity, from family to community, play a crucial role in the development and transmission of synthetic cultural models designed to mediate conflicting beliefs and promote cohesiveness and shared identities among group members (Mathews, 2000). And it might not be possible in a postmodern world, where there is no agreement on how life “should” be lived, what is important and so on. Cultural consensus is more possible in traditional societies characterized by greater cultural
cohesion. The process of arriving at cultural consensus through the integration of contradictory systems of knowledge is a difficult enterprise beyond the capabilities of many individuals (Mathews, 2000).

Media plays an important role in modern constructionist perspectives. For example, a study of national newspaper feature articles (N=105) conducted by Welch, Fenwick, and Roberts (1997) concluded that the media creates most of the social panic due to crime. Similarly, Chaney (1996) concluded that mass culture involves an organized social perception of the diverse ways of constructing ideas. Chaney also concludes that culture is socially constructed, referring to a social theory of culture. Also, in media, photojournalism plays an important role in the construction of worldviews and mediating reality through social constructionism (Newton, 1998).

The experiences and discourses of women are subjugated knowledges, bringing these knowledges into hegemonic discourse alters what counts as knowledge; it amounts to an insurrection (Foucault, 1993). Describing this insurrection is the focus of feminist theory (feminist research) (Hekman, 1999). Individuals are obliged to unravel themselves before society, allowing them to be controlled by the society they are moving in. Limits imposed on individuals by society can be broken by individuals' thorough examination of who and what they are (Hekman, 1999).

Social constructionism offers an opportunity for subjugated knowledges to be heard. Dean and Rhodes (1998) state that social constructionism leads to the inclusion of marginalized stories and of stories that have yet to come into focus. Hekman (1999) takes the notion of marginalized a step further by asserting that: “feminist issues are not just marginalized, they are invisible.” Dean and Rhodes encourage practitioners (e.g., public
health professionals, social workers, clinicians, etc.) to be collaborators rather than experts in assessing problems and issues. How people make sense of the world influences how they react to the world. The authors present a series of case studies (e.g., family relationships, gay and lesbian parenting, etc.) among clinical social work students following a social constructionist perspective. Students are encouraged to follow an egalitarian model that fosters equality, openness, and tolerance as well as to discuss alternative stories. Critical thinking helps students and practitioners determine through discussion and narrative what counts as a “better story.” The result is a movement away from universal, theory-bound (empirical, rationalistic) notions of health and functioning toward a more relative (relativistic) and culturally sensitive perspective for co-construction of meaning. Constructionism insists on sharing power, it encourages us to consider views other than our own as different rather than better or worse (Dean & Rhodes, 1998).

Critiques of Social Constructionism

Most of the critique directed toward social constructionism comes from realism (Burningham 1998; Burningham & Cooper, 1999). Realism, as explained by Slife and Williams (1995), holds that the methods of science allow the scientist direct access to the reality of the world, that a world exists independently of human sense-making.

Slife and Williams (1995) also establish that unlike empiricism (common experience) and rationality (common sense), social constructionism has no firm standard for validating its epistemological claims. However, the authors ascertain that most social constructionism appeals to pragmatism, which works effectively within a culture. Social constructionism is relevant to our understanding and our place in the natural world.
Social constructionism attempts to move beyond the dualism of empiricists and rationalists and place knowledge within the process of social interchange (Gergen, 1985), based on the notion that a researcher is a product of a particular culture (Truan, 1993) and “research itself is a social process” (Babbie, 1986).

Social constructionism has been criticized for detracting attention from environmental and structural problems and for failing to contribute to attempts to manage them ( Burningham, 1998). Gey (1996) suggests that social constructionism rejects the distinction between public and private spheres, and egalitarianism (equality), in the sense that speech advocating inequality is opposed. Bonnett (1996) criticizes social constructionists’ lack of reflexive rigour. It is asserted that giving too prominent a place to interpretive flexibility has a corrosive effect on the utility and critical potential of sociological accounts of problems and phenomena ( Burningham & Cooper, 1999).

De Cecco & Elia (1993) conceptualize social constructionism as a depiction of the individual as an empty organism that is filled and shaped by culture and society and is devoid of consciousness and intention. The authors compared the theory with biological essentialism in the basis of homosexuality and propose an alternative view of biological, personal, and cultural influences. Critiques of social constructionism argue that culture is the form that biology takes, the connection between biology and culture is consciousness and intentionality, the uniqueness of culture is the existence of collective intentionality ( Heckman, 1999; Searle, 1995). Similarly, modern essentialism, the belief that certain phenomena are natural, inevitable and biologically determined, argues against social constructionism that the core belief of essentialism cannot be truly conjoined with social constructionism (DeLamater & Hyde, 1998). That is, although some theories bound
biology and social influences together, essentialism (e.g., sociobiology, genetic research, brain research) stipulates that biological and social influences cannot be conjoined (DeLamater & Hyde, 1998; Halwani, 1998; Stein, 1998). An implication of social constructionism is that we need to drop absolutist and essentialist notions of knowledge, so it discards the idea that there is a fixed set of a priori truths ‘out there’ to be discovered and eventually forcing themselves upon us if only the right methods and techniques are employed (Schmidt, 2001).

Critical realism, although not denying the role of language, emphasizes the implication of material-causal processes in other modes of construction that are independent of language use and the realities it creates (Baillie & Corrie, 1996). This assumption goes against the focus that constructivist perspectives place on language, discursive construction does not entail material-causal processes (Baillie & Corrie, 1996).

Most of this criticism is directed toward strict constructionism, which avoids making any assumptions about ‘the reality’ of conditions and focuses entirely on the claims made about them (Burningham & Cooper, 1999) or is liable to invert rather than resolve the problems of strong essentialism, including those of its biological reductionist guises (Sayer, 1997). Strict constructinists are not interested in assessing or judging the truth, accuracy, credibility, or reasonableness, of what members say and do (Schneider & Kitsuse, 1989). Nonetheless, the present study follows a more moderate constructionism—a contextual construction—which recognizes biological realities, but stresses the social context (Loustaunau & Sobo, 1997).

Constructionist response to critics by stating that there is no need to deny biological realities: cancer exists and kills women regardless of how women understand
cancer. That might well be taken as a “true fact.” Yet how women understand cancer and cancer screening nonetheless is critical to their health and well-being. In this sense, constructionist examinations are not in opposition to those using a realist or essentialist theoretical framework. Incorporating social construction of women’s understanding of their own health will strengthen public health programs on HPV and cervical cancer control.

**Social Constructionism and Public Health**

Health care is a cultural construct arising from beliefs about the nature of disease and the human body (Office of Minority Health, 2000). Cultural issues are central in the delivery of health services, treatment and preventive interventions (Office of Minority Health, 2000). For minority ethnic groups, the social world produces both social and biological effects with long-term impacts (Davey Smith, 2000). Research efforts of conjoint or interactionist research uniting biological and social influences have been made (e.g., sexuality, racial and ethnic health disparities) with a constructionist perspective (DeLamater & Hyde, 1998). Sociocultural aspects that shape racial and ethnic health disparities need to be critically addressed for the provision of care and the long-term sustainability of our health care system (Briggance & Burke, 2002). Especially since the racial and ethnic composition of the U.S. population is currently changing most dramatically since the turn of the 20th century—the number of foreign-born residents has increased by 6 million since 1990 and comprises about 25 million of the general population (Briggance & Burke, 2002).

The associations between ethnicity, SES, social position, and health are clearly apparent, but the complexity of these interrelationships has not been fully recognized in
much of the research conducted over the past century (Davey Smith, 2000). Although disparities among racial groups exist, researchers tend to focus inappropriately on race in public health, rather than on ethnicity or culture (La Veist, 1996). Culture has been used to study misconceptions about cancer as a variant of the lack of knowledge approach (Balshem, 1993; Chavez, Hubbell, McMullin, Martinez, & Mishra, 1995; Wood et al., 1997). Since definitions of illness are ultimately cultural products, their meanings are influenced by social attitudes and cultural stereotypes (Grove, et al., 1997).

Further, popular medical knowledge, such as that arisen from popular media (television, radio, newspaper, magazines) affects the manners in which illness is understood (McCurtis, 1979; Saillant, 1990). This popular medical knowledge is virtually unrecognized in the clinic, namely oncology and more specifically in cervical cancer screening (Knopf, 1976; Mathews et al., 1994; McCurtis, 1979; Saillant, 1990). Lantz & Booth (1998) conducted a study of the social construction of the breast cancer epidemic in the U.S. by documenting qualitative content trends in popular magazine articles coverage of breast cancer between 1980 and 1995. Larger fears about change and chaos in a society are often communicated in discourses about social problems, particularly those involving life-threatening diseases about which there is much scientific uncertainty (e.g., cancer) (Lantz & Booth, 1998). The authors conclude that the view that the U.S. is experiencing an epidemic of breast cancer has been and continues to be constructed in part by the popular media through a complex social process. Understanding the social construction of illness contributes to health policy in a variety of ways, primarily by illuminating how the effects of class, race, gender, language, technology, culture,
political economy, institutional structures, and professional norms often constrain or influence the possibilities for intervention (Brown, 1995; Lantz & Booth, 1998).

*Social Constructionism and Cervical Cancer*

*Epidemics appear, and often disappear without traces, when a new culture period has started; thus with leprosy and the English sweat. The history of epidemics is therefore the history of disturbances of human culture.*

Virchow, 1970

Cultural practices dictate the emergence of different types of cancer. For example, the almost complete decline of stomach cancer during the 20th century in the U.S. or the decline in melanoma mortality in Australia for persons born after 1950 show that public health researchers should channel efforts and resources into addressing lifestyle factors (which may surface from cultural tenets) that cause cancer (Colditz, 2001; Reichman, 1995).

The importance of exploring lay constructions of disease and of biomedical procedures such as cervical screening is especially acute in developing countries where local explanatory models of illness frequently diverge radically from biomedical paradigms (Fielding, 1978; Wood et al., 1997). In their anthropological study among three different language groups in South Africa, Wood et al. (1997) followed a constructionist approach through in-depth interviews to understand cervical cancer screening practices and the process by which local knowledge about the illness is constructed. Results show that women were primarily screened when symptomatic and that many associate the Pap smear with diagnosis and treatment of sexually transmitted infections. Women’s discourse reveals a belief that the Pap test is used to “clean the womb” (Wood et al., 1997). In addition, related to cervical cancer, were identified: fear of vaginal exposure, expectation of pain during screening, being asymptomatic, gender of
practitioner, and belief that cervical cancer is terminal and associated with promiscuity (Wood et al., 1997). Women perceived womb cancer as terminal and constructed this knowledge from personal and community experience with the illness (Wood et al., 1997). It is important to note that information provided by health professionals (physicians, nurses, public health practitioners, health educators, etc.) also impacts construction of local health knowledge and beliefs (Wood et al., 1997).

Qualitative research can be used to relate the broader social context in which persons operate to try and untangle the factors involved in their decisions to accept, reject, or accommodate to new sources of knowledge (e.g., cancer screening) and to more fully understand the complex relationships that exist between mental models and social actions (Mathews et al., 1994). Too often we assume that patients who delay seeking treatment for cancer or who fail to utilize screening services available to them are either lacking in knowledge, too poor to access services, denying reality, or are excessively fatalistic; these patients have well-worked out ideas about their own health and about disease—ideas that must be considered in cancer control (Mathews et al., 1994). It is recommended that studies of the social construction of illness should also explore the ways in which definitions of health and illness are understood by practical actors in daily lives (Waters & Denton, 1997).

Hyde (2000) studied the social construction of cervical cancer in New Zealand. The author analyzed the contention of lay beliefs about cervical cancer and the medical profession between the late 1960s and 1980s. The study was based on a critical discourse analysis of papers and correspondence on cervical cancer published in the New Zealand medical literature. Inquiries into cervical cancer medical practice were disputed by the
laity. The author concluded that medical knowledge (cervical cancer) or what is accepted
as medical knowledge is located and negotiated within a social context.

Regarding cervical cancer screening services, the literature suggests that
institutionalizing programs of mass surveillance and regulation rather than ad hoc
systems are more socially accepted (Bush, 2000). Opportunistic screening of cervical
cancer among women is more susceptible to social inequalities than systematic screening
programs (Rohlfs, Borrell, Pasarin, & Plasencia, 1999). Singleton (1996) analyzed
women’s construction and maintenance of the United Kingdom’s Cervical Screening
Programme. In the postmodern approach, Singleton recognized multiplicitous mutable
identities involved in a continuous process of negotiation of discourses of sexual
promiscuity, women’s identity, exclusion of women from decision making, and the
subjugation of woman’s knowledge and experience of her body. Results show that no
stable viewpoint exists about making decisions of lay participation in the Cervical
Screening Programme (Singleton, 1996). In another study of the same program, McKie
(1995) argues that the female body, in this case the cervix, is a site for state, professional,
and male surveillance and control, through a screening program where women feel
obligated to participate. Looking at women’s perspectives and listening to their voices
can assist in providing more relevant cervical cancer information and services.

Women draw on specific contexts and relationships through which participation
in, or compliance with, cervical cancer screening is given meaning (Howson, 1999).
Howson (1999) presents the idea that participation in cervical cancer screening may also
be embedded within a moral framework of self-responsibility and social obligation.
Feminists assert that women are made, not born, and thus gender and even sex are social,
not natural, constructions (Hekman, 1999). This allows feminists and social constructionists to challenge what have appeared to be biological views about women’s role in society (Bell, 1994; Hekman, 1999).

Cervical cancer screening obstacles do not arise from ignorance (or lack of knowledge—as it is often portrayed); they partly result from the richness of local knowledges about cancer and the Pap smear (Gregg & Curry, 1994; Wood et al., 1997). Bush (2000) explored the importance of cervical cancer screening discourses through in-depth interviews among 35 women, ages 20-64, in South Yorkshire, England. The author asserts a need to understand how cervical cancer screening discourses are negotiated, accepted, and resisted by women. Bush concludes that the meaning and objective of mass screening programs must be considered by those involved in planning, implementation, research and use of screening services. Thus, a need to understand those local knowledges as they relate to cervical cancer screening may assist public health practitioners in development of relevant screening programs.

Preliminary Data Collection

A rapid appraisal technique, conducted in August 2001, was used to collect preliminary data to help guide this study (Calvo, 2001). A rapid appraisal is a qualitative methods pilot study, following anthropological approaches, used to understand primary health care services among diverse cultures and specific populations (Beebe, 1995; Scrimshaw & Hurtado, 1987). It is also considered an approach for developing preliminary, qualitative understanding of a situation (Beebe, 1995). The methods used for the rapid appraisal were key informant and natural group interviews.
The University of South Florida’s Institutional Review Board (IRB# 99.774) approved the research protocol with Waiver of Written Documentation (Appendix B-IRB Letter of Approval). Oral consent to participate in the study was sought from participants following the University of South Florida’s IRB requirements. The waiver was requested because from the researcher’s community research experience among Hispanic populations, the use of official forms would affect the study in a natural environment, which was the purpose of the rapid appraisal.

**Key Informant Interviews**

Semi-structured interviews of key informants (N=10) were conducted providing insight about the Panamanian health care system and services available to women for cervical cancer screening. Key informants selected were professionals working in the field of public health, cancer control and clinical oncology as well as academicians with knowledge and experience in treating and reporting cervical cancer in Panama.

Key informants confirmed that cervical cancer is a major public health problem in Panama. A gyno-oncologist physician involved in studying cervical cancer in Panama, mentioned that this type of cancer affects all sectors of the population, regardless of socioeconomic status (SES). She shared the experience of one of her patients, who was a Master degree educated banker considered of higher SES die of the disease because of advance stage cancer upon diagnosis.

Health education campaigns or educational materials on cervical cancer are not available to the population. Key informants mentioned several risk factors that they believe are associated with the high rates of cervical cancer in Panama. These risk factors include: promiscuity of men and women (this was mentioned by all key informants as the
main cause) and poor sexual hygiene among men. From a medical standpoint, key informants mentioned the lack of women participating in screening services. When asked the reasons for women avoiding screening, they said that the women simply “lack education.” Overall, key informants showed a widespread medical model worldview. Social and cultural concepts were not mentioned by key informants even when probed by the researcher.

Natural Group Interviews

Natural groups were considered an ideal method to conduct this rapid appraisal because the researcher was able to generate knowledge and information on the perceptions, concepts and practices of Panamanian women (from both the researcher and participant perspectives) in a relatively short period (De Koning & Martin, 1996). Natural groups are preexisting social networks or groups, which exist independent of the research study in a natural setting. The format is usually informal and unstructured, an interview guide is used, but loosely followed and information is recorded by notes instead of audiotape (Coreil, 1995). Cultural tendencies to form groups of relatives, co-workers, neighbors and other situations can be applied in research to elicit information from local people about health, health care use, and for further phases of projects providing a safe setting where views are expressed (Beckerleg, Lewando-Hundt, Borkan, Abu Saad & Belmaker, 1997).

Representation from different social strata, age groups, and educational backgrounds was sought with each group conducted. Working class women in Panama City, Panama, over 18 years of age were recruited for the group interviews. Different age groups were selected purposefully to represent adult women across generations from
young adults to elderly (Wood, Jewkes, & Abrahams, 1997). Working class in this context was based on social hierarchy as: lower, middle, and higher working class (Alcalay & Mendoza, 2000). Income information was not requested from the women since cultural factors would deter women from responding to this type of personal information to the researcher and might affect the study.

Three natural groups were conducted (N=10). The women ranged in age from 30 to 95 years of age. Educational levels ranged from none to college educated. This classification was determined by different social factors observed in Panama, such as, education, type of employment and area of residence in Panama City. Women were not directly asked about their specific income, because this type of inquiry is not welcome culturally.

Women mentioned behaviors to stay healthy, such as, proper nutrition, physical activity, and smoking cessation. When sick, women mentioned to self-medicate. Analgesics, anti-inflammatory, anti-cough, antibiotics, and birth control pills are readily available over-the-counter from pharmacists. Women mentioned avoiding going to the doctor unless very sick and symptomatic.

Regarding cancer in general, women were asked about causes, treatment, early detection, and cure. Some of the causes of cancer mentioned by women included tobacco, sun exposure, chemicals, alcohol, genetics/hereditary, radiation, pesticides, stress, and cellular phones. All women said that cancer signifies death. This is consistent with literature regarding cancer beliefs among Hispanics in the United States (Harmon, Castro, & Coe, 1996; Meade & Calvo, 2001; Meade, Calvo, & Cuthbertson, 2002).
When asked if they participate in any screening (e.g. Pap Tests, referred to as Papanicolaou) practices women said that they only go to the gynecologist (usually physicians perform Pat tests in Panama) if they feel some discomfort such as: odor, bleeding and pain. They wait until being symptomatic to receive a female examination. All women reported that the first time they ever went to have a Pap test done was due to some discomfort or because they were pregnant, but never for preventative purposes.

Further, women who knew about regular screening guidelines (once a year after age 18 or earlier if sexually active), avoided getting annual check-ups. Only two women reported going to their annual check-ups, the first had been diagnosed with the Human Papillomavirus (HPV) [when she mentioned HPV, the other women in the group did not know what this was, it was later explained to them after the group session] and the second because her mother had died from some type of cancer.

Women said they do not like getting a Pap test because they feel embarrassment/shame, discomfort (talking to the physician), fear, humiliation/denigration, stress and scared to learn about results. Younger unmarried women who go to the gynecologist are considered: “mujer que conoce varón/woman that knows man.” So, younger unmarried women are considered promiscuous if they go to the gynecologist. In Panama, a woman’s reputation is considered foremost socially. Finkler (1994) asserted this same notion in other Latin American countries.

Women said that they do not have much information regarding cancer in general, including cervical cancer. Women said that there is a lack of information available to them about health in Panama. Reproductive health and cervical cancer are topics often
ignored in health campaigns. Some women mentioned hearing about breast cancer on television, but not cervical cancer.

In summary, Panamanian women included in the study do not participate in preventive screening services. A dichotomy exists between the medical and the social-cultural worldviews. Although several barriers (e.g., cost, work, lack of time, etc.) were identified, health knowledge and cultural constructs play important roles in the health status of the women’s population. Health education regarding women’s health topics, especially cervical cancer, is not available nationwide.

Qualitative Research

Systematic qualitative research can make a unique contribution to health services research (Barbour, 2001). In-depth semi-structured interviews are an efficient tool to study Hispanic social networks, such as the Central American kinship social networks of recent immigrants studied by Menjivar (1995) in San Francisco, California. Qualitative research serves as an inductive analysis (Byrne, 2001a) to enhance the understanding of the people being studied from an emic (insider’s) perspective in the subject’s natural environment (Byrne, 2001b). Despite important epidemiological and clinical research regarding cervical cancer among women in Panama, no study has asked women themselves (Adalbjarnardottir, 2002) how they understand and socially construct cervical cancer and cervical cancer screening.

Slife and Williams (1995) define qualitative research methods as:

“procedures for investigating human action that do not involve measurement and quantification, but allow subjects to describe their own behavior and experience in the language native to their experience, and investigators to undertake the analysis of human phenomena in conversational language rather than numbers” (pg. 234).
Qualitative research methods generate rich, detailed, valid data that usually leaves study participants’ perspectives intact (Steckler, McLeroy, Goodman, Bird, & McCormick, 1992). Qualitative research is a way in which researchers can “give people a voice” (Balshem, 1993, pg. 137) and benefit from a narrative that links process to practice by attending to the voices of the people of interest (Rappaport, 1995). Qualitative research describes the “how” and “why” of existing phenomena (Steckler et al., 1992).

Researchers working with Latino groups can facilitate the cultural sensitivity process by asking open-ended questions, such as in qualitative methodologies, concerning health or illness as opposed to asking leading questions (Holland & Courtney, 1998). Listening and acknowledging the importance of cultural influences on health and illness is vitally important because all individuals have a right to their cultural beliefs, practices, and values (Holland & Courtney, 1998).

Danes, Oswald, and Esnaola (1998) used qualitative methods to study couples’ decision making processes in Panama City, Panama. The authors determined that the use of qualitative methodology in the form of open ended interview questions allows respondents to answer “however they choose each of the decision situations” (pg.3). In this study, the authors ascertained that qualitative research provides the tools to understand the inter-dynamics between people in decision making, in this case between husbands and wives in Panama, a society in which family plays a central role and is strongly influenced by the Roman Catholic Church. This church influence causes family interactions to be perceived as private. The use of qualitative methods allowed the authors to study this private aspect of Panamanian life.
Similarly, using grounded theory to guide the research methodology, Strickland (1996) conducted in-depth interviews, focus groups, and participant observation to learn about cervical cancer screening interventions among Yakima Indian women. The main cultural theme voiced by the women is *walking the journey of womanhood*, which includes starting the journey, blooming, heading the household, and becoming elder. The results show that to develop effective screening interventions, the structure of care, provider-patient communications, and community education for the Yakima women must be addressed. In addition, messages need to be wellness and community oriented and health education messages should incorporate cultural tenets such as storytelling, talking circles, and role modeling. In this manner the authors were able to apply qualitative research methodology to assist in the development of effective health education and screening interventions that are culturally relevant to Yakima women. In a similar manner, qualitative research can contribute to the development of relevant and effective health education and screening interventions that can be developed for other women, such as Panamanian women.

Narrative research, such as within feminist theories, can bear in social science research using evidence from in-depth interviews with cervical cancer patients the conditions, relationships, and dominant meanings about gender and sexuality in which their lives have evolved (Bell, 1994). Qualitative research methods are founded in an understanding of research as a systematic and reflective process for development of knowledge that can somehow be contested and shared, implying ambitions of transferability beyond the study setting (Malterud, 2001). Alternative criteria in qualitative research are suggested (Hamberg, Johansson, Lindgren, & Westman, 1994),
where credibility, dependability, confirmability and transferability correspond to internal validity, objectivity, and generalizability, respectively. Relevance, validity and reflexivity are also proposed as overall standards for qualitative inquiry (Malterud, 2001). Hence, qualitative research is also subject to systematic criteria for scientific rigour as quantitative research (Malterud, 2001). Responsible application of qualitative research methods is a promising approach to broader understanding of clinical realities, such as cervical cancer (Malterud, 2001).

This study was mostly qualitative in nature, using behavioral research techniques such as semi-structured individual interviews and group interviews guided with an interview guide. Within the individual interviews techniques such as free listing and pile sorting among the first 30 participants were used to understand characterization of health related items. The researcher maintained a diary for field notes. Most of the notes related to conversations with public health personnel at health centers, clinics and hospitals.

Synopsis of Literature Review

International literature regarding cervical cancer focuses mostly on clinical and epidemiological data. In turn, international non-epidemiological literature on cervical cancer is based on research conducted from a multi-disciplinary public health perspective by scientists from a range of backgrounds including social epidemiology, public health medicine, social oncology, health promotion, anthropology, and sociology (Wood et al., 1997). In addition, studies conducted to elucidate lay women’s perceptions of cervical cancer have been mostly limited to knowledge, attitude and beliefs (KAB) surveys with a focus on Europe and the United States (Wood et al., 1997). A noticeable gap in literature
exists, with few studies available discussing lay women’s perceptions of cervical cancer in Africa and Latin America, the regions most affected by cervical cancer worldwide.

The importance of exploring lay constructions of disease and illness, and of biomedical procedures such as cervical cancer screening is especially acute in developing countries where local explanatory models of illness frequently diverge from biomedical paradigms (Wood et al., 1997). In addition, social constructionism can be a form of social justice where narrative and constructivist approaches to clinical work help us listen to the voices from lay persons (Dean & Rhodes, 1998); it has emancipatory potential (Sayer, 1997). This study has multiple practical applications. For example, it provides an opportunity to address women’s cancer screening to better their health and listens to women’s voices (experiences, perspectives, desires, needs), especially women in non-dominant countries. In narrative studies following social constructionist perspectives, knowledge is created instead of discovered and context is all important (Dean & Rhodes, 1998).

In summary, health can be determined by historical, biological, behavioral, social and physical environments. So, each aspect related to these broad determinants of health must be addressed to assure access to care among Latinos and other racial/ethnic minorities. In addition, policies and interventions must be developed to adequately address inequality of care. To illustrate, aging, diet, physical activity, smoking, stress, alcohol or illicit drug abuse and injury or violence can result in illness or disability. Furthermore, housing, public transportation or lead exposure can also affect an individual’s health (USDHHS, 2000a). Policies and interventions can provide powerful and positive effects on the health of individuals and the community (USDHHS, 2000a).
However, to reduce health disparities, it is imperative that these policies and interventions be racially and culturally relevant. This can be accomplished by understanding construction of illness among the intended group (e.g., a priority population).

In conclusion, the unequal burden of disease is evident among racial and ethnic minorities in the United States. Latinos, as well as other priority populations, experience higher negative health outcomes than other populations, mainly Anglo. As the Latino population continues to grow in the United States, health disparities affecting this group will continue to develop. Epidemiology and risk factors of infirmity among Latinos should be further understood. As lack of relevant and supporting data continues to exist, knowledge dissemination efforts should proceed (research, scientific publications).

Globalization and increased immigration of Latinos also increase the types and statistics of disease and illness. Healthier people increase productivity and economic growth, which is what drives Latino immigration to the United States and what makes their large influx tolerable in this country as well. A concerted effort must be made by health service providers and decision-makers to deliver effective, efficient and culturally relevant health care to Latino populations in the United States and internationally.

In general, people in Latin American countries experience adverse health effects. Factors that exacerbate health status in Latin American countries include: cultural factors, socioeconomic factors, income disparities among countries and individuals, lack of health care resources, political organization, social structure, demographic and macroecological processes. Health assessments conducted by the Pan American Health Organization, USAID, Jacques Van der Gaag for the World Bank and Rina Alcalay for the Western Consortium for Public Health show parallel trends among countries in Central America,
including Panama (Alcalay, 1988; Van de Gaag, 1995; PAHO, 1996; USAID, 2000a; USAID, 2000b). These health assessments report that Latin American and Caribbean countries show some of the greatest social inequities in the world.

All sociopolitical and economic issues that these countries face limit the ability of the public health sector to adequately distribute health care services. In addition to a fragile public health structure in Latin America that have made traditional health care difficult, the emergence of new disease epidemics, such as HIV/AIDS, chronic disease (e.g., cancer), increasing violence, environmental hazards and new and re-emerging diseases (e.g., tuberculosis) have made the health problems in Latin America worse. These new and re-emerging disease epidemics bring escalating health care costs and the need for reform, all within the context of volatile political, economic and social systems.

Women in Panama experience high incidences of HPV and cervical cancer. Structural public health factors seem adequate for the delivery of cervical cancer screening services among women in Panama. Regular screening prevents at least 70% of potential cervical cancers (Alexander, et al., 2001). Nonetheless, women in Panama do not tend to practice screening behaviors. Understanding the construction of cervical cancer screening among Panamanian women could help address the lack of screening participation. A dearth of literature exists regarding sociocultural experiences of health and illness in Panama, specifically as it relates to cervical cancer (most of the information available is of an epidemiological or clinical nature). A need exists for anthropological approaches to health research (Chavez et al., 2001). Information on the construction of cervical cancer screening among Panamanian women could help address health
disparities among women of priority populations in similar situations in the United States.
CHAPTER III-METHODS

The purpose of the study was to explore the constructed meanings of cervical cancer and cervical cancer screening among women in Panama City, Panama, as well as, sociocultural factors that might deter or encourage women from seeking screening services. Semi-structured individual interviews and group interviews were conducted among working class Mestizo women in Panama City, Panama ages 20-40 years of age. This population of women presents the highest incidence of human papillomavirus (HPV), 52% of all women in Panama. Thus, this group of women is at high risk for developing cervical cancer. This third chapter describes the methodology that was used in the study, including research questions, sampling, recruitment, study design rigor, including reliability and validity, data collection and analysis and interpretation processes.

Research Questions

Research objectives guided the research questions on Panamanian women’s understanding of the meaning of cervical cancer and cervical cancer screening.

Objective 1: To understand the meaning of cancer, cervical cancer, and cervical cancer screening constructed by Panamanian women.

Research Questions:

a. How do women think about cervical cancer screening?

b. What are women’s perceptions about cervical cancer screening?
c. What factors encourage or deter (e.g., family, religion, culture, etc.) women from seeking screening services?

d. How do women perceive preventive care?

e. How do women perceive cancer?

f. What relationship, if any, do women make between sexuality, health and cervical cancer?

Objective 2: To understand social influence on Panamanian women regarding cervical cancer screening.

Research Questions:

a. What social norms affect women’s understanding of cervical cancer screening?

b. To what extent do others’ opinions influence women’s attitudes regarding cervical cancer screening?

c. Who or what influences women’s communications about health and medicine?

d. Whose opinions most highly influence women’s attitudes regarding cervical cancer screening?

Objective 3: To observe the impact of cervical cancer and cervical cancer screening information transmitted by local media.

Research Questions:

a. What are women’s perspectives about health information in the media?

b. How do women react to health information presented to them in local print media?

For future health education endeavors [not part of theoretical framework]:

Objective 4: To identify Panamanian women’s learning preferences of health messages.
a. Where do women receive their health information?

b. What information channels would be more engaging for women?

Methodology

The following section focuses on the methodology used to conduct this study. Sub-sections are presented on study population, setting, inclusion criteria, recruitment, data collection processes, technical aspects, field notes, rigor, and data analysis.

Study Population

The focus population of the study was adult working class Mestizo women in Panama City, Panama between 20-40 years of age. The total population in Panama City represented by this age group is 244,060 women (Contraloría General de la República, Sección de Estadística y Censo, 2001). This is the population sub-group with highest incidence of human papillomavirus (HPV). Fifty two percent of women within this age group are infected with HPV. Consequently, this population is at high risk of developing cervical cancer. From a health education standpoint, this population should be targeted with prevention and early detection messages before they develop cervical cancer.

Setting

Individual and group interviews were conducted at clinics, health centers, restaurants and at women’s homes in Panama City, Panama. Each site was selected by the women themselves to provide a natural setting for the women and conduct the interviews in locations where the women would feel most comfortable. Clinics provided initial access to women who are regularly and not regularly screened. Clinics that serve distinct socioeconomic (low, middle, higher economic status) sectors of the population provided the initial point of contact. Panama is a country where class differentiation is clearly
demarcated; the distinction of settings was easily achieved. Clinics of La Caja del Seguro Social provide services to lower socioeconomic sectors of the population. Some of these clinics can be crowded and dirty. The Clínica San Fernando (San Fernando Clinic) provides services to middle level socioeconomic sectors of the population. This is a small hospital with a less crowded environment, located close to downtown in Panama City. Hospital Paitilla (Paitilla Hospital) provides services to higher socioeconomic sectors of the population. This is a small hospital that provides services to patients of higher SES. It is located within one of the most exclusive areas of Panama City. The clinics are located within distinct geographical locations in the city, where persons of each identified SES strata might seek health care services.

Women opened their homes to us. Some women would have sodas and snacks for us, although we brought snacks as well. During the group interviews at women’s homes, family members greeted us and talked to us for a while. They would then leave us to conduct the interviews. Our visits were seen as important events for the women and their families.

*In-Depth Semi-Structured Interviews*

*Inclusion Criteria for Individual Interviews*

Women included in the study were Mestizo women born and raised in Panama City, Panama and lived in this city their entire lives. Women between the ages of 20-40 years of age who are married, single or women cohabiting with a partner, with or without children were included in the study. In addition, women who are regularly screened, not regularly screened (over 3 years since last Pap test), and women who have never been screened for cervical cancer participated in the interviews. These subgroups were further
divided by socioeconomic status (SES) based on the location of the interview and background information.

*Exclusion Criteria for Individual Interviews*

Women who are younger than 20 years of age or older than 40 years of age were not included in the study. Women who are not considered of Mestizo ethnicity, such as those of Native American, Black (Afro-American), Caucasian, or Asian ethnic backgrounds were not included in the study. Women who lived in other countries and cities outside of Panama City were excluded in the study (Appendix C-Interview Inclusion-Exclusion Criteria Tool).

*Demographics*

Upon completion of the interview, women were asked to complete a short demographics sheet or biographical questionnaire (Debats, Drost, & Hansen, 1995). The biographical questionnaire contained open and fixed response questions about age, sex, marital status, prior education, previous cervical cancer screening practices, and number of sexual partners. Some open-ended questions allowed participants to respond specifically to questions about their history, e.g., Have you ever had a Pap test done? When was the last time you had a Pap test done? These demographics and screening history were not limited to categories so more detailed information could be collected. Respondents may have felt more comfortable responding to certain open-ended questions, since many people in international settings are not used to responding to structured questions which might seem too formal (Baer, 1998). Open-ended questions also help identify range of answers that can be offered to respondents in more structured interviews in future studies (Salant & Dillman, 1994). In addition, open-ended questions
allowed women to add new categories that the researcher had not thought about when developing the study. For example, women mentioned being unida (cohabiting).

From a cultural perspective, some of the demographic questions might be evaluated by women as private information, such as number of sexual partners. Open-ended responses allowed participants to feel more comfortable when answering these personal questions (Appendix D-Demographics Information Instrument). The demographics sheet was pretested with ten Panamanian women and they all suggested to keep the sheet as it was, since it was simple and easy to complete.

Sample

Rather than aspiring to statistical generalizability or representativeness, qualitative research seeks to reflect the diversity within a given population and purposive sampling offers researchers a degree of control to avoid selection bias inherent in pre-existing groups (Barbour, 2001; Byrne, 2001c). Following Wood and colleagues’ (1997) study on the social construction of cervical cancer screening among rural Black women in South Africa, the study deliberately sampled regularly screened (annual Pap tests), not regularly screened (e.g., 3 years or more since last Pap test) and unscreened women (never had a Pap test) for interviews. The in-depth semi-structured interview sampling technique was a nonprobability sample, where the respondents were available, accessible, and willing to participate, but not all members of the population had an equal chance of participating in the study (McDermott & Sarvela, 1999). A nonprobability sample technique was selected due to the nature of the sensitive information of the study and the limited resources of the researcher (Green & Lewis, 1986). Nonprobability samples supported with ethnographic data are highly credible and are useful in exploratory
studies, such as this study (Bernard, 1994; Stewart, 1997). The non-probability sample was accomplished at clinic settings where we approached women and asked them to participate in the study. Health professionals at clinics identified women who were there to be screened.

During the study, it became apparent that *snowball sampling* would be necessary to accomplish the quota sample determined in a quota sampling matrix (Table 4). In snowball sampling, we asked key participants if they could recommend other women to participate in the study (Bernard, 1994; McDermott & Sarvela, 1999). The snowball effect was also observed to occur spontaneously, where women in the study recommend other women to participate of their own account. Women became interested in the topic and the process itself.

A quota sampling matrix (Table 4) guided the sampling of populations of interest and determined the proportions of those subpopulations for the final sample (Bernard, 1994). A sample size of ten or more women per matrix cell or homogeneous group (low, middle and high SES regularly screened women, not regularly screened, and never screened) is considered adequate for the study of social phenomena using a theoretical base (Sandelowski, 1995). It was proposed that a total of 108 women were included in the study for individual interviews; nonetheless, the total sample size was 117 women. Oversampling as additional interviews occurred among some subgroups of women to gather more information on certain topics and to reach theoretical saturation (repetitive pattern in responses).

Thirty-six regularly screened women, thirty-six women who are not regularly screened, and thirty-six unscreened women from lower, medium and higher
socioeconomic status were proposed to be interviewed in the study for individual interviews. During interviews, it became evident that further interviews among some subgroups of women were necessary. For example, instead of doing three interviews with regularly screened married women between 20 and 29 years of age of middle SES, we interviewed six women of this subgroup. At the same time, there were some subgroups of some difficult to identify, these were mostly younger women who are not regularly screened, married or unmarried. This was expected to occur once in the field. Consequently, forty-one regularly screened women were interviewed, thirty-four not regularly screened women were interviewed and forty-one who had never been screened were interviewed (Table 4).

Table 4. Quota Sampling Matrix of Interviews with Women

<table>
<thead>
<tr>
<th>Screening History</th>
<th>Marital Status</th>
<th>Age Group</th>
<th>Socioeconomic Status</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>Regularly Screened</td>
<td>Married</td>
<td>20-29</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30-40</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Unmarried</td>
<td>20-29</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30-40</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Not Regularly</td>
<td>Married</td>
<td>20-29</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Screened</td>
<td></td>
<td>30-40</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Unmarried</td>
<td>20-29</td>
<td>2</td>
<td>3</td>
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Recruitment

Recruitment of Regularly Screened Women

A grab sampling method or central location intercept method was used as nonprobability sampling technique for the present study (McDermott & Sarvela, 1999). The grab sampling method was employed at gynecological departments of the clinics to reach women who are screened. This sampling method is recommended to study difficult to identify subjects as are women in Panama who are screened for cervical cancer (Bernard, 1994). This method proved most useful in finding women who are most regularly screened at clinics and health centers. We basically approached women at health centers or asked health professionals to identify women who were being screened.

Study participants were approached at central locations where women are screened for cervical cancer, namely at clinics of La Caja del Seguro Social, Clínica San Fernando (San Fernando Clinic) and Hospital Paitilla (Paitilla Hospital). Permission to conduct the present study from clinic administrators was requested. Assistance in recruitment of women was also requested from friends, health care practitioners, administrators or lay community workers in introducing the researcher to the subjects as a form of building trust from community members (Green, Daniel, & Novick, 2001; Kreuter, Lezin, & Young 2000).

Once potential participants were identified, criteria for inclusion-exclusion into study were determined (Refer to Inclusion-Exclusion Criteria Section). If women met inclusion criteria, they were explained the nature of the study, that participation was completely voluntary and confidential and that results will be used as aggregate data. Oral informed consent was sought in Spanish as approved by the University of South
Florida’s Institutional Review Board (Appendix B). If women agreed to participate in the study they were asked if they preferred to have the interview at that location or proceed to another location where they might feel more comfortable. Women were asked if they objected to having the interviews tape-recorded. All women approached accepted to participate in the study and to have the interviews tape-recorded.

Women who preferred to participate in the study at a later time or different location were asked to provide their contact information to make an appointment for the interview or determine the appointment time and date at that moment. The women themselves determined the time, date and location most convenient and appropriate for the interview. This allowed women to be interviewed at a location where they felt most at ease and comfortable.

Recruitment of Not Regularly Screened Women

Due to confidentiality laws, clinic records were not accessible to identify this subgroup of women. Hence, snowball sampling technique was used to identify these women. Irregular screeners (e.g., last Pap test 3 or more years before study) were identified using a snowball sampling technique. Clinic records were not accessible to identify this subgroup of women. This particular subgroup was the most difficult to identify, especially the younger women. The snowball sampling technique was most useful in identifying this group of women; the result was matched women with similar backgrounds across subgroups.

Other women in the study and the community (not participating in study) were asked to identify women who they thought were not regularly screened by the time of the study. Women were asked to identify women who do not get regular female check-ups.
The identified women were contacted, explained the nature of the study and asked to participate. If they agreed to participate, an appointment was made to meet with them and be interviewed at a central location (e.g., their homes, restaurant, etc.).

Recruitment of Unscreened Women

Women who have never been screened were also identified using a snowball sampling technique. Snowball sampling is useful in studies of social networks of small and difficult-to-find populations in community studies (Bernard, 1994). This word-of-mouth technique assists in locating an otherwise invisible group (Grbich, 1999).

Ostrander (1980) recommends asking other women in the social group or network with similar backgrounds who would be willing to talk to us. In this way a type of “matching” occurs between women screened and not screened and this will ensure comparability between groups (Menjivar, 1995). The snowball technique was applied and became useful in identifying this subgroup of women.

Unscreened women were recruited by asking regularly screened and not regularly screened women to identify other women who have never been tested. We also asked other women in the community, who were not participating in the study to identify women who they thought might not have been tested for cervical cancer.

Unscreened women were contacted by researcher or research assistant. The women were explained the nature of the study and for their voluntary and confidential participation. Women who agreed to participate in the study determined the date, location and time for the interview. This assisted in allowing women to control the research situation and feel more comfortable to participate in study.
Group Interviews

Four group interviews were conducted among women to observe and understand their reaction and social dynamics to local print media regarding cervical cancer (N=15). This was the minimum number of groups proposed in the study. I decided to end the groups at four since saturation of data occurred and responses became repetitive. Each group was a mixed group of regularly screened, not regularly screened, unscreened, married and unmarried women. Three to four women participated in each group. Groups were maintained small, since the purpose of the groups was to observe and discuss the reaction to the information with and among women. Larger groups would perhaps not allow this process to occur.

The groups became an enjoyable experience for the women and us. They were all conducted at women’s homes and on Saturday mornings since most of the women worked. We brought snacks and small makeup bags or earrings as gifts to thank them for their time. Women enjoyed the group experience as well as the gifts and suggested conducting educational sessions in this format. The gifts were a nice addition to the experience as women noted not receiving anything after participating in interviews. The groups became our weekly outings and it provided us with the opportunity to observe women at social settings. Women asked that more groups like these were conducted within communities (e.g., community centers) or at health centers.

During the group interviews, I first thanked the women for participating in the study. Oral consent was first sought and introductions then took place. Handouts of copies of local newspapers with information on human papillomavirus, cervical cancer and cervical cancer screening were distributed among the women (Appendix E-Sample of
Local Newspaper Articles). Each woman read a different article and then proceeded to discuss the information. This exercise provided a medium to observe discussion and construction of meanings as they occurred. Women also responded to questions from the interview guide (Appendix F- Interview Guide). Demographic sheets were completed at the end of the group interviews (Appendix D-Demographic Information Instrument).

Recruitment of Women for Group Interviews

All women individually interviewed were asked to participate in group interviews. The group interviews took place in central locations (e.g., women’s homes) and at times identified by women. Women in the community and at clinics were approached and asked to participate in these group interviews. Some women who had participated in individual interviews offered to have the groups at their homes. They also provided names of women they thought would be interested in participating in this study.

The Process of Data Collection

Individual Semi-Structured Interviews

Pre-/post-interviews were conducted among women who are regularly screened and interviewed at clinics. Their experiences with the health care system were explored by conducting an interview before and an exit interview immediately following their exam. The in-depth interviews followed a semi-structured platform with the assistance of an interview guide (Appendix F-Interview Guide) (Stead, Brown, Fallowfield, & Selby, 2002). The interview guide begins with an icebreaker (e.g., What did you do for the holidays? etc.), from general day-to-day and family topics, followed by health topics, use of media for health information, then cancer, cervical cancer, cervical and cancer screening. Although cervical cancer is a problem in Panama, it might not be foremost in
women’s mind. This anthropological technique of interviewing, from general to specific, allows us to understand how health topics might fit in women’s daily lives.

The interview guide for individual interviews was developed based on preliminary data and based on study research questions and objectives (Calvo, 2001). Information collected from freelisting and pile sorting assisted probing during individual and group interviews. Freelisting provided information from the women’s point of view without the researcher imposing her own beliefs. For example, research question from Objective 1 (Refer to Research Objectives in Chapters 1 or 3), asks if women find a relationship, if any, between sexuality, health and cervical cancer.

Cervical cancer screening questions were divided for regularly screened women, not regularly screened, and unscreened women. For example, women were asked “What kind of women go get a Pap test/female check-up?”; for regularly screened women “What are the reasons you go get a female check-up?”; and for not regularly screened women “What are the reasons you have not returned for a Pap test?” The guide evolved as interviews were conducted. Some of the questions and language/terminology were adapted to fit the local character. For example, women felt comfortable talking about vaginal problems, so we used this term instead of problems down there.

Many interviews were conducted by myself in an attempt to avoid interviewer biases. Nonetheless, a research assistant who is trained in social work, familiar with the community and the culture of the women accompanied me during recruitment and data collection and conducted interviews. I trained the research assistant. During the first interviews she limited herself to the interview guide, but during debriefing I explained that she should probe and further inquire during conversations with women in future
interviews. The assistant also acted as an observer and recorder by taking notes of the interviews. Notes on body language, language and hesitations of participants were recorded by the research assistant (recorder). The research assistant regularly and systematically reviewed audiotapes. This type of information assisted me in further understanding sociocultural aspects and enhance the qualitative framework.

In addition, all interviews were conducted in natural settings selected by women in the study where they felt most comfortable. If the women were interviewed at clinics, a private room or area was used to conduct the interviews. All the interviews were conducted in Spanish. The women were instructed to respond to the questions posed and elaborate in their responses. The researcher administered the questions and probed accordingly. According to the women’s preference, they read or did not read the interview guide. Women should feel at ease to continue a conversation with the researcher during the interviewing process and in turn provide rich text data. The interviews were construed as “a conversation with a purpose” (Kahn & Cannell, 1957 as cited by McDermott & Sarvela, 1999, pg. 229). The guide evolved through the interviewing process, at times spontaneously. Women’s feedback was considered. For example, many women talked about violence in their communities, so this became an icebreaker. The interviews followed a natural speech often used by the women in their daily lives. Although difficult at times to identify women to participate in the study, the interviews became a pleasant process for both the women and us. We all learned in the process.

*Free Listing.* The first thirty women participating in individual interviews were asked to list all the things that women can do to stay healthy. If female check-ups (Pap
tests) were not mentioned, further probing occurred. This technique is called free listing. Free listing is a simple, yet powerful technique used to study cultural domains (Bernard, 1994). Free listing allowed us to study the women’s set of beliefs without imposing any of our own. Free listing allowed women to mention items that we had not considered as behaviors for healthy living and indigenous to women. For example, some of the women mentioned dancing or going to the beauty salon as ways of being healthy because the later helped their self-esteem.

**Pile Sorting.** Once a list of things a woman in Panama can do to stay healthy was identified in the free listing exercise, each one of the items was written on separate flashcards. The 30 women who did free listing also did pile sorting. Women were asked to sort by categories the items on the cards. Women were asked to “sort the cards into piles, putting things that are similar together into a pile” (Bernard, 1994, pg. 249). Specifically, a free pile sorting technique was used. This is an unconstrained pile sorting method. Women sorted the piles freely as they wished except single cards in separate piles or placed all cards into one single pile (Bernard, 1994). The women were not interrupted during the pile sorting process. This process took about 10 minutes. After the women were done sorting the piles into meaningful categories, then women were asked “Why did you put these together?” “What does this pile mean?” and “How is this pile different from that one?” Their responses were recorded. The piles were documented in *Word* by listing the different items per pile. Originally, it was intended to ask all women participating in the interviews to perform pile sorting, however, this concept was too difficult for the women to grasp and was limited to women who also did the free listing.
Group Interviews

Small group interviews (3-4 women) were conducted to observe and understand women’s reaction to local print media messages and social dynamics in discussing those messages (Appendix E-Sample of Local Newspaper Articles on Cervical Cancer and Screening). Previously published newspaper articles about cervical cancer screening were shared with the group of women. The groups were mixed, including regularly screened, not regularly screened, unscreened, married, and unmarried women. Representation of each subgroup of women was sought with one commonality among women so they felt more comfortable in a group setting. For example, groups of all younger women, but with different screening practices. We observed the interactions between women and whether they accepted or rejected the messages presented to them through local print media.

All interviews were conducted by myself. Both assistants participated in the groups to observe and record reactions, while I facilitated the group interactions and responses. The group meetings were conducted on Saturday mornings since most of the women worked. At the end of the interviews, women received small gifts (makeup, bags, and earrings) to thank them for their time and effort. All groups were a fun positive experience and women suggested using this format of health education and promotion programs.

The first group was conducted at the University of Panama’s College of Social Communication. The group was conducted there as one of the women helping recruit women had recently graduated from this college and was able to schedule a small classroom for the group session. The classroom had small hexagonal shaped tables,
which seated up to six people. We thought this seemed formal, although women appeared comfortable. The other three group interviews were conducted at women’s homes.

During group interviews women reacted to printed cervical cancer information presented to them from local newspapers (Appendix E- Sample of Local Newspaper Articles). Each woman received a different newspaper article, read it and shared the information with the women in the group. Women in groups reacted to the information and also shared their personal experiences and understanding of screening.

Technical Process of Research

Pretesting Instrument

The interview guide was pretested or pilot tested among Panamanian women with similar backgrounds as those expected to participate in the study. The women included in pretesting of the instrument were included in the study itself. Ten women were asked about the appropriateness of language being used in the questions, the ease of understanding of the questions (literacy), ethno-cultural innuendos, and comfort level with questions (Pasick, Stewart, Bird, & D’Onofrio, 2001). If some of the questions were construed as being too personal or offensive, the women were asked how these questions could be changed to a more comfortable level. Changes in the interview guide were made accordingly. Pretesting of the instrument also helped determine the length of interviews and the adequacy and relevancy of the questions for the study. Readability formulas were not used to determine the literacy level of the instrument, since the questions will be administered by the researcher or research assistant. Women did not read the interview guide during once the data collection process began during interviews. The process of
pretesting of the interview guide assisted in addressing issues of validity, reliability and transferability in multiethnic research (Meade et al., 2002; Pasick et al., 2001).

Audio-Taping Interviews

Before each interview (individual and group) began and after obtaining oral consent to participate in study, women were asked if they objected to being audio-taped or tape-recorded. All women in the study agreed to being tape-recorded. A small table recorder was used to record the interviews. Sixty-minute tapes were used to record the interviews to avoid the tapes jamming in the recorder, since longer tapes (e.g., 90 minutes) can jam easily. Also, 60 minute audiotapes provide better quality recording. Additional tapes were used according to the length of the interview and properly marked for identification. The names of the women interviewed were not used to ensure confidentiality; the tapes were numbered and dated. The audio-tapes were used to transcribe interviews. One tape was used for each individual and group interview; this facilitated the identification of the interviews.

Transcription

The audio-taped recordings of the interviews were transcribed verbatim in Spanish. Verbatim transcription of audio tapes assisted in eliminating any type of bias and to avoid human error. I selected a person to transcribe the data in Panama City. She transcribed every word and included hesitations. We would get together periodically as she progressed with the transcriptions and she shared her observations. Once finalized, the transcriptions were read as the audio-tapes are played to determine accuracy of transcription. The transcription was supervised by myself and checked for accuracy.
Translation

All interviews were conducted in Spanish, the native language of women in the study. The complete verbatim transcripts of the interviews were not translated into English, except for ten interviews of different sub-groups of women translated for review of non-Spanish speaking researchers in the U.S. Summaries of emergent themes and categories as they emerged during data analysis were also translated into English to share with non-Spanish speaking researchers. The data analysis and interpretation were conducted in Spanish and the findings were translated into English for reporting and presentation purposes. Salient quotes from interviews are presented in English translation to enhance the reporting of the results and present women’s understandings.

A certified professional translator reviewed the English translations of quotes against the Spanish quotes. The translator revised the translations with the prudence of not presenting the English quotes in formal language, but maintaining the flavor of the women’s popular speech. The certified translator reviewed the quotes within Chapter IV (Appendix G-Certification of Professional Translation).

Debriefing

After each interview a debriefing process occurred between the primary interviewer and recorder. This debriefing process assisted us in checking and establishing whether the women’s viewpoints were adequately interpreted through comparison (Giacomini & Cook, 2000a). During debriefing, the setting, body language, hesitations, and working of respondents were discussed and documented.

Further, observations and probes were determined in a discussion and consensus process. In addition, daily telephone contact and weekly meetings among the research
team took place. In these meetings, we discussed changes in the sampling and probing, as well as observations made of interviews. The debriefing process was most helpful in keeping check with the research protocol and coming to realizations together which sometimes on our own did not occur. Feedback on our interviewing techniques was also important in defining the information sought and fine tuning the process.

Non-Participation

Originally it was proposed to systematically track all women who declined participating in the study. However, all women approached accepted to participate in the study. Non-participation was suggested as means to understand cultural aspects that affected women’s participation. Total participation in the study also offers insight into cultural factors for participation. Most women said that they were interested in their health and that they welcomed new information. Gifts were also given to women in individual interviews, but this occurred at the end of the interviews. Women were not aware of the gifts until the interviews were finalized, so this is not considered as a factor in participation of women in the study. This is important to note because women were willing to participate in the interviews without the need of receiving an incentive.

Social Process of Research

Conducting this study in Panama has been one of the most difficult and yet satisfying experiences of my life. Going to health centers, observing public health practices and settings in Latin America was an invaluable experience for me as a health researcher. Gaining access to women at health centers was fairly easy. But what became the most enjoyable experience for me were the group interviews at women’s homes. Observing the women at their natural surroundings, especially at low income homes, was
revitalizing. Women were so open to us and helpful. We would not have been able to do this without the women’s support. One of the most salient experiences was a group interview we were going to conduct at low SES woman’s home. She lived in a crowded neighborhood in a hill. There were no roads to get into this neighborhood or *barriada*. The three of us (me and the two research assistants—Lina and Diana), parked the car outside on a busy road and walked for what seemed to us to be miles toward this woman’s home. We were carrying sodas, snacks, gifts, tape recorders, notepads and walking in the heat under the bright Ecuadorian sun. By the time we got there we were exhausted, but we were welcomed by the woman’s entire family, including grandparents. It was so wonderful that we forgot the exhausting walk. Most of our experiences were positive. Women welcomed us into their homes and into their worlds. They asked for more conversations, as opportunity for them to share their thoughts, beliefs and experiences.

Another experience, on a more negative note, was during transcription of interviews. The woman, a young twenty-three year old working class young woman, single and living with her parents, after transcribing the initial batch of interviews decided to get screened. She was diagnosed with HPV. She received cryotherapy to freeze the lesions. After this, we would regularly talk about her own experience with HPV. She helped me understand many sociocultural issues that I feel I would not have focused on without her insight.

**Incentives**

Monetary incentives were not provided to participants due to lack of resources and also because it is not common practice in international research to provide financial
remuneration for research participation. Nonetheless, as identified in preliminary data (Calvo, 2001), women in Panama enjoy receiving personal items such as makeup bags or hair accessories accompanied by information materials as incentives for research participation. In this study, similar types of incentives (e.g., makeup; bags; jewelry) were presented to participants at the end of the interview sessions. Women enjoyed the gifts and mentioned not having received gifts before when participating in surveys or classes. Women who asked for information received pamphlets on breast and cervical cancer and information on where to get tested.

Field Notes

Log

Diana (research assistant trained as social worker) and I maintained a handwritten logbook for scheduling, agenda of interviews and any other research-related occurrence. Following Bernard’s (1994) recommendation, each day in the field was represented by a double page of the book. On the left-hand side the scheduled activities were recorded, while on the right-hand side the actual occurrence a record was entered. Even days when nothing occurred were recorded. A calendar was also used to denote activity; this provided a more visual understanding of daily activity.

Jotting

I carried (and still do) a notepad at all times to write down any information or insight. In this manner, anything that might strike me, was recorded. Jotting can be lengthy notes of just a few key words (Bernard, 1994). If I decided to take notes while talking to an informant or during an informal conversation, I asked for permission to take notes during the conversation. Many of the field notes for this study were recorded in this
manner. I found this manner of recording useful and insightful, even more so than typing the notes on the computer. Sometimes I would be having a conversation with someone, if it was a person whom I knew well, I would say “give me a minute.” I would write our conversation, think and they come back to the person and continue the conversation.

*Field Notes*

The use of field notes in this study also helped me in documenting self-reflection through an iterative process. Two types of field notes were recorded: methodological and descriptive field notes (Bernard, 1994). Methodological field notes, as the name implies, refer to research methodologies (e.g., talking to key informants on a regular basis; feedback from research assistant). Descriptive field notes describe the setting, the interviews, logistics, unfamiliar processes, and other aspects that need to be described. Personal thoughts and ideas were also recorded in the field notes as form of a diary. All field notes were recorded by hand in a notepad.

As a researcher, I reflected on the research questions, the role as a researcher and research assistant, attitudes, feelings, impact of the researcher on the women being studied, reflection on logistics and any changes to the research process (Power & Williams, 2001). Debriefing discussions were recorded in the field notes and reviewed during analysis and interpretation of data. This information is presented in the study results as personal insights of findings.

*Role of the Research Assistants*

The first research assistant (Lina) assisted in coordinating the study. Lina is a lay person, 34 years of age at the time of the study, married with a young daughter and son. She has knowledge of cervical cancer screening Panama and of local Panamanian media.
She worked for several years at a gynecologist’s office, so she has contacts in the health care field, which assisted in recruitment of screened women and communications with clinic staff. During preliminary data collection she was instrumental in recruiting women and accessing key informants for interviews. This experience was also useful in determining cultural innuendoes which was considered when approaching women at clinics. She also has a background in mass communications, which is helpful in understanding and accessing local media, for example, she was helpful in determining the lack of availability of local television programming archives for content analysis. Lina is also fully bilingual in English and Spanish.

The second research assistant (Diana) participated more hands-on during the research process and in day-to-day activities. She has a bachelor’s degree in social work. Diana helped recruit women. I trained her to conduct interviews, on how to approach the women and the information needed for the study. The research assistant also conducted interviews. She also acted as an observer and recorder (note taking) during interviews with women. She was instructed to observe body language, pay attention to pauses, hesitations, and other aspects of communication during interviews with women. After each interview a debriefing session occurred between researcher and research assistant. Observations of body language and women’s responses were discussed, as well as, tips on probing and how to better develop interviewing techniques.

In addition, we determined together if wording of questions should be changed. Diana and Lina also reviewed field notes, audiotapes of interviews, and transcripts of qualitative data. They reviewed summaries of interview findings and wrote their own observations and if they disagreed with findings (e.g., emergent themes). Personality is
important in qualitative research, both are pleasant women, Diana’s demeanor upon approaching the women helped recruit participants in a seamless manner.

*Conducting the Interviews*

Each interview lasted between one and two hours, a few times they lasted three hours. Time for building rapport before the interview and talking after the interview was considered. A debriefing session followed each interview or was done via telephone each evening when the team had not met during the day. Approximately two to three interviews were conducted per day. To conduct a total of 117 interviews and address logistical issues, we conducted interviews between January 2003 and March 2003. Teamwork was crucial in coordinating and conducting the interviews. All individual interviews were conducted first. Time to review data of individual interviews was allocated before moving into group interviews. This was useful in assimilating the data before conducting the group interviews and applying the information into the group processes. Group interviews (N=15) were conducted in April-May 2003, once we had finalized discussing individual interviews.

*Assessing Rigor, Validity, Reliability, Transferability and Reflexivity*

*Rigor*

Credibility of research is enhanced through rigorous techniques and methods that produce high-quality data (Patton, 1999). Rigor of the study was determined by principles of reflexivity, validity, reliability and transferability (generalizability). Rigor in qualitative research refers to the systematic approach to the research study and following a delineated process in a tight research design. Major issues to address are the extent to which the researcher has disturbed the setting, the potential for selective interpretation
and presentation of findings, and whether or not all aspects of the phenomenon have been addressed in the study (Grbich, 1999). Issues related to rigor of the study were addressed through the use of preliminary data, the use of snowball effect in sampling, familiarity with the subjects’ culture, and the assistance of local health care providers. The setting of interviews was also important, all locations were selected by women themselves, and this allowed women to feel that they contributed to the study. Some of the women offered their homes for the group interviews and even contacted the other women themselves. The hospitality at women’s homes made us feel welcomed and at home, during certain interviews, families (mothers, grandparents) would be present to greet us and then would retire during the interview process. The participatory nature of the study allowed ownership of the study to be transferred to the women and therefore ensuring access to more information during the interviews.

Validity

Validity refers to the appropriateness, meaningfulness and usefulness of the specific inferences made, to the quality of the data derived, and the associated claims made when examining the results (McDermott & Sarvela, 1999). In this case, validity refers to whether the study investigates what it is meant to study (Malterud, 2001). Validity in qualitative research lies in the reader being convinced that the researcher has accessed and accurately represented the social world under study (Grbich, 1999, pg. 59).

The degree or level of truth of the responses given by participants increases validity of the study. This can be accomplished by developing trust through building rapport between researcher and subjects and by having a local key individual accept the researcher in the social network. Since the primary researcher and research assistants are
originally from Panama City, Panama building of rapport and trust from the women in the community occurred. The women were instructed that they only had to answer the questions they felt comfortable responding. Validity is also accomplished by presenting multiple quotes, including field notes, and attending to complexity. Our understandings are complex, so inconsistencies—even contradictions should be explored. If the researcher had questions about the data during the data analysis phase, community key informant interviews helped answer questions. This process also assists in addressing validity of data. Results and findings present salient quotes of interviews.

Reliability

Reliability refers to using research methods that provide information that is consistent, dependable and stable (McDermott & Sarvela, 1999). In qualitative research, reliability is also assessed by the reader and lies in the capacity of the researcher to present a coherent, complete and meticulously checked exploration of all aspects of the topic under investigation (Grbich, 1999, pg. 59). In this study, I followed a complete and meticulous exploration of all sociocultural, folk and popular aspects related to cervical cancer among women in Panama. Reliability exists where there is an indication that the studied subjects’ views and meanings have been accessed (Grbich, 1999). Most data was collected solely by the research assistant and myself. I also trained the research assistant as an additional effort to address reliability.

In addition, inter-rater reliability was addressed by asking another researcher familiar with Panamanian culture to review select raw data of the interviews. In this study the external researcher was a sociologist in Panama. Any discrepancies were resolved by discussing the findings between researchers. In this manner, any subjective judgments of
an individual researcher can be addressed (Pope, Ziebland, & Mays, 2000). Reliability as consistency of meaning was addressed by consulting with other researcher’s interpretation of the data through discussion until consensus is reached (Meade, Calvo, Baer, & Rivera, 2003; Madill, Jordan, & Shirley, 2000). A reliability check was conducted by asking a researcher to act as an independent judge (Cope, 1995). The independent judge was a psychiatrist who works in public health research at the Gorgas Memorial Institute for Health Research in Panama City. She had been Minister of Health in the early 1990s. The independent judge reviewed verbatim transcripts of interview tapes. This researcher also independently coded ten interviews of a random sample of data, one interview from each tenth. The principal researcher and the independent judge discussed the coding until 80-90% intersubjective agreement (consensus) between them was reached (Cope, 1995).

Transferability

Transferability is related to external validity and to generalizability. External validity is the ability to generalize the results of a particular study to other persons, settings and times (McDermott & Sarvela, 1999). In general, qualitative research is not obviously generalizable because, by definition, it is context specific. Nonetheless, Malterud (2001) and Morse (1999) propose that findings from qualitative research can be transferable to other populations in similar situations. The goal of research is to generate new knowledge that can be shared and applied beyond the study setting, but is not supposed to be valid for population groups at large (Malterud, 2001). Qualitative research offers the researcher a corpus of richly descriptive findings that can be transferred to other situations (e.g., other Latinas) and even other types of phenomena (e.g., other forms
of cancer or other diseases) (Byrne, 2001c). Hence, what is true of people in one situation is likely true of other people in a similar situation (Grbich, 1999). Qualitative research methods are founded on an understanding of research as a systematic and reflective process for development of knowledge that can be contested and shared, implying transferability beyond the study setting (Malterud, 2001).

**Reflexivity**

An assessment of the researcher’s subjectivity was conducted as a process of reflexivity (Malterud, 2001). During all steps of the research process, the effect of the researcher was assessed, recorded and shared. This was accomplished through the use of field notes during research and the tape recording and transcription of interviews as *audit trails*, in case others are interested in auditing the data (Grbich, 1999). Audit trails refer to tracing the conceptual development of the study from raw data through data reduction, analysis and reconstruction (Grbich, 1999). Bias, in the sense of undesirable or hidden skewness, will then be accounted for instead of eliminated. Subjectivity was then identified through this process. Subjectivity arises when the effect of the researcher is ignored (Malterud, 2001). Recording the researcher’s personal thoughts and experiences also provides useful information (Giacomini & Cook, 2000a). These personal notes are further used on supporting data presented in the results section.

Reflexivity starts by identifying preconceptions brought into the project by the researcher, representing previous personal and professional experiences, pre-study beliefs about how things are and what is to be investigated, motivation and qualifications for exploration of the field, and perspectives and theoretical foundations related to education and interests (Malterud, 2001). Preconceptions are not biases unless the researcher fails to
mention them; personal issues can be valuable sources for relevant and specific research as well as changes in the researcher’s position and perspectives throughout the study (Grbich, 1999; Malterud, 2001). I also reviewed the data with a clear mindset trying to avoid any previous notion or contemplated findings. The findings resulted from data analysis and the researcher tried to avoid portraying personal opinions as finding emerged.

**Data Analysis**

The contextual data collected was organized with assistance of a qualitative research computer program, *Ethnograph V5* (Scolari, Sage Publications Software, 1997; Vanclay, 2000). The use of a computer software program for qualitative data analysis enhances consistency, rigor, and methods unavailable by manual codification (Weitzman, 1999). Interview transcripts were read looking for emergent themes during the process of data collection in an iterative process. An ongoing inductive analysis was conducted in a *constant comparison*, where each item was checked and compared with the rest of the data to establish analytical categories (Pope et al., 2000). In this manner, any insights could address during the data collection in interviews. The iteration between data collection and analysis assisted us in well-developed further interviews (Giacomini & Cook, 2000a).

The transcripts were inserted into the computer program. The data was pared down to represent major themes or categories that describe the phenomenon under study (Byrne, 2001d). This consists in identifying, coding and categorizing patterns found in the data as themes, categories, labels or schematic models. Codes were used to conduct searches to extract and retrieve segments of data that represent the sought themes and
categories (Appendix H-Codebook for Analysis). In addition, the editing (data-based) analysis style was used by forming the basis for data developed categories, which then were used to reorganize the text so that meaning can be clearly determined (Malterud, 2001; Murdock, 1971). The data were categorized and compared by subgroup of women. The interview data, including pile sorting, were analyzed from each participant independently as well as in a cross-case analysis (Byrne, 2001d), where comparisons among different group categories were made (e.g., low income screened women vs. low income unscreened women, etc.).

Further analysis of data occurred manually. Transcripts were printed and divided by subgroup of women. Then transcripts further divided as emergent themes and categories became apparent. This practice assisted in determining patterns among subgroups of women and allowed for comparisons. Through reading I took notes of the themes in a notepad and along the right margin of the transcripts. Results of data analysis materialized through this form of analysis.

Analysis of demographic data was done with the assistance of the SPSS statistical analysis tool. The quantitative data generated from the demographic data coded and entered in Microsoft Office Excel and then transferred to SPSS for analysis. Descriptive statistics were used to summarize and organize the data set and used to report findings. Descriptive statistics of demographics include mean age, age ranges, mean level of education, educational attainment ranges, profession, among other information. The results are tabulated and interpreted in graphs and tables.

Freelisting of preventive health care among Panamanian women also provides quantitative data. The number of items in the lists, frequency, and rank order in this list
was analyzed. The researcher assumes that the nearer to the beginning of a list an item occurs, the more salient it is for the women (Bernard, 1994). A comparison between groups of free listing and order in lists of items is done among different women subgroups.

Interpretation is an important aspect of qualitative data analysis. Qualitative analysis is a process of summarizing and interpreting data to develop theoretical insights that describe and explain social phenomena such as interactions (social structure and interrelationships), experiences, roles, perspectives, symbols and organizations (Giacomini & Cook, 2000b). The interpretation of the data is dependent upon the researcher’s background, profession and culture. In an effort to ensure a systematic process, Elder and Miller (1995) suggest an interpretative analysis following a theoretical coherence. Elder and Miller’s model construes the qualities of parsimony (invokes a minimal number of assumptions), consistency (accords with what is already known and inconsistencies are well explored and explained), clarity (expresses ideas evocatively and sensibly), and fertility (suggests promising directions for further investigation).

Interpretation of findings in the study follows Elder and Miller’s model of interpretation for qualitative research. The assistant (observer) was asked to review interpretations of data analysis to determine if my interpretations were parallel to the observations during the interviewing process. In addition, community key informants were asked to assist in interpretation of data whenever I might have any questions. Any discrepancies were discussed until consensus of interpretations was reached. Reporting of data contains multiple examples of women’s talk, where salient quotes of interviews are utilized to represent findings.
Summary

Research objectives helped guide research questions for this study. Multiple methods of qualitative research techniques were used to collect data, including: individual research interviews, freelisting, pile sorting, and group discussion sessions. Data were collected during the first half of 2003 among 132 young Mestizo women, 20-40 years of age in Panama City, Panama. All interviews were tape-recorded with women’s permission and transcribed verbatim. Aspects such as validity, transferability, and reliability of data were addressed to ensure research study rigor. Data were organized using Ethnograph and analyzed by stratification of subgroups of women. Results are presented thematically using multiple quotes to support findings.
CHAPTER IV-RESULTS

Chapter four presents the results of the study. Social constructionism, explained in Chapters I and II, serves as the guiding theoretical process to understand the information collected in the study. The results are presented thematically based on data provided by women. Data was collected conducting multiple qualitative research techniques including free listing, pile sorting, semi-structured individual interviews and group discussions. All interviews were conducted in Spanish. The data are further supported by information from field notes gathered during observation and personal conversations with community members and health care professionals. Narrative data in the form of quotes are used to support observations. Health beliefs of women include factors which do not deter women from screening (e.g., family, religion, cost) and factors which affect women’s screening behavior (e.g., fear, female influence).

Research questions based on research objectives provided structure to the study. Women shared their understanding of health, cancer, cervical cancer, reproductive health and cervical cancer screening during interviews that provide qualitative data for this analysis. The data collected provide insight into women’s understandings of the meanings of cancer and screening behaviors resulting from media, female and male social networks, and health care practitioners.

The primary objective of this study was to understand the meaning of cancer, cervical cancer, and cervical cancer screening as constructed by Panamanian women.
Specific research questions included: 1) How do women think about cervical cancer screening? 2) What are women’s perceptions about cervical cancer screening? 3) What factors encourage or deter (e.g., family, religion, culture) women from seeking screening services? 4) How do women perceive preventive care? 5) How do women perceive cancer? and 6) What relationship, if any, do women make between sexuality, health and cervical cancer?

A second study objective was to understand social influences on Panamanian women regarding cervical cancer screening. To answer this objective the following research questions were asked: 1) What social norms affect women’s understanding of cervical cancer screening? 2) To what extent do others’ opinions influence women’s attitudes regarding cervical cancer screening? 3) Who or what influences women’s communications about health and medicine? 4) Whose opinions most highly influence women’s attitudes regarding cervical cancer screening? 5) Do men deter women from getting screened? and 6) Who forms women’s social networks and support systems?

A third study objective was to observe the impact of cervical cancer and cervical cancer screening information transmitted by local media. Research questions included: 1) What are women’s perspectives about health information in the media? and 2) How do women react to health information presented to them in local print media? Finally, for health education purposes, women shared their opinions on how relevant health information should be delivered to them and other women in their communities.

The results include demographic information of individual and group interviews, sociocultural factors important to women that do not influence their screening behaviors (e.g., family, religion, self-medication), structural factors (e.g., cost, experiences with
health care system), women’s health beliefs that influence their screening behaviors (e.g., health model, religion, fear, reproductive health, prevention, vaginal hygiene, social influences) and social construction. The chapter ends with a short summary of results.

Demographic Information

Individual Interviews

One-hundred and seventeen (N=117) individual interviews were conducted among low, middle and high socioeconomic status (SES) Mestizo, women 20-40 years of age indigenous to Panama City, Panama. These women included those self-reporting as regularly screened (at least once a year), irregularly screened (last Pap test was at least 3 years before the study period), and never screened (women who had never had a Pap test) (Table 4-Quota Sampling Matrix, see Chapter 3, pg. 97). Information on age, marital status, educational attainment, preferred language and sociocultural status (SES) is presented in Table 5.

The average age of women interviewed was between 26-30 years of age with ranges from 20 to 40 years. Women between the ages of 20 and 40 years are at the highest risk for developing human papillomavirus (HPV) infection (Reeves, 1985). Thus, these women are at-risk of eventually developing cervical cancer. Thirty-nine percent of the women were married and 7.7% were living with a partner outside marriage or cohabitating (unida). The average educational attainment of women was twelfth grade, with a minimum of 7th grade education to a maximum of graduate education at a master’s level. Many of the women had some college education, but had not graduated from college. Most women (91.4%) selected Spanish as their preferred language and most had been screened at least one time in their lives (66.7%). The average length of time since
last Pap test for women who have been screened was fourteen months, ranging from minimum of screening at the time of interview to nine years since last Pap test. Women from all SES levels (low, middle, high SES) participated in the study.

Table 5. Demographic Information of Women Interviewed (N=117)

<table>
<thead>
<tr>
<th>Age*</th>
<th>Marital Status</th>
<th>Educational Attainment</th>
<th>Preferred Language</th>
<th>SES</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-25 (19.9%)</td>
<td>Married (38.8%)</td>
<td>Below 12\textsuperscript{th} grade (17.1%)</td>
<td>Spanish (91.4%)</td>
<td>Low (31.9%)</td>
</tr>
<tr>
<td>26-30 (29.3%)</td>
<td>Single (54.3%)</td>
<td>12\textsuperscript{th} grade (14.6%)</td>
<td>English (8.6%)</td>
<td>Medium (36.2%)</td>
</tr>
<tr>
<td>31-35 (23.3%)</td>
<td>Cohabiting (7.7%)</td>
<td>Some college (61.2%)</td>
<td></td>
<td>High (31.9%)</td>
</tr>
<tr>
<td>36-40 (24.1%)</td>
<td>College degree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Items that do not add to 100% are due to non-response from participants.

Group Interviews

Four group discussions or interviews were conducted. Group interviews were small so that live social construction processes could be observed as women reacted to print media (local newspaper articles) on cervical cancer screening and human Papillomavirus (HPV). A total of 15 women participated in the group interviews.

Most women participating in group discussions belonged to the 26-30 years of age range. The average marital status was single, with a third of the women living with their partner or cohabitating. The average educational attainment of participants was high school (12\textsuperscript{th} grade). Most of the women participating in groups were of low or middle
socioeconomic status (SES). The preferred language was Spanish; only one woman mentioned English as her language of preference. A third of the women thought the Pap test is performed annually, while the other women believed the test is done every six months.

**Screening Status**

Among the individual interviewees, one-third of the women had been screened sometime in their lives at time of study (N=40; 30.3%). Of all study participants, four (3.0%) women had been tested within the month preceding the study. Twenty-two (16.6%) had been tested between five to seven months at time of interviews. Twenty women (16.6%) had not been tested for three years. Nine (6.8%) women had not been tested for over four years, and nine (6.8%) women had not been tested for nine years. A majority of the women participating in the individual interviews and group discussions thought that the Pap test is performed every six months. A few thought it was more often, citing screening every three months, monthly and even once a week. Few women cited recommended annual screening guidelines (American Cancer Society, 2001). Of the women who participated in the group interviews, one third of the women had never been screened for cervical cancer (received a Pap test). Of the women who had been screened, the date of their last Pap test ranged from 1 to 30 months since last test. Only one woman in the four groups had the Pap test performed regularly (once a year).

**Sociocultural Factors Important in Women’s Lives**

In this section, sociocultural factors important to women are explored. These sociocultural factors, although important in women’s lives, were not considered deterrents to screening. Through individual semi-structured interviews and freelisting
exercises, women were asked to list the most important things in their lives. Across all
groups of women, regardless of socioeconomic status (SES) and screening history,
family, religion and health were the most important aspects of their lives. Results are
presented in narrative data utilizing vignettes or quotes to support findings. Women in
Panama tend to use the noun one as they refer to themselves. Similarly, women
frequently used diminutives which are expressed in the translation of their narratives with
adjectives such as bit or little.

Family

Almost all women in the study mentioned their family as the most important thing
in their lives. Within the family, women who had children responded that their children
are the most important aspect of their lives, followed by their mothers and then their
husbands. Women’s responses about their hopes and desires focused on their children’s
future. Women hope their children receive an education and are able to obtain
employment so they have the opportunity to achieve an improved quality of life. Women
also mentioned that their health is important, however, the focus is mostly on the family’s
overall wellbeing. A married 40 year old working mother of two teenagers and of low
socioeconomic background (SES) told us about her family.

The most important things are my family and my health. My family, my
children, are who I love the most. For them to be together. For my
children, to get an education and move forward, that’s what I would like.
We desire that our children become professionals. And in this way for
them to get jobs according to the profession each of them studied.

For my family, I would like for all of us to be together, that each of us, my
brothers, my mother, that we are all in wellbeing, with good health. For
my children to do well in school and that God keeps them in good health. I
want them to be in a nice house, that they don’t need anything, that they
have food and have everything they need.
Another woman, of middle SES told a similar story.

For my family to be stable, and at least to have good health and a better day each day. As they are my children, I try to at least offer them what they deserve, because I brought them to the world but one has to try to offer them each day something better.

Women’s lives in Panama focus on family life. When asked about what matters most to them and their desires, invariably women expressed family as being important and a focal point of their lives.

Religion

Religion is important in most women’s lives. The majority of people in Panama are Roman Catholic. Women from all subgroups mentioned religion as a factor intertwined with every aspect of their lives. However, the Catholic faith does not seem to deter women from seeking cervical cancer screening services. As I was preparing to conduct this study, a colleague from the U.S. asked if I thought that since a majority of people in Panama are Catholic, women might not seek screening services due to religious beliefs. I decided to include an interview question on the importance of religion in women’s lives. All women agreed that religion, specifically God and faith, play a significant role in their lives. Women mentioned asking God to keep them in good health. However, women did not report religion as deterrent from screening. A married woman in her early 30’s of low SES was interviewed while she waited for her Pap test appointment at a health center.

Well, religion plays a very important role in my life, because God for me is the main thing at our home. Because of how He is, we try to have a better life. During these days we have been celebrating Christmas, which is one of the sources of faith that one has, to believe in God. One celebrates the birth of Jesus, this means that one has a God. I mean, at least I believe in
God Almighty, who is The One who keeps us well each day. I ask Him for health, and above all, I have faith.

Faith and that all things that I ask will come true, at least a better financial stability, who better than God to offer this to us, who else but Him. He is The One who has us here with a purpose. I have always believed that God has us here with a purpose. I know that for me the purpose must be, until now I realize it, that for me, it has been to give myself to my children, to keep them from suffering, so tomorrow they have a better future.

She proceeded to tell me how religion is socially constructed within families through generations.

Religion plays a very important role in my life. Since I was a little girl, they taught us to believe in God, to have moral values and just like our parents, from generation to generation, in that same way I have taught my children.

The previous quote exemplifies behavior shared by many Panamanian families. Many women were brought up Catholic and go to church regularly. Although important, the Catholic faith does not seem to interfere with women’s daily lives. The only association between religion and health observed in the study was when women said: I ask God to keep me and my family in good health. Nonetheless, religiosity does not directly alter daily behavior, much less health behavior.

Health Beliefs and Practices

Women’s understanding of health beliefs and practices were derived from individual interviews, freelisting and pile sorting exercises. A freelisting exercise was conducted among the first 36 women individually interviewed. Freelisting elicits qualitative and quantitative data without imposing a set of beliefs on the interviewees (Chavez, McMullin, Mishra, & Hubbell, 2001). As an additional effort to avoid interviewer bias regarding any health and/or cervical cancer screening beliefs, a general
health question was asked to women: *What are the types of things a woman can do to stay healthy?* The freelisting question was asked in this manner to determine if women included female checkups in their beliefs, attitudes and knowledge about living a healthy lifestyle. To determine which beliefs were most common, women were asked to list all the things a woman can do to stay healthy.

Freelisting is useful in providing cultural information on shared values, attitudes and beliefs about a topic. Indeed, the women listed items that I had not thought about earlier, such as *bailar* (dancing), *apariencia personal* (physical appearance) or *ir a la playa* (go to the beach). Results of the freelisting exercise are presented by screening history of women (regular screeners, irregular screeners and non-screeners) to determine if each subgroup of women presents a different set of beliefs or cultural domains regarding health. Eleven regularly screened women, eleven women who are irregularly screened and fourteen women who had never been screened for cervical cancer participated in the freelisting exercise.

Women provided a listing of their own beliefs on behaviors that help them stay healthy. The information is ranked by number of responses per subgroup of women and compared (Table 6). Women in all subgroups agreed that exercise and nutrition are important in maintaining a healthy lifestyle. Almost all women in the freelist exercise understood screening as important. Nonetheless, groups of women varied on the types of screening women understood as important. Eleven and nine, irregular and regular screeners respectively, listed receiving a Pap test as an activity women do to stay healthy. Whereas, only two non-screeners mentioned an annual Pap test as a means of staying healthy. All women who had never been screened believed that going to the doctor for
regular general checkups other than a Pap test was important, as compared to the other groups. Overall, women that participated in the freelisting exercise were preoccupied by their personal image, self-esteem and behaviors to maintain an emotional balance (e.g., dancing, listening to music, going to the beach). Feeling good about themselves is a factor that women associate with being healthy, reflecting a holistic approach to health mentioned by most of the women participating in the study.

Table 6. Activities a Woman Can Do to Stay Healthy
(N=36)

<table>
<thead>
<tr>
<th>Item</th>
<th>Regularly Screened (N=11)</th>
<th>Irregularly Screened (N=11)</th>
<th>Never Screened (N=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise</td>
<td>11</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>Eat right; eat nutritious foods</td>
<td>11</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td><strong>Regular Pap test</strong></td>
<td><strong>9</strong></td>
<td><strong>11</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td>Personal appearance and hygiene</td>
<td>8</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Dance, listen to music—to release stress</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Avoid habits such as drinking, smoking and drugs</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Comply with daily work hours</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Have a stable financial situation</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Listen to health advice in the media—television, radio, newspapers</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Talk to friends</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Have only one sexual partner</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Not self-medicate</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Breast exams</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>To do general tests—blood pressure, weight, glucose (sugar)</strong></td>
<td><strong>2</strong></td>
<td><strong>0</strong></td>
<td><strong>14</strong></td>
</tr>
<tr>
<td>Use birth control</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Drink eight glasses of water each day</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Always smile</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Go shopping</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Go to the beach</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Avoid stress</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Once the women developed the freelist, the women wrote each item in their list on flashcards. These same women were then asked to make piles of the flashcards with the items that went together. The purpose of the pile sorting technique was to observe the categorization of concepts in the culture of the women participating in the study. Categorizations are socially constructed (Loseke, 1999) and are an important representation of a culture. Once women sorted the flashcards, they were asked to discuss the reason for grouping the items together.

Overall, the categorization of health beliefs was similar across screening subgroups of women. Although women differed in their cervical cancer screening behaviors, they thought about health in ways more alike than different. Women grouped together nutrition, exercise and going to the doctor. All different medical exams (e.g., breast, Pap, general checkups) were grouped into another pile. Self-esteem, shopping, personal hygiene, and stress releasing practices such as dancing went into the same pile. Financial stability was also associated with less stress in respondents’ lives. Avoiding cigarette smoking, alcohol consumption and drug use were usually piled together. Women found it hard to categorize sexual health (e.g., having one sexual partner) with other items. However, women from all subgroups associated sexual behavior with health. They explained that a safe sexual lifestyle “es importante para evitar enfermedades” (is important to avoid diseases).

Women explained that nutrition and exercise are related to each other because they both affect body functions. The women also described that self-esteem, personal appearance and stress releasing activities help establish a good and positive emotional state. Women also talked about the importance of personality. Having a “bonita
personalidad" (nice personality) was associated with feeling good about themselves through their appearance (e.g., hair style, hands manicured). Women listed sexuality and sexual behavior in the freelisting exercise and then grouped them together during the pile sorting exercises, which helps understand the question about the association of sex with health in general.

**Staying Healthy**

During in-depth interviews and the freelisting exercise, women were asked: *What are the types of things a woman can do to stay healthy?* Women approached health holistically by following a model of health that included physical, emotional, social and spiritual health constructs as important. All women in the study, regardless of screening history and socioeconomic (SES) status, mentioned nutrition and exercise as positive behaviors that promoted healthy living. Some women across groups also mentioned avoiding behaviors such as alcohol, cigarette and drug consumption to stay healthy.

Women also considered mental and spiritual health as important. Women explained mental and spiritual health as stress releasing behaviors such as going to the beach, dancing, praying or going to church, going for a drive, going to the hair salon, dressing nicely and spending time with friends and family. Some women also mentioned reading, education and work responsibilities as behaviors they followed to stay healthy. Interestingly, regularly and irregularly screened women mentioned going to the doctor as a behavior important to staying healthy. However, only half of the women who had never been screened mentioned going to the doctor as a factor that helps in healthy living.

A 31 year old married woman of low SES who is regularly screened explained her views on health while interviewed at a health center. She understood that diet and
exercise are essential in maintaining a healthy lifestyle. She also believed that going to
the doctor and maintaining a balanced mental and social health helps her wellbeing.
Financial stability was also important for the woman as it was for other women in the
study. For her, health involves many aspects of daily life, not just the absence of disease.

*Leading a healthy life would be like...hum, exercising, eating well and
mainly, I think,...that health, that one needs to feel good about health.
Sometimes I try to walk a little bit, I don’t exercise a lot so I just walk. I
don’t eat a lot and do drink a lot of water. I like to read, go shopping, I
like going out a lot, going to the beach. I like going out to dance and to the
hair salon. I feel really good with this. Well, I also follow religion [to stay
healthy], going to mass [to church] a lot.*

*I think that I live a normal life, I do drink alcohol but only when I am at a
party. I don’t smoke. I don’t take drugs, none of those things. I lead a
healthy lifestyle in that aspect. I have only one sexual partner, I think this
is the most important thing, not being promiscuous.*

*For me health also includes, above all, to have a good financial stability.
A good financial situation is important. I think that if one feels good
financially, I mean, is not that one needs to have tons of money, because is
not about the money itself, but because at least one does not feel
overwhelmed by debt and those things. After you have financial stability,
then you can have good health. Why? Because you can eat well and those
foods are good for you. Once you are well financially, you can take time to
walk and also to get constant check-ups with the doctor.*

Another woman explained a similar belief about health in general.

*To lead a healthy life what one should do is study, so psychologically, you
don’t have traumas or problems. And then financially also, without any of
these problems, then we could try to have a peaceful, healthy life.*

Women believed that stress due to financial difficulties and other daily factors of
life were important to health. Women also believed that if they led balanced social,
mental and spiritual lives, this reflected on their health. Sexual practices were also
important to some women’s health. During interviews and free-listing exercises, some
women mentioned sexual behavior as an important aspect of healthy living. Although not
a majority, women across all subgroups mentioned this behavior on their own without being prompted during interviews.

Panamanian women appeared to relate sexual relationships to health. During the freelisting discussions and in-depth interviews, women talked about how sex was related to health. The following quote of an irregularly screened, single woman in her 30’s of low SES. It depicts the association between sexual activity and health.

_We should not change partners, our partner should always be the same because sometimes many diseases that a woman might have comes from the male and then they [men] give it to their partner._

However, women did not seem to understand the association between sexual health and cervical cancer. As noted in the previous quote, women reported avoiding having multiple sexual partners to stay healthy and to prevent sexually transmitted diseases (STDs) or infections from occurring, namely AIDS.

**Preventive Care**

Women in Panama practiced preventive care though hygienic behaviors (vaginal cleansing) and by getting tested as a form of prevention. Some women mentioned other forms of prevention such as having one sexual partner. However, most women focused on vaginal hygiene and getting tested as a means of prevention. Only four women in each subgroup of screening history (N=12; 11%) mentioned condom use for prevention of sexually transmitted diseases (STDs). Interestingly, almost all women mentioned fear of Acquired Immune Deficiency Syndrome (AIDS). Nonetheless, condom use had minor mention despite the existence of AIDS awareness and condom use campaigns in Panama. Vaginal hygiene and getting tested as preventive measures are discussed in the following section.
Vaginal Hygiene

Vaginal hygiene among women in Panama was perceived to be an important determinant of sexual health. Women associated vaginal health and *preventing* disease with hygiene, including vaginal cleansing. Many of the women interviewed mentioned using vaginal douches, creams (pastes) and vaginal suppositories for treatment and prevention of vaginal infections and diseases. Health care providers advise against the use of these vaginal cleansing methods because it can increase the probability of infection (Lewis Alexander, La Rosa, & Bader, 2001). Despite this recommendation, vaginal cleansing seems to be widely practiced among Panamanian women, especially after menstruation. Supermarkets, pharmacies and drug stores sell a variety of feminine hygiene supplies over-the-counter and women discuss this practice among themselves in relation to the concept of vaginal health.

Women use vaginal douches believing these cleansing devices are an effective solution to vaginal problems. Almost all women in the study, independent of screening history, age and SES discussed the use of douches to treat vaginal itching, secretions and odor. Elevated levels of humidity in Panama commonly cause spontaneous female infections (e.g., yeast infections, *Candida*) which women treat with over the counter medications or medications suggested by a pharmacist. During individual and group interviews women discussed the use of vaginal suppositories and douches. Some women even reported having the cleansing implements prescribed by their doctor.

Although vaginal cleansing with douches, creams and suppositories was widely practiced among most women in the study, the use of vaginal cleansing supplements was even more saliently described among irregularly screened women. This particular group
of women understands cleansing as a means of maintaining vaginal health and to prevent disease. The majority of irregularly screened women in the study perceived prevention as an important aspect of women’s health. However, prevention in the context of actually preventing a disease from occurring focuses on the use of vaginal creams, lotions, douches, and suppositories for cleansing. Women believed that cleansing their vagina will prevent future vaginal problems and diseases.

Irregularly screened women, for the most part, discussed vaginal cleansing as a form of maintaining feminine health. The following quote represents the responses of women who are irregularly screened regarding vaginal cleansing.

*I always use vaginal suppositories, creams and in two occasions I did a vaginal douche. It was prescribed, but thank God down there I think I am doing well because nothing strange comes out [referring to vaginal secretions].

*I think it is very important to take care down there since it is a very important part of the woman. I think that doing exams, putting in [inside vagina] medications with vaginal suppositories, pastes, those that the doctors send us to be clean.

The following quote illustrates the belief of prevention and treatment through hygiene.

*How to prevent...doing treatments, as long as one cleans, as long as the doctor sends you creams and vaginal suppositories, one cleans and cures all of those diseases that there are. At least I always cleanse with those creams they send me. I cleanse everyday.

Some of the women reported having the doctor prescribe the cleansing implements. The following quote was of a woman who had never been screened.

Nonetheless, she recommended going to the doctor for vaginal douches.

*Well, as I said, one needs to be clean, usually through the use of douches. But, it is recommended that the doctor sends them to you. And, I say this
by my own personal experience. I mean, when I became a woman [referring to the moment she began menstruating], I began to do this [vaginal cleansing] so I would have good health. Is good to have personal hygiene, well vaginally I mean, because one has sexual relations and semen stays there [inside vagina] and it does not come out. One also needs the vaginal suppositories, but the problem is that one has to go to the doctor, so he can prescribe them.

Although she recommended going to the doctor for prevention of vaginal problems, she had never had a Pap test performed. Women of all subgroups, especially irregularly and never screened, reported vaginal cleansing or hygiene as a form of disease prevention through the use of suppositories, douches and creams.

A young woman in her twenties of high socioeconomic (SES) background who had never been screened mentioned her cleansing habits as a form of disease prevention in the following quote.

By showering regularly you can prevent a vaginal problem. This is what I understand. Heh, using appropriate garments for our body, and maybe if I have doubts, go to a doctor so he can answer my questions and be able to use the adequate medicines. To use the adequate medicines for a disease we might have.

An irregularly screened woman explained vaginal cleansing for prevention.

Prevention, hm...how to prevent...having treatments, I mean, as long as the doctor sends you creams, one can cleanse and cure. At least I always clean myself with my creams to cure all those diseases that are out there.

I shower every day, always cleanse with warm water and every night before going to sleep I clean myself [vagina] and put my things, my creams.

Women maintained vaginal health by preventing and treating disease through vaginal cleansing or hygiene. Some women mentioned receiving prescriptions for vaginal cleansing from doctors. The doctors might recommend the devices or medications for
treating a mild infection, but women perceived the concept as cleansing the vagina as seen in the following quote.

*I keep vaginal health through cleansing, first of all through cleansing. The majority of cancers come because of infections, when they don’t take care of it [the infection]. And, that goes with hygiene, just like with those who have many sexual partners as well.*

This quote showed the belief that reproductive health and sexual health are achieved by maintaining constant vaginal cleansing. Women tended to associate reproductive health to pregnancy. In her narrative below a woman linked vaginal cleansing, with pregnancy and reproductive health. In the following quote, she also mentioned clothing and how it related to cleansing and humidity.

Women keep vaginal health through cleansing. Well, cleansing by not using alkaline soaps, they need to be neutral soaps. They need to keep that area free of a lot of quantity of hair, because it gives a lot of fungus. Not to use a lot of jeans [blue jeans], since jeans give fungus. Hm, and after each period, vaginal suppositories to clean it [the vaginal area]. Many don’t do that. Even after giving birth...after giving birth, the care [cleansing] should increase since women in general end up with it [vaginal cavity] opened up and allowing more bacteria to enter.

Women at risk of disease are those who have several sexual partners and those who do not maintain hygiene in that area [vaginal area]. A super, super, super hygiene in those areas. Those areas should be kept very clean because it is the most covered area [of the body], so it is the one which is the most humid.

We should always use vaginal suppositories, also not use very tight clothes. For example, jeans are very tight clothes and very thick for our body. And the weather here in Panama is very hot, we have to use soft clothes to protect our bodies.

Another example of prevention through cleansing comes from a single woman in her thirties of low SES. The last time she had been screened or had a Pap test done was
nine years before our conversation with her. She maintained vaginal hygiene to prevent disease.

Well, I think almost the same thing I said [regarding sexual behavior], that for example in my case, every time after I get my period and it passes I do a cleansing. One sticks inside some vaginal suppositories and does a cleansing, and in that way one stays healthy, well, clean.

In summary, vaginal hygiene was an important aspect of Panamanian women’s health beliefs. Women understood that by cleansing the vagina they maintained female health. Women seemed to relate vaginal hygiene to intercourse and to menstruation. Under both circumstances women are left with fluids within their vaginal cavity, so women might have perceived that through vaginal hygiene they removed these fluids from the body and maintained female health.

**Getting Tested as Prevention**

Women viewed preventive care as important. Even women who had never been screened for cervical cancer mentioned getting regular check-ups as important for health. Check-ups for women who irregularly or never had a Pap test included blood, sugar (glucose) and urine tests. Many women in the study understood the Pap test as a manner of detecting and preventing any type of female problem or sexually transmitted diseases (STD) or infections (STI), instead of a process for early detection of cervical cancer. The Pap test was generally understood by Panamanian women as a way in which female diseases were prevented rather than detected early. If normal results occurred repeatedly, some women saw no need to return for periodic testing. Once the effect of the Pap test ends, a woman needs to get another Pap test. A small number of women in the study explained the Pap test as a means for early detection. Women also reported that the
cleansing or prevention through the Pap test lasts a certain period of time (e.g., six months) and for this reason women need to be periodically tested. Some women talked about receiving the Pap test as frequently as every three months so they can prevent any type of disease or vaginal infection from occurring. The following quote is of a married woman in her thirties of low SES interviewed at a health center.

**How can a woman prevent a vaginal female problem?** Well, I think that the way to prevent, for me, is doing a Pap test on time. I believe that with this [the Pap test], I can determine if I have any type of disease or infection.

Risk was also associated with not getting tested regularly. Since the Pap was often seen as a way of preventing disease, if a woman does not get screened then she will most likely develop a female problem. Some women also believed that if there were no signs or symptoms of an abnormality then perhaps there was no need to have a Pap test. The following quote from a regularly screened woman explained the understanding of risk.

*Generally, sometimes they [other women] don’t do it [Pap test], they don’t feel there is something wrong and that they don’t have anything. And when one goes to see what it is that feels wrong, then there is no cure.*

*Well, it is that since women disregard a lot by not having the Pap test done and that [cervical cancer] can be prevented. It is a cancer that has a high percentage here in the country, which is distressing, but it can be prevented.*

A woman in her thirties of low SES and cohabiting with her partner, who at the time of our conversation had never been screened explained to us her views about vaginal cleansing through the Pap test. Her understanding about cleanliness is also observed among other women who are irregularly screened and other women who have never been screened. The belief is that a woman can achieve cleansing through the Pap test for
prevention of all female diseases. Although she had never been screened, she understood both the Pap test and vaginal hygiene as forms of prevention.

> Well, I think that one needs to have besides personal hygiene [vaginal cleansing], periodic sanitary attention [from a physician], like with the Papanicolaou [Pap test], which many of us don’t do. Well, I don’t do it either.

Regularly screened women often mentioned regularly going to a gynecologist for prevention. The effect of the Pap test, according to the women, lasts a certain period (e.g., a year, six months) and after this period ends women should have the test performed again. The following quote of a regularly screened married woman explains the understood concept of the periodicity of performing the Pap test.

> I think that a woman who has the Pap test may last up to one month, three months, even up to one year [the effect of the Pap test]. Those women need to do the Pap test regularly. The Pap test can last up to a year; but they need to regularly do it, because that is how they clear sexually transmitted diseases.

Most regularly screened women participating in the study reported that by regularly going to the gynecologist they would prevent a vaginal infection or sexually transmitted disease. Most women in the study believed that the Pap test is for prevention and that the test’s effect lasts a certain period of time. Hence, the Pap test is done for prevention or to avoid diseases and is not seen as a test for early detection of cervical cancer.

**Self-Medication**

During preliminary data gathering, the common practice in Panama of self-medication at a pharmacy emerged from discussions with women (Calvo, 2001). I wanted to explore this practice in greater detail during this study to determine if self-medication
affects screening or other health seeking behavior. Many of the women in the study went to pharmacies (drug stores) and requested pharmacist’s advice for minor health problems. For example, if a woman has a cold, a headache or an allergy she might go to a pharmacy. For important health problems (e.g., extreme pain, bleeding, trauma) women visited a medical doctor at a clinic, health center or hospital. A pharmacy can also be a less expensive alternative than going to the doctor. Women repeatedly noted that it costs less to go to the pharmacy than to the doctor. Pharmacies are alternatives for women as compared to health care facilities due to perceived cost, time (open 24 hours), availability, and location. A woman in her late 30’s of low SES, who had never been screened, explained her reasons for self-medication.

*When I have a health problem I go to a health center [receive free health care services]. If I have money I go to a clinic [pay for health services]. If it is something mild, like a headache, or something like that, I go to a pharmacy. I guess it is recommended to go to a doctor, who is a specialist and that he tells you the medication you need, although pharmacists have knowledge about diseases as well.*

Pharmacy location also influences women’s utilization of this resource. There are pharmacies in every neighborhood, the accessibility and working hours of pharmacies facilitates their utilization. The accessibility of services attracted women to utilize pharmacies and seek health advice from pharmacists. The following quote from an irregularly screened woman refers to the convenient location and working hours of pharmacies.

*Let’s see, well the majority of times, I go to the pharmacy because it is closer. I ask the doctor [referring to the pharmacist], I ask the doctor what works for what thing, that man in the pharmacy, that old man that helps there. He knows a lot, he gives me medication. I buy from him what I need and that has always worked for me.*
Another woman explained how the working hours of pharmacies are more convenient than health centers.

_Sometimes I go to the pharmacy because the health center is not opened 24 hours; it only opens eight hours a day. And although there is no doctor there [at the pharmacy], I go to the pharmacy which is the best indication._

_Generally, one goes to the pharmacies because all of a sudden you might not feel well, like on a Saturday or Sunday. Usually on those days the clinics are open, but one will first go to a pharmacy, where maybe one might think that it will go better there._

She then proceeded to share that if the pharmacist gave her a medication and it worked then there was no need for her to go to the doctor for minor health problems.

_Perhaps they will tell you “take this medication that it might help you.” And maybe one comes and takes it, and it works. So for this reason one always goes to a pharmacy without the need to go to the doctor. If it is a minor problem I go to the pharmacy, if it is important then I go to the doctor._

_I mean, when there are small illnesses which one knows, like a cold or a headache that one knows what it is about, otherwise not._

Another woman shared her experience of self-medication through the use of a vaginal douche for vaginal hygiene.

_I have the personal experience that I bought douches at the pharmacy myself. I put them inside of me and that caused me urine problems [urinary tract infection]. I had to go to the bathroom many times and it was because of the small device the douche has [applicator], so it is not very recommended to self-medicate._

Going to the pharmacy for medication was a commonly practiced behavior in Panama. However, this behavior was mostly observed to treat minor health problems such as headaches, a fever or a cold. Going to the pharmacy is not a substitute for going to the doctor for important health issues or for screening services. Nonetheless, the
availability of over-the-counter vaginal cleansing supplies might affect female health and regular screenings.

**Cervical Cancer Knowledge**

Women in the study, including those women who regularly went to a gynecologist presented limited knowledge on cervical cancer and Human Papillomavirus (HPV) and the relationship between the two. Most of the knowledge shared by the women was presented as “Yes, I’ve heard about it [HPV or cervical cancer], I heard that a lot of women get it.” This awareness, rather than knowledge, was more prevalent among regularly and irregularly screened women. Women who had never been screened expressed limited knowledge and awareness of different female cancers and the relationship between HPV and cervical cancer.

Women also viewed all female cancers as one, without differentiating between cervical, uterine or ovarian cancer. Women explained female forms of cancer as cáncer de la mujer (women’s cancer or female cancer). Also women shared that cervical cancer affects the womb, reflecting a gap in information about female anatomy and the process of cervical cancer as described in the following quote of a regularly screened young woman in her 20s of low SES and cohabiting with her partner.

*Regarding cervical cancer, well, I’ve heard that it is a disease that is detected in women’s wombs and that it is generally found in those women who seldom frequent a gynecologist.*

Basic cervical cancer knowledge is limited among women in the study. Women talked about cancer in general, about the Pap test and about cervical cancer awareness; however, information on cervical cancer, HPV, anatomy of the cervix, the purpose of a Pap test and other reproductive facts was not discussed by women. This lack of
knowledge was more evident among women who had never been screened than among regular and irregular screeners. A few women related cervical cancer to the uterus (the womb) which is a close assumption due to the location of the cervix. Some women who were interviewed at health centers during screening shared more cervical cancer knowledge information as compared to women who had never been tested. However, gaps in information were evident even among regularly screened women. The following quote is of a regularly screened woman interviewed at a health center while waiting to be screened.

*Have you ever heard of cervical cancer?* Yes, I have heard about this type of cancer.

*What have you heard?* I have heard about it, but not totally in depth.

Another regularly screened woman interviewed while waiting at a health center gave us her answer regarding cervical cancer.

*Yes, I have heard about this type of cancer. I have read about it in books. It is a very dangerous disease that attacks women regardless of race or religion. It is a disease that can affect any woman.*

A common belief is that cervical cancer or important vaginal disorders have distinct signs or symptoms. Some women talked about odors and observable stains which to them are related to cancer. Cervical cancer like other female disorders (e.g., pelvic inflammatory disorder and Chlamydia) tend to be asymptomatic until advanced.

The following quote is of a married woman with children of middle SES, who is regularly screened. She was interviewed while waiting for her Pap test at a local health center. During the interview it was evident that she did not understand the association
between screening, cervical cancer, and HPV. She also associated cervical cancer with the womb. Here is her story when asked what have you heard about cervical cancer.

*Well, about [about cervical cancer], no I do not know about the cancer…I don’t know much. I don’t have much information. I just haven’t heard much.*

After probing, she further shared some of her understanding of cervical cancer. She believed that only women who do not frequently visit a gynecologist get this form of cancer.

*All I have heard is that it is a disease that is detected in women’s wombs. And that generally it is found in women who do not frequent the gynecologist. Once they go they realize they have a disease.*

The story is common among women in Panama. Information is sometimes available through the media; however, the message does not remain with the women. The information provided is limited and it focuses mostly on awareness. In most cases women had not heard at all about cervical cancer, the human papillomavirus or the association between each, especially women who had never been screened.

**Structural Factors**

Structural factors refer to aspects related to the health care system in Panama which might affect screening. In this case, factors include cost of screening and experiences with screening services. Preliminary data suggest that structural factors do not deter women from seeking screening services in Panama. Although some women shared negative experiences with the Panamanian health care system, these experiences did not seem to deter them from seeking screening services.
Cost of Screening

Scientific literature on cervical cancer often associates this particular type of cancer with poverty (Borrayo & Rae Jenkins, 2001; Farley & Flannery, 1989). Preliminary data suggested that this is not the case in Panama. Women’s attitudes and behaviors seem similar across socioeconomic (SES) groups. In addition, health care practitioners reinforced this assessment among women in Panama. Health care practitioners discussed that women of low SES have access to health care. In addition, they also mentioned that women of higher SES were also affected by cervical cancer.

Women in the study were asked to list factors which might affect screening behavior. A majority of women in the study, regardless of SES background did not list cost as a barrier to screening. Only a few women (n=7) mentioned cost as a barrier to screening. These women were mostly of low SES and a couple of the women were of middle SES. Regularly screened women of different SES never mentioned cost as a barrier to screening or as a factor which might affect screening behavior. Regularly screened women even of low SES did not consider cost to be a barrier to screening.

Pap tests are available free of charge at Ministry of Health’s community health centers and for low-cost at Social Security Fund clinics and Panamanian Cancer Society clinics; however, some women are not aware of the availability of these free or low-cost services. A young single woman in her twenties of middle SES who had never been screened, explained her thoughts regarding cost and how it relates to health care.

*Regarding health, I think that nowadays, considering the financial situation and if a person doesn’t work, she doesn’t have health insurance. It is very expensive, to go to private clinics or even to public hospitals. It is very expensive to be in the hospital as well as to get medicines. And for*
that reason, one should try not to get sick. If you do get sick [it should] only be of minor things.

Sometimes I feel terrified. I am afraid of getting sick and that my mom or my dad cannot cover the expenses of hospitalization or the cost of medicines.

A married woman with children who had not had a Pap test done by her 40th birthday, explained that she learned about the Pap test when she went to the doctor the first time she became pregnant. However, she explained that she has not gone to be screened due to cost.

Well, when I was pregnant they told me that now I have to be tested. But I haven’t gone yet. Because when I, when I get the money I will go. I haven’t had the money to go have it done.

The previous narratives are examples of two women who have never been screened due to the understanding that testing is expensive. These women reported that they could not afford to have a Pap test done, despite the low cost of the test in many health care facilities. Nonetheless, the number of women who perceived cost to be a barrier to screening was low. The rest of the women interviewed did not mention cost of screening.

Experiences with the Panamanian Health Care System

Overall, women in the study did not allow negative aspects of the health care system to impact their screening behavior. Although many women described the health care system as bureaucratic, creating long waiting periods for appointments, this did not seem to negatively affect screening behavior. Some women believed that nurses and doctors did not offer caring or humane service and were impolite and offensive in their treatment. Most women who had never been screened mentioned enduring negative
experiences with the health care system. In contrast, regularly screened and irregularly screened women equally mentioned both positive and negative experiences with the health care system. However, these women explained that negative experiences did not deter them from screening. Women of higher SES, especially among the irregularly screened and regularly screened groups of women, mentioned positive experiences with the health care system. Women of higher SES may be able to afford private clinics for their health needs.

In the following quote a regularly screened woman of middle SES described her negative experiences with the Panamanian health care system. Despite her negative health care system encounters she still sought health advice from her doctor.

_I always try to go to the health center or to a clinic of the social security, well to the doctor. Sometimes the nurses don’t have patience with the public and the treatment of nurses to patients is not very good._

The following narrative was shared by a married woman in her 30s of low SES who mentioned that the treatment received by doctors and nurses at public health care institutions was inferior and frustrating. Even so, she was interviewed while waiting for the Pap test at a local public health center that provides free or low cost screening. She exemplifies regularly screened women, who despite negative experiences with the health care system and providers are willing to continue screening.

_Well, for me, the experience has not been, not so, not very good. The appointments, when they are with specialists the waits are very long, very tiring and very slow._

_Sometimes they [doctors and nurses] are a bit, they are not patient with the public, so it is not a very good experience, the treatment nurses offer [female] patients is not good._
Sometimes people go to a doctor and they tell the doctor “my belly hurts, my stomach hurts,” then they will not check you. They will rather send you a medication. Logic tells you to take the medicine, because you have taken it before. But they do not go deep into the issue to see what can be the problem. That it can be related with something they know well.

In contrast, another woman also regularly screened with similar background and interviewed during her wait at a health center, shared her positive experience.

I haven’t had any problem with doctors in Panama. I have always done well with my appointments, they treat me well. I take my children also, they treat us well. I make an appointment at a clinic, on-time, punctual, I haven’t had any problems, never.

The gynecologist I have is an excellent gynecologist. Well, I guess that like everything else, there are many differences and deficiencies in what is the health care treatment. But it hasn’t happened to me with my doctor.

Several regular screened women were interviewed after having a Pap test. They were asked to share their experiences regarding the process of the Pap test itself and how they felt regarding the test and the health care practitioner. The following narrative was shared by a regularly screened woman after having her Pap test. In her narrative, she introduced the theme about fear of results.

The experiences during the test were almost the same of a lifetime of doing the test. But, I always feel a bit anxious before they give me the results. My experience, my fear. What will I have? What will be the diagnosis of this test?

For me the test in itself is not uncomfortable. It simply bothers me when I wait for the results. This is the part that makes me fearful. I mean, that they give me bad news, that there is a malignant cell, but in the exact moment that I have the test done, I don’t feel uncomfortable, to the contrary, I feel at ease. This was a very beautiful experience for me. The doctor checked me, took my samples and then said that when they had the results, they would call me to give me the results. I didn’t feel pain or nothing, it was quick.
Another woman shared her opinion about the Panamanian health care system. She felt that it is the patients’ responsibility to follow the system as well as the doctor’s prescribed treatment. She explained that if people do not follow physician’s prescriptions and the required processes within the system, the results are negative experiences. However, she explained that if people follow instruction the outcome is positive.

*The health system in Panama has a good level if you follow the steps [indications or instructions] that the doctor gives you. If not, people tend to be very distracted about their own health and do not worry about following the treatments that the doctors prescribe, so I don’t think they can have good health that way.*

Overall, women from all different SES and screening histories shared both positive and negative experiences with the health care system in Panama. Most women agreed that private clinics offer better treatment. Long waiting periods and poor treatment by health care providers were the most common complaints voiced by women regarding public health care facilities. Even so, the system along with its long waiting periods and poor treatment in general did not seem to affect women’s screening behavior.

**Reproductive Health**

In Panama, the Pap test is viewed as related to reproductive health rather than to a more generalist perception of women’s health or to early detection of cervical cancer. The Pap test is commonly associated with pregnancy. First observed during preliminary data gathering (Calvo, 2001) and supported in this study, many women who received regular Pap tests learned about screening when they became pregnant for the first time. The women also seemed to view the Pap test and pelvic exam as one in the same. These women were offered the test when they visited the doctor for prenatal care. Some of the women who were irregularly screened mentioned that they did not return for regular
screening because they had never been pregnant. Some women reported not having a need for the Pap test because they never had children. In contrast, women who had never been screened did not mention pregnancy in association with the Pap test.

The following quotes were shared by two married regularly screened women of different SES. In the quotes, the women explained how they learned about the Pap test through prenatal care. The first quote is of a woman of low SES.

*I learned about the Pap as I went to give birth [during pregnancy] to one of my children. Through the talks they give [providers at health care facilities], I learned that you do it regularly.*

The following quote is also of a regular screener, but of middle SES.

*I went to the health center when I became pregnant with my first child. The doctor said I had to have the Pap test done. So, I began doing it.*

Women in the study who participated more actively in screening tended to view reproductive health as their responsibility. In that context, the regularly screened women take control of their actions and of their health behavior, including sexual health. In contrast, women who had never been screened or who are irregularly screened did not mention health as their own responsibility.

A regularly screened woman shared her understanding of health responsibility.

*I get periodic check-ups to stay healthy, hm, in general, every six months I get the Pap test. I have control over my sexual health. We think about so many things right now. There are so many, so many manners in which to get infected with so many diseases that sincerely, when you least expect it, then you get infected.*

*I think that we should be better informed, so we can have a better experience about health and have a good control over our health.*

*All women who are sexually active, it is their responsibility to have control over their tests periodically to have control of their life and health.*
Another regularly screened woman married and of low SES, also talked about personal responsibility and understandings of women’s reproductive and sexual health.

When I think of disease, more than anything, I think on all the distractions that we human beings have. Sometimes we feel some pain, or we have a blemish or spot on our skin, or something, but we do not give it the proper attention. We are distracted on other aspects of life.

I really feel sad, because I think that science has advanced so much for us to not pay attention to this aspect and not seek the methods to get cured.

I think that we should get checked, go get our tests done, hm, using the medication that we need, doing everything that the doctor tells us to do. I think it is necessary for us to be conscious of our body, which is ours, and that we need to take care of it.

Overall, women believed that the Pap test was associated with reproductive health. Women often learned about screening once they became pregnant for the first time and sought prenatal care at a health care facility. Women reported screening as a test needed during reproductive years and during sexually active periods.

*Female Anatomy*

Female anatomy was not clearly understood among women in the study. Although not expressly asked, women did not differentiate among female organs. Women used terms such as allá abajo (down there) and vagina to refer to the female anatomy in general. Women did not differentiate between the vagina, cervix, uterus and other parts of the female anatomy.

Cervical cancer and female anatomy knowledge were not specific. Women did not report differences among the female organs, the effects of cervical cancer or infections.

As noted by this irregularly screened woman of middle SES.

Hm, I’ve heard about that type of cancer [cervical cancer]. A lot of spots come down and out of you. You get infections and well, that can damage
your womb. And that spreads all over until everything is completely gone, until you die.

Women did not talk about female anatomy. The lack of understanding of female anatomy might create confusion in the understanding of screening and cervical cancer. This makes it difficult for professionals to explain the different types of female cancers and the purpose of the Pap test.

**Understanding of the Pap Test**

Women who knew about getting the Pap test done regularly, believed that Pap tests are performed every six months or more often and the purpose of a Pap test was for cleansing the vagina or to prevent disease. The Pap test was understood as a way of cleansing the vagina for prevention of female diseases, rather than a method for early detection of cervical cancer by taking a sample of the cervix. Women also did not seem to differentiate between the Pap test and the pelvic exam. Women did not understand the Pap test, the purpose of the test or how it was performed. This lack of understanding was predominant among women who had never been screened, but it was also expressed by women in other groups. The following quote regarding the Pap test was made by a woman of low SES who had never been screened.

*I have heard about the Pap test from family members. They tell me that it is an important test to check how your reproductive organs are doing.*

She further continued her observations about the Pap test.

*We need to learn about how the Pap test can prevent any disease.*

The following is a short narrative from a regularly screened woman who sought a Pap test and general check-ups for prevention of disease.
Well I think...that for me—prevention—is having a Pap on time and with that I feel that one can find any disease on time or any infection one might have. It can be going to the gynecologist or general practitioner...it is a routine that the doctor always does to examine you; it can be vaginal or urine or blood test; is a routine that the doctor always does. That you have to be examined and that the more check-ups you get it is better. One can prevent diseases or other types of situations through the Pap test.

The same woman also discussed the use of contraception associated with increased risk of disease.

Well, if the woman is, for example, a person who uses the copper-T, right? And the woman has, let’s say, two years since being checked, two and a half years, that woman could be, how do you say, on time to catch cancer. First because it is an iron [referring to metal] material and that can cause many stains, it gives you bad odors, she could be ready to get cancer.

Another regularly screened woman shared her reasons for having a Pap test done consistently. She also discussed her use of contraception as a reason for regular screening.

I have the Pap test done every six months, more or less. I learned [about the Pap test] once I had sexual relations the first time, from there I began getting check-ups with the gynecologist and they began taking care of me. I mean, I’ve always had the Pap test done, and since I use the copper-T even more so, I have the Pap test done.

Some women who are irregular screeners discussed cervical cancer and its relationship to prevention of female diseases. These women talked about the importance of screening. However, they did not get a Pap test regularly. The following quote is of an unmarried irregularly screened woman in her thirties of middle SES.

The best way to prevent a feminine problem down there [vaginal] is by having a regular control or check-up. This means that having regular Pap tests periodically, since with this test, is the only way that you can really know your sexual condition that you might have.
The following quote is of another irregularly screened woman, married in her twenties of low SES.

*I repeat the idea, that having a good control of your regular Pap you maintain [vaginal health]. Through this test, you find out if you have a vaginal problem, if you have an infection, of what type it is, of what level [how severe] and what treatments you follow for it.*

Women understood the Pap test as a form of disease prevention. This is in contrast to the biomedical definition of a Pap test which is a screening test for detection of abnormal cells in the cervix; a technique used by health care professionals to detect cervical cancer. Women understood that the Pap test was important. During group discussions women also talked about information on embarrassment, fear, lack of time, and pain of test. The result was an understanding that the Pap test was important, but the negative experiences outweighed its importance. Women used these tenets as their reasons for not being tested.

*Understanding of the Human Papillomavirus*

Few women in the study knew of the Human Papillomavirus (HPV). Some women who had heard of HPV mentioned that HPV is sexually transmitted; however, they did not understand the association between HPV and cervical cancer. Women who had never been screened were unaware of HPV. A common response was: *No, nunca he escuchado de eso (No, I have never heard of it).* Many regularly screened women had heard of HPV but did not understand HPV transmission, its effect or the relationship to cervical cancer. A regularly screened woman talked about her understanding of HPV.

*[About human papillomavirus and genital warts] that they are transmitted through sexual contact and that they should be avoided, at least if the person has sexual contact she should always know who she is with to avoid that type of problem.*
Can you explain to us what you’ve hear about the human papillomavirus and genital warts?

Well, I have seen videos on television. I have seen shows about that also. But I am not so drenched on the topic. I don’t have much information.

Few women understood HPV transmission. The following quotes are from two different women who explained their understandings of HPV transmission through sexual contact. The two women are from similar backgrounds, except for SES level, both were interviewed at a university. The first quote is of a married irregularly screened woman in her thirties of higher SES.

What I remember is that it is transmitted through sexual contact and that it should be avoided. At least if the person is going to have sexual contact, she should know who she does it with [who she has sexual relations with]. I have heard that the virus is transmitted by the man because he has relations with different women, he is promiscuous. When the man is promiscuous it has a higher occurrence. In Panama the numbers are increasing, of people with this virus.

The second quote is of a married irregularly screened woman in her thirties of low SES.

Yes, I have heard about genital warts. Also, in indigenous areas, I have a friend who is a nurse. She says that the majority of Indians [referring to local Panamanian indigenous tribes] are infected with the human papillomavirus.

In the previous quotes, two women of similar age, screening and marriage status but of different SES have some awareness of HPV. Although the first woman seems to have increased awareness, both women do not have a clear understanding of the processes of infection. HPV transmission and its association with cervical cancer is not clearly understood among Panamanian women. A gap in available information regarding HPV is evident in Panama.
Cervical Cancer and Screening

An important aspect of the study was to investigate how cervical cancer and screening was understood by Panamanian women. Women in the study discussed who should get screened and why women did not get screened. The following section presents women’s understanding of these issues.

Who Should Get Screened?

Women participating in the study were asked what type of woman needs a check-up? And what type of woman is at risk of acquiring woman’s cancer? Across all groups of women, the response was that all women needed a Pap test. However, according to the responses received, women who have or have had multiple sexual partners are at higher risk of developing cervical cancer and sexually transmitted diseases (STDs).

Many women related sexuality with vaginal health. Some of the regularly screened women mentioned going to the gynecologist when they began their sexual activity. Other women discussed not having a need to be tested since they are currently not involved in a relationship. Women believed that they needed to be involved in a relationship to be sexually active. If they were not in a relationship it was understood that they would not be sexually active. Women associated increased risk of vaginal health problems with women who they labeled promiscuous (having multiple sexual partners). This includes having been with more than one partner during the course of their sexual life or having several partners during the same period.

A married woman in her thirties who is irregularly screened explained her views on sexual risk behavior and what type of women are at increased risk of developing vaginal problems. She understood that there is a relationship between sexual activity and
vaginal health. She also understood that all women are at risk of developing a woman’s cancer. However, she observed an increased risk proportional to the number of sexual partners a woman might have in her life. She used the term ladies to identify married women who do not have multiple sexual partners. As other women in the study, she believed that women with multiple sexual partners are at higher risk of developing diseases. She shared her thoughts about the need for screening.

*I say that we are all women, and we should all participate [in screening]. I think we all need to be tested, all women.*

*All women, regardless of age, sex, race, or religion need to be tested. All women need a check-up. All women, even ladies, older, younger, very old, all should be checked. All women, it does not matter class or race, Black or White, we should all get tested and get a Pap. As I said previously, I think all women, because I have even heard of people that have never had sex and have died of cancer. That we all need it [Pap test], all types of women.*

*Sometimes we think that women of the life [women with multiple sexual partners] need a check-up more than we do. Us who we say we are ladies. I have seen at the health center those women of the life [referring to prostitutes], as it is often said, they come each week, and get weekly check-ups [the Ministry of Health requires sex workers to get weekly STD testing at public health care facilities]. There are some who are smarter than us. And I think that those women have better health than we do. Better than us, who we say we are the ladies. Perhaps, us the ladies are the ones who need to seek more professional help with respect to diseases. But all promiscuous women are the ones who are in danger and should be tested.*

In the study, women tended to distance themselves from the risk of developing a female disease, especially irregularly screened women. Although they understood female cancer as a cancer that any woman can develop, they tended to distance themselves from the risk and behaviors which they associated with the risk of cervical cancer. Women distanced themselves from risk by mentioning other women who have multiple sexual partners, women from rural areas, and women who do not go to the doctor. Some women
also emphasized that men are the ones who transmit diseases to women. The following quote is from the same woman who continued sharing her understanding of risk.

*I have heard that it is men who develop the disease and that it is them who transmit it to women through sexual relations. Those women who have sexual relations and are not careful, they do not prevent, they do it with all kinds of men. Those women are at risk, the ones with a lot of sexual partners and those who do not maintain hygiene in that area [vaginal area].*

In the following quotes an irregularly screened woman explained her understanding of who should get screened.

**What type of woman needs to be checked?** A woman who has a baby, a woman who has problems with her menstruation, me [all women need to be checked]. I mean by not having a regular check-up constantly women run the risk that later on they will have cancer.

For example, those women that never get checked, who are following the wrong steps, in the wrong life and never go to a health center or hospital.

Women understood that they can all develop a female cancer (e.g., cervical cancer). However, they tended to distance themselves from the risk. By blaming others for the risk or transmitting diseases, women decreased the perceived risk they might have of developing a disease themselves. Irregularly screened women justified not being screened by not taking responsibility for their own health and blaming other people. This is in contrast with regularly screened women who take responsibility for their own health and screening behavior.

*Why Women Do Not Get Screened?*

There are many factors that affect women’s screening behavior. At times, some factors might be structural in nature. However, most factors that affect women’s screening behavior refer to sociocultural domains, including family responsibilities, fear
of test, embarrassment, lack of symptoms and fear of test results. In the following quote, a married woman described family responsibilities, embarrassment, and fear as factors that affected screening behavior.

*Women are also considered like the protector of the family and the paternal figure is more absent. Even they [men] are afraid of having the prostate exam done. If the woman does not go with them, then they do not go. The woman always carries the torch; her priorities are their children, the husband, forgetting about herself.*

*The majority of women don’t go have the test done because of embarrassment and fear, but it is something simple and quick, nothing out of this world.*

Intent regarding screening varied among women who had never been screened. The intent to get screened depended on the type of information the women received. Other women’s information was most influential on women getting screened or the intent to get screened. If a woman received positive information about screening she was more likely to seek screening services (e.g., greater intention).

A few women, who had never been screened, said they decided they would never go to a gynecologist. However, they took their children to regular doctors’ visits. A young working mother, who had never had a Pap test, shared her thoughts about this situation while sitting at her home’s porch on a hot summer afternoon. This young woman, like some of the other women who had never been screened, indicated no intent to seek screening services.

*Nowadays, many Panamanian mothers worry a lot about their children’s and husband’s health and neglect their own. This is an important and determinant factor. They are sick and neglect their own health. Health is the main thing, but as long as my family is in good health, I feel good.*

*I take my children to the doctor, to the pediatrician. I take my children to the doctor only, that is it. I don’t, I don’t get treated. They have told me*
that I need to get tested [Pap test], but I never do it. Sometimes when I go to the clinic to take my children, they have talks. Social workers have talks. Sometimes on television, magazines, and newspaper, they also have things about health, I follow some advice, but not all.

As with most women in the study, she also thinks about her children’s health before her own health.

Well, yes, the times I’ve been to the health center about hypertension I need to follow a control. I should start again to go to the cardiologist. But even at the Santo Tomas [public adult hospital] it costs an arm and a leg, and it is not within my possibilities. I always place others before myself. I first take my children to the doctor. I’ve had to go get treated before and haven’t done it.

An irregularly screened woman shared her knowledge about all women being at risk of developing cervical cancer. However, she only went to the gynecologist while she was pregnant.

Regarding the Pap test. What I used to do before, was to have it done periodically; before I had my last child. Around four years ago was the last time I had it done, and the girl is going to be six years old. I have let myself go a lot regarding that.

All types of women need a check-up, I have a stepdaughter, she is a teenager, and I tell her that she needs to be checked. It is not about her having relations [sexual relations] or not, I say all women.

As depicted in the previous quotes, women understand that all women are at-risk of developing cervical cancer or a female problem. However, family responsibilities prevented women from seeking screening services.

Some women did not get screened due to fear of test results. Some regularly screened women explained that “Many women do not go for fear of results.” Regularly screened women’s fear drives their screening decision as well, but it is expressed as frequently getting a Pap test to prevent disease. Women who had never been tested fear
the test itself as they have heard stories of pain and embarrassment. Irregularly screened women fear test results or feel that they are well enough not to return for regular health screenings. Women talk amongst themselves and share stories and sometimes myths about health and health care, and these become known as truths.

A sexually active woman who had never been screened explained her own reasons for not getting a Pap test due to lack of adequate information. She explained that although she had some awareness about the Pap test, she did not clearly understand what she should do to get tested.

_It is, generally, it is said that it is the knowledge of us women that since we have our first sexual relation that we should have the Pap. But many times, we leave it to the side. Many times, when we begin so early, many times women begin very early [to have sexual relationships]. I did not, I began having my sexual relations late, and I was not well informed on what I should do._

Women from all groups understood vaginal cleansing or hygiene as a form of prevention. Irregularly screened women discussed the use of vaginal cleansing items more saliently than the other groups of women. Many of the women who practiced vaginal cleansing through the use of douches, suppositories and creams did not feel a need to be tested. A common folk knowledge frequently expressed by women in the study was the frequent practice of vaginal cleansing through the use of creams, vaginal suppositories and douches. A woman who had never been screened explained how she maintained female health.

_I do periodic douches, that they sell and some treatments. There are also vaginal suppositories for some, for the cleansing of the woman._
Sometimes vaginal cleansing replaced going to a physician for screening or to treat female problems. Thus, some women who practiced vaginal cleansing observed no reason for seeking screening services.

Cervical cancer and other female disorders (e.g., Chlamydia, HPV) tend to be asymptomatic on the onset. Many women only went to a physician if they felt ill or if they noticed physical changes. However, going to the physician for control and early detection of cervical cancer is not commonly practiced among Panamanian women. Most irregularly screened women that mentioned going to the doctor only if they felt ill: “yo asisto al médico cuando me siento mal” (I go to the doctor when I feel sick). Further, some women did not get screened because of the lack of observable symptoms or of feeling ill. The following quote was of a woman who had never been screened.

Well, thank God I have had good health. So I haven’t had the need to have a very important disease treated. I have been healthy, so I haven’t had the need to go [get screened].

The following quote from a woman who had never been screened reflects the general understanding that the Pap test is not necessary when a woman appears to be healthy.

I won’t do it because it is not necessary and we think that it is not necessary, because we look apparently healthy and we don’t know what we have there.

Normal test results also affected screening among irregularly screened women. Some women reported that if they had repeated normal test results then they were fine and there was no need for them to return for regular testing. The following quote of a young woman who is irregularly screened illustrated this premise.
Well, I have had the Pap test done, yes. But they have all come out well. I do not do them, I don’t do them very regularly, I do not do them very regularly, but the ones which I had done came out well.

Some women in the study who had never been screened discussed their lack of screening behavior due to the absence of a health problem. Similarly, some irregularly screened women believed that after a series of normal test results they did not need to continue regular screening. Both groups of women understood that normal test results and asymptomatic experiences indicate a lack of need for screening or seeking health care services.

Fears about Cancer and Screening

Consistently throughout the study women expressed an association of cancer and fear. How women talked about fear was generally distinguished among women based on their screening status. Few women (n=6) in the study said that they did not fear any type of disease. These women, who did not fear disease, were all of higher SES and most sought regular screening. Regardless, fear of disease was evident across all subgroups of women. Overwhelmingly, Acquired Immune Deficiency Syndrome (AIDS) and cancer were the most feared diseases among women in the study. AIDS was mentioned by every woman who felt fear of disease, even more frequently than cancer.

The majority of the women who decided against a Pap test did so because of fear. Fear was constructed based on negative information received from other women such as pain, embarrassment and fear of results. Most importantly, the fear of the unknown, of not being informed of what occurs during the Pap test and what the purpose of the test were strong determinants of non-screening seeking behavior. Lack of accurate information regarding the test itself affected screening behavior or intent to get screened.
When asked about fear of disease, a common response was *I am terrified of AIDS and of cancer*. This was a comment made by a single woman in her thirties of low socioeconomic background. However, it represents the responses obtained from most women regarding fear of disease regardless of SES or screening status. Women also feared sexually transmitted diseases or infections in general. A few women mentioned diabetes and heart problems as diseases they feared. The following section presents results of women’s understanding of fear. Fear includes fear of mortality, fear of the unknown, fear of the Pap test, and fear of pain and discomfort.

*Mortality*

Invariably, all women with fear of disease, which were almost all women in the study, equated cancer with death. Women were asked what was the first thing that came to mind when they heard the word cancer. Almost all women across the different screening and SES subgroups agreed that cancer signifies *death (muerte)*. Women saw cancer as ultimately fatal, symbolizing death. Many women had known someone who died of cancer.

One of the women who had never been screened expressed her thoughts on reasons for other women not being screened related it to fear. She explained that although advanced cancer treatments exist, cancer causes death. In the following quote fear associated to death due to cancer is depicted.

*Regarding cancer. It comes to my mind, death comes to my mind, because who gets cancer dies. On the long run I think that you die, regardless of what people say, like if there are treatments and things, but cancer is cancer.*
The following quote of a married regularly screened woman in her 40s of middle SES illustrates the fear women experience due to mortality associated with cancer.

*Well...cancer for me is as if you said that I’m going to die tomorrow; is like death...well...that is why I am a bit scared and afraid. When I hear that word [referring to the word cancer], death, something fatal that one cannot resolve.*

The following quote was presented by a young woman in her twenties of low SES who cohabits with her partner.

*When I hear the word cancer, sincerely I feel fear because it is a disease that one knows that in a certain way, if it is not detected on time it causes death.*

The following quotes from different women in the study also depicted the fear of death due to cancer experienced by Panamanian women. The first quote is of a young woman in her twenties, of low SES who is an irregular screener.

*The first thing that comes to my mind [regarding cancer], if one day I ever get that, the first thing I think of is death, if I’m going to die. And I hope that through God’s doing, I don’t have that, but that is the first thing that comes to my mind, that I will die then.*

The second quote is of a married regular screener in her 40s of middle SES.

*Thinking about cancer, I think that I’m going to die. That thing [cancer] to me, it terrifies me to think that, well, because I have seen a lot of sick people that have suffered this disease. And when they end up bed ridden, it is a very sad thing to see them. And for me, this is painful, that I have seen this. And, to think that this could happen to me, that is why I have this enormous fear. And for this, I always go have this done [Pap test]. At least the Pap I do.*

Fear of mortality is observed across SES groups and it might impact some behavior. A middle class married woman in her thirties who is irregularly screened explained to us her views about health and cancer.
About the products I take, I am taking some natural products. I try not to take medications unless they are natural. Prevention, so I rather take natural products. The first thing that comes to my mind [when I think about disease] is cancer, because in my family there is a lot. Almost always hereditary, it has touched many of us women, that little word. I feel a bit worried [about disease], at least before one [referring to herself] used to say that we would die of old age. That those diseases would affect you when old, but I have lived in my own flesh that is not about old age, that young people suffer many diseases nowadays.

When asked, if she fears a particular disease, she responded:

Yes, the one I mentioned earlier, cancer. I have heart problems, and I don’t fear a heart attack, but rather the cancer. What do you fear? Fear of thinking that I am here today and tomorrow I will not be here. What are my children going to do, that is my fear. Lately there is more consciousness about health. And we began this year living in this manner [paying more attention to health].

I have talked a lot to my neighbors [female neighbors]. I always communicate with a friend [male friend] who is a doctor and he is always scolding me because I don’t have my exams done regularly. I am trying to develop more consciousness. We have begun to assist more regularly to the doctor.

Most women in the study fear cancer. The fear of mortality due to the understanding that cancer causes death was present among most women in the study across screening, age, marital status and socioeconomic subgroups. In general, women in the study believed that cancer signifies death.

Fear of the Unknown

Much of the fear and embarrassment experienced by Panamanian women resulted from the unknown. For example, fear of being tested because the women did not know what occurs during a Pap test. Also, women who were screened feared the results of the test. Some women feared the period between being tested and obtaining the results of the test.
Regularly screened women were asked the reasons why they thought other women did not get a Pap test regularly. In general, their response was that women feared the results of the study, feared disease, or feared the test itself. The topic of fear regarding cancer was expressed by all women interviewed. However, differences among screening subgroups were observed. Regularly screened women feared cancer, so they went to the gynecologist regularly to have a Pap test done because they believed they could prevent or avoid diseases by going to the gynecologist. Some irregularly screened women feared abnormal test results, so they decided not to return for follow-up or further testing. Women who had never been screened feared the test so much that they just did not want to go through a procedure they did not understand.

The following quote was from a woman who had never been screened, suggesting lack of screening due to fear of the procedure of the test.

Well, once I went to have some tests done, a general test so I could get my health card [health ID or certificate of good health for work], that generally they always order a general exams on everything. Well they sent me to have that particular test done [Pap test], but I didn’t do it. Why didn’t I do it? Because I felt that when, I mean, when one has never had a particular test done and one does not know the reason for that exam sometimes one gets scared. Sometimes someone gives you information, I mean the wrong information, and for that reason on that day I did not have that test done. I did not do it for fear, for fear of a gynecologist. My sister has also told me to do it, but I haven’t done it for fear, for fear I have not done it.

Women explained fear as feeling depressed, sad and anxious. The fear was also described as feeling worried or concerned about something. Respondents’ narratives expressed concern about the unknown and feeling of insecurity. A married woman mother of four explained fear in the following narrative.
Fear for me is something like a feeling, like an emotion. Fear is something that I have come from the inside and that makes me feel unsure, insecure, anxious and depressed. With fear, it is like something that makes me nervous.

I feel depressed, hm, out of control, I feel as if I am not there, because it is not the same to be healthy than to be sick. In this life, you need to think about everything. Fear or feeling scared for me is almost the same. It would be for me like a wait, an anxiety, like an empty space that you feel deep inside your heart. An anxiety that slowly enters you, as if something was going on and it is not going on. Like a chill that enters your whole body and one feels as if that is it. So, one [referring to herself] places that fear on a certain thing or I feel fear that something might happen. Sincerely I really could not explain to you what my fear is. All I know is that I feel anxious.

The following quote is from an irregularly screened woman. Her decision to not go back to the doctor was based on fear. After her abnormal test result she decided not to go back because she did not know what would happen.

*When I had my second child, the doctor said that I had to do, that I had to do a small test because it showed some fibromas [fibrous tissue], but until the sun came out today, I never, never went back to the health center to see those small fribromas, the roots of the fibromas.*

Regarding fear, an aspect that varied among women was the type of fear they felt and the resulting behavior this fear caused. Some regularly screened women acted to alleviate the fear they felt regarding vaginal or reproductive health. Regularly screened women felt that by regularly having a Pap test, they would actually prevent any type of reproductive disease. A woman who regularly sought screening tests explained why she frequently had a Pap test based on her fear of cancer and of the test not working for prevention.

*Just having a test once a year, you can prevent that [cervical cancer]. There is a type of cancer, I cannot remember what it is called right now. But it is a cancer that appears and that it develops inside, very quickly, even if you have the yearly test. So I always tell women that are sexually*
active to have their test done every six months. Between you and I, I get my test done up to three times a month, because I don’t trust the Pap [the results of the test].

Irregularly screened women, in general, decided not to return for a Pap test after a prolonged period due to embarrassment, fear of discovering results, including having abnormal results or having repeated normal Pap results. Some women who were irregular screeners attributed their lack of regular screening to fear. A married woman in her thirties from a middle socioeconomic background who did not get screened regularly talked about her fears. She feared being at-risk of cancer and did not get screened based on her fear.

*Well, the doctor who has seen me before has told me about all the implications of having family antecedents, but on the mother’s side. Those are the ones who have more propensities to cancer, so I am one of them.*

A woman who had never been screened explained her awareness of the test and need to be screened. She had not been screened due to fear of the unknown and test results.

*Well, I have thought many times about having it done and I had a series of tests done referring to other parts of my body, and I said, that one is missing, and I will not let it go beyond this month. I am going to do it! I haven’t decided not to do it, to the contrary, I am pushing myself to do it. But the truth is that I am afraid that they will say that I have something, this terrifies me.*

In the previous quotes, women understood the importance of being tested regularly and the implications of family history; however, the women avoided screening for fear of the unknown and of having abnormal test results.
Fear of the Pap Test

Overwhelmingly, women who had never been screened feared the test itself as well as the process of being tested. This was expressed as fear of the Pap test due to fear of pain or discomfort, fear of the doctor, and embarrassment. The fear of the Pap test itself reflects a lack of appropriate information available to women. A woman in her late thirties who had never been screened expressed her fear of the Pap test and how this affected her screening behavior.

For me fear is like a barrier inside of me that is within my personality, if I do it or not do it [the Pap test]. In reality that needs to be overcome.

I think I should do it, as I said, I am thinking about doing it, not only because I have heard about cancer and all of that. I think that I should do it to have good health and to prevent diseases.

I have considered, I have taken consciousness of having my test done, the Pap, and due to personally letting myself go. I have not done that test and have to do it to avoid a disease the day after tomorrow. Why haven’t you done it? I have fear, sincerely, I have fear.

The fear of the test is a factor that affected many women’s screening decision. Some women even discussed feeling the fear physically within their bodies as they thought about the test. Women are aware of the fear felt by other women. The following quote is from a regularly screened woman who expressed her message to other women about screening and fear of the Pap test.

I tell women, I paint a pretty picture to them, so they go [get tested] without fear. I tell them that is something very interesting. That it will not hurt, that it is necessary for all women to have it done. I tell women not to fear the test.

The fear of the Pap test influenced women to avoid screening. The fear of the Pap test was mostly experienced by women who had never been screened. Most non-
screeners received information from other women who had negative experiences with the Pap test.

**Pain and Discomfort**

Women in the study believed the Pap test to be painful. The belief that the test is painful resulted from some of the women’s own experiences. However, a majority of the women who understood the Pap test as being painful drew the information from other women. It is not clearly delineated whether the understanding of pain associated with the Pap test stems from actual pain felt or from women’s understanding of pain due to screening. The following quote is from a woman who had never been screened. She shared her understanding of the pain and discomfort associated with the Pap test.

*I have heard that cancer here in Panama is affecting women a lot. Why? Because they don’t get their Pap test. Because many of us refuse to do it, because of feeling uncomfortable, that it hurts, and this and that, and one has the tendency to say no.*

In the previous quote, a woman who had never been screened described the importance of screening and the impact that cervical cancer has on Panamanian women. Nonetheless, she refused to be screened due to the understanding that the Pap test causes pain and discomfort. She had formed her understanding from conversations shared with other women.

Another young woman mentioned that she learned about the pain of the Pap test from her sisters.

*My sisters told me that it hurts a lot and that it is very embarrassing.*

Many of the women who had never been screened believed that the Pap test causes pain and avoided screening based on that understanding. Since the women had
never been screened the understanding that the Pap test causes pain and discomfort might be drawn from other women.

Embarrassment

Women experience embarrassment in two distinct manners. Some women discussed embarrassment as modesty illustrated by having a physician looking at their private parts. Other women discussed embarrassment as loss of confidentiality by being seen at the clinic having a Pap test done or by having their personal health information disclosed. The following section discusses modesty and confidentiality issues associated with embarrassment of being screened among women in the study.

Modesty

Many of the women who had never been screened talked about the embarrassment they believed women feel when going to the gynecologist to have a Pap test done. Most of this embarrassment stems from modesty. Regular screeners spoke about humility other women felt regarding the test. Some women did not want to be seen naked by a stranger, even if it was a physician. A woman in her thirties, cohabiting with her partner and who had never been screened, explained her views about embarrassment.

And I abstain from having it [the Pap test] done because of embarrassment, even if we had our first sexual relationship, one thinks, oh, no, I am not going to open my legs so the whole world can see me. And we do not know how can we prevent a disease. Actually right now, I am not very clear on that and I think that I should have my Pap test done. How often, is it every six months that it is done?

The following quote was shared by a regularly screened woman. She understood the importance of the Pap test as a form of cancer and STI prevention. Nonetheless, she discussed the embarrassment shared by many Panamanian women as a form of modesty.
As I speak with women, sometimes women have these myths. Why myths? Because we think that this test is something immoral. Since, we allow ourselves to be examined by a man who is not our husband and this is seen wrong upon the eyes of others. But really we should not see it that way, rather we should see that this is one of the best ways by which we can control our life and avoid diseases like cancer, like gonorrhea, syphilis, like so many sexual diseases that right now there are, in the city. I think this is a good way to have control over them [the diseases].

Although the previous quotes were shared by women who were sexually active, they believed that it is embarrassing to have a Pap test done. The modesty shared by some Panamanian women prevents them from seeking screening services.

Loss of Confidentiality

Panamanian women tend to protect their confidentiality. Women discuss reputation and what will people say? Regarding screening, loss of confidentiality refers to being seen at the clinic getting a Pap test or when health care providers expose screening information about women. Some women believed that if they were seen at the clinic by other people their confidentiality might be affected. Women also shared experiences where practitioners at health centers and clinics openly shared confidential information. The following narrative is an excerpt drawn from a group discussion. In the narrative a woman discussed among other women in the group an example of loss of confidentiality at a health clinic.

Another situation that occurs and that I do not agree with, is that many times there are pictures of women stuck on the bus stops, outside the health centers, showing that this person has a disease, not to get close to that person. This is not reasonable and it is unjust, because supposedly there is a disease that women get, that if they don’t go to the health centers immediately they will start publicizing to inform the community that they have such disease. This is not pleasant.

If you suffer of something, many people don’t like other people to know, because it is very embarrassing. Even on one occasion at the health center
of Pedregal, a girl was diagnosed with the HIV virus. The doctor came out and started yelling at her, that with how many men had she gone to bed with, why did she have AIDS. So, who wants to go to a health center where if you are diagnosed with this type of disease, that nobody would like to have, since it is embarrassing and above all, the whole world finds out. That is something which makes a woman feel very bad and also if you don’t go to your appointment, they start posting your picture around, and give all the information about the person, this is unethical, this situation. This then causes women not to want to get tested.

Although Panamanian law closely guards patients’ confidentiality, in an effort to follow-up with public health compliance, practitioners might not always adhere to confidentiality guidelines during health care delivery. Some women in the study experienced the breach of confidentiality at health care facilities causing them to avoid screening or returning for follow-up.

I was working on a vaccine study in Panama at the time of the study and experienced firsthand the loss of confidentiality issue. I went to visit the nurses working in a different study in a rural Social Security clinic in Colon, an African-Caribbean town located in the northern part of the country about an hour and fifteen minutes from Panama City. As I walked into the pediatrics waiting area, I saw the walls covered with long handwritten lists of names. I asked one of the nurses about the lists. She said that the names were of mothers who had yet to bring their newborns for vaccination. I left that day thinking about the lists and returned a couple of weeks later. The lists were gone. I asked the nurse what had happened to the lists, she said that some of the mothers in the community got upset for having their names displayed. The mothers explained to the nurses that other women in the community might consider them as being incompetent mothers. So, the nurses took the lists down. Months later I returned to the clinic and asked the nurses once more about the lists. The nurses said that although mothers did not
appreciate being listed on the clinic’s walls, the nurses still practiced this listing when they felt it was necessary. Panama has high immunization rates; according to the Ministry of Health almost 98% of the pediatrics population is completely vaccinated. However, in an effort to comply with public health requirements, providers might unwillingly break confidentiality regulations.

Morality

Morality issues influenced women’s view of screening. Women in Panama understood that there was some relationship between sexual behavior and female health. Women believed that women who have multiple sexual partners are at increased risk of developing diseases. Women also believed that only men transmit STIs. Some women understood sexuality and that the number of sexual partners was an important factor associated with female health. Some women discussed the need for having one sexual partner as a manner in which women can maintain female health. The following quote was of a regularly screened woman who believed that men transmitted infections, so a woman should have only one sexual partner.

To prevent disease, well doing, taking care of oneself and having the Pap test done regularly, hm, not having a bad life [referring to sexual behavior] and not changing partners. Your partner should always be the same, because sometimes there are many diseases that women catch. These diseases are contagious from the male sex and they give it to their partner.

In addition, some women believed that only women who had multiple sexual partners should be screened. Women based this belief on the increased risk women with multiple sexual partners had to be infected. This belief indicated a morality label where
the women believed that women who had multiple sexual partners were at increased risk of diseases and that only these women should be screened.

*I think that all women have a certain risk, risk of getting cancer. But those promiscuous women apparently are the ones who are at higher risk. Well, I think that those women who are around more. I mean those women that have different, well another type of life. I think that those women are at higher risk of getting that disease.*

Some women also discussed the transmission of HPV infection by men who have multiple sexual partners. Some women reported men as being *promiscuous*. These women understood that men who have multiple sexual partners would transmit infection even if the men were involved within a relationship.

*Well I have heard that it [about HPV and genital warts] occurs a lot. Men are who transmit it. And when the man is promiscuous, even among couples, women get it and it is transmitted by their husband.*

During the pile sorting exercise, women separated sexuality from other healthy behaviors. In this categorization, women separated sexuality and number of sexual partners. Women understood this cultural domain as one separate from other health promoting behaviors such as nutrition and exercise.

**Social Influence**

The following section contains information on social and cultural influences that affect screening behavior. The influence can be positive or negative. Media, physicians, female networks and men are important factors which influence women’s understandings and knowledge about screening and cervical cancer.

**Media Influence**

Mass media in Panama was influential among women. All women in the study received information from all types of media sources including television, newspapers,
magazines, radio, and a few women used the Internet. Within media sources, women received most of the cervical cancer and human papillomavirus (HPV) information from television, women’s magazines, and newspapers. A few women mentioned obtaining health information from the radio. A 40 year old woman who had never been screened shared the information she received from the media and her understanding of cervical cancer.

Well the first time I heard about it [cervical cancer] was on the news on Channel 13 on television. And, what I have heard is that it is a disease that if treated on time, they take out all the inside parts of the woman.

Another woman who had never been screened discussed sources of health information.

When I’m home I see health information in magazines, in newspapers sometimes it is in the newspapers, but I read more books. I should follow them right [follow the health advice she reads], but I don’t.

During small group discussions, women were presented with local print media on cervical cancer from newspapers. Women reacted to the information presented to them. The purpose of the group interviews was to observe women’s interactions and reactions to cervical cancer screening information from local media. In the group discussions, the women read the information (each woman received a different newspaper article), shared the information with one another and reacted to the information as a group. The group discussions provided a live simulation of social construction processes, in this case how women use media to understand cervical cancer and screening. I wanted to know if women would disclose personal information openly. Women in group discussions, even if unknown to each other, talked freely about health information from the media.
A discussion among three women during a group interview at a woman’s home prompted the sharing of information and construction of meaning. Women mentioned social and structural factors that affected screening, as well as media influence on cervical cancer screening. The following is an excerpt from this discussion among women in the group setting.

Margarita: Newspapers like the Siglo and La Crítica (tabloid newspapers) that are bought by many people, in a small corner of the front page show the number of women in Panama City that die due to the cancer because they did not get the test done. My mom had a 38 year old friend who never had a husband, but died of cancer. So it doesn’t matter if you have one or not [husband] it is important to do the Pap test to avoid it [for prevention].

Itzel: As soon as the woman begins having sexual relations she should practice the Pap test. Cancer should not be promoted only during the time of the year [referring to October for breast cancer awareness month], it should be promoted 365 days of the year.

Margarita: I think and insist that it should be worked with the community centers and the health centers, it is beneficial to take into account women’s opinions.

Cecilia: Another important factor is that youth don’t have the consciousness, today young people have sexual relationships at a very early age, this is why it is important to inform, and create awareness and divulge through the media.

Margarita: I think that we should constantly do the Pap test and especially during the age of risk. I think there is not a strong campaign where women can have information at the community level, community groups, health centers, since they don’t work together and are not very involved. I think the information does not reach us and that we don’t have social security so we can get the Pap test. Even if they say it is affordable for three dollars. These three dollars can be used for something else. I think it should be even more affordable [referring to lower cost].

Itzel: I consider that the woman is less preoccupied with respect to the Pap test. They don’t have consciousness of the importance of it. Sometimes they don’t do the test because of embarrassment, that they are having sexual
relations. Others don’t do it because of the money factor, others because of lack of time, or because they don’t have husbands.

Facilitator: What have you heard about the Human Papillomavirus?

Itzel: I have heard that it is transmitted by the man.

Margarita: It is incurable, you live with the papilloma.

Cecilia: Also, that it is transmitted by the man.

During this discussion, women shared their own understandings and previous knowledge about cancer. The women also shared the information they read in the newspapers during the group session. The resulting discussion prompted information, opinions, beliefs and knowledge sharing among the women. The previous example illustrates the discussions women have amongst themselves when exposed to media. The women also drew from their own personal experiences and from other women’s personal experiences to form understandings of meanings and behaviors. Women took the information from the media, shared it with other women and supplemented the information from media with their own experiences and with information they previously received from other women. Media is an influential source of information for women. Women from all subgroups obtained health information from the media. This information is applied in women’s screening behaviors and social construction processes.

Physicians’ Influence

Across subgroups of women participating in the study, physicians were regarded as respected figures. Women in Panama generally listened to doctor’s advice when it was provided. Regularly screened women received most of the health information from their...
doctors. The other groups of women received their health information from other sources (e.g., media, friends, family) as compared to regularly screened women.

Regularly screened women in the study were more knowledgeable about medical concepts than women from other groups. Regularly screened women were also more responsible for their health and their screening behavior and complied with recommended screening guidelines. A 32 year old, regularly screened woman, married with a young daughter, talked about receiving information from her doctor. She explained who she talked about health with and where she received health information. She also mentioned how she learned about the Pap test.

> About health, I always try to go to my gynecologist, who is the person that I trust a bit more and I ask him about any abnormality I might have at the moment. I seek doctors’ help because I think that they are the most suitable for any type of problem I might have if it is regarding health.

> Generally, if I’m sick or one of my children is sick, I try to go to the doctor. I always seek a doctor’s advice or of people older than me.

> As the reason for the Pap, it came when I got pregnant with my first pregnancy. When one goes to the health center for prenatal control, there they talked to me that I had to do the Pap and all those other things, which is where I learned that you have to do it every six months or each year.

Another woman shared her experiences gathering information from physicians and other health care providers at health care facilities.

> I go to the health center, I ask the doctor or any other person who might know of health more than me, about health. I ask about what I’m feeling and how I feel and that the person tells me what I have and inform me where can I go get better answers for what I’m feeling.

This narrative is common among regularly screened women. This group of women learned about the Pap sometime in their lives, usually through the media, from other women, husbands or when they became pregnant for the first time. However,
doctor’s influence on knowledge formation and screening compliance is important among regularly screened women. They developed a relationship with their gynecologist or with another health practitioner at their local health care facility and proceeded to consult with them about their own health issues or that of a family member. Regardless of the situation, women who felt comfortable speaking with a health care provider most likely sought health advice from health professionals and complied with screening guidelines.

**Female Influence**

Female social networks were strong determinants of women’s health behavior and important factors in the construction of folk and popular knowledge. Across all subgroups of women in the study and regardless of screening history, female networks from family members (mother, sisters, daughters, cousins), neighbors, co-workers and classmates were basic to women’s development of health understandings. Most of the construction of health knowledge among Panamanian women results from interactions with other women.

Women spoke to other women about their own experiences with the health care system, about specific doctors, childbirth, their health and the Pap test. Women talked to other women about their Pap test experiences, such as being painful, the embarrassment, fear or reinforced positive messages such as STD testing and cancer prevention. Women shared positive and negative screening behavior information with each other. A regularly screened woman of low SES, 26 years of age, living with her partner in a small two bedroom house, interviewed at a health center shared her experiences on talking about health.
I always talk to women at the health center, a family member or a friend. We always strike up conversations about the topic. I always say that it is important to get the test done since that is how you can prevent so many diseases like cancer, which is one of the main diseases. And many women are afraid of having the Pap test because then they can find themselves with a problem.

During a group session, a woman shared discussions of female interactions regarding screening and female health.

Whenever I have the opportunity, I talk to my neighbors [female neighbors] about these topics, with my daughters, my sisters, etc. I also think that many times women have this taboo. They ignore what is the Pap test or simply think that it is not necessary to do it because of embarrassment, waste of time, or that when you get there, there are no appointments available, they first look at the pregnant women, it is a whole protocol [according to the women, doctors treat pregnant women first at the health centers].

In this manner, social construction and sharing of knowledge occurred among women in Panama. Women learned about other women’s experiences and acted based on the information they received. If the message they received about the Pap test was a positive cue, they most likely got tested or were aware of the need for testing. If the message was a negative one, women would not be tested and further disseminated this negative information. For example, the following quote of a woman who had never been screened refers to receiving information from other women on the pain and bleeding caused by the Pap test.

I mean some people that I know do it [the Pap test], they tell me “oh, no, that when I go there, it hurts” they tell that that they were bleeding because of the test.

Although, biomedical information about HPV and cervical cancer was not widely available to women, some information on access to health care services and check-ups
was shared among women. Most women reported behavior based on the information they received from other women and understood the information presented by other women.

The following narrative referred to the construction of cervical cancer knowledge based on female interactions and media. The woman in the narrative reinforced previous observations, including that men were not a deterrent to screening. During conversations, women shared their experiences about the Pap test. She mentioned other women’s experiences with the test and the topic of pain, bleeding, and embarrassment due to screening. The young woman had never been screened. She shared that at one point she went for testing. Nonetheless, based on previous information she received from other women and also during the time of her test appointment, she decided not to proceed with screening.

*Well, I have talked about it [the Pap test] with some girls at school [university]. Well, it is a topic they talk about all the time. Also, I have heard about it through media and communications, the newspapers, and television.*

*I don’t think my partner [male partner] minds that I tell him about the test. And he knows that it is something that will help me be healthy and I don’t think this is a problem.*

*I mean, some people that I know have it done say “ay, not that, when I go there they leave me walking, that I cannot walk or that it bothers me” [referring to pain felt due to testing]. Something like that. There are many people that have even bled when they do that test. I couldn’t tell you if it hurts or not, until I have it done. They always say that the Pap hurts a lot.*

*Talking to people, to women one knows, friends, and I imagine that it spreads through word-of-mouth, of the importance of having a Pap test, of the importance it has. I do talk to a friend, I have many girlfriends with whom I always speak about those things and if I have an apprehension about something I ask them. And they advise me on what to do.*

*Some girlfriends were the ones who told me about the Pap test and what they told me is that it was very painful. Also that it is very embarrassing.*
That doctors who treat you stick their hand in there you know [referring to the pelvic exam]. That one feels a bit embarrassed, so she, they, said it was too painful. So, sometimes you get carried away by what others say and many times you let yourself be convinced.

One day I went to an appointment, people were talking about it [the Pap test], that it was painful, and that it was bothersome and all of that. But I don’t know yet because I haven’t done it [she did not get tested].

I’ve talked with family members, who have told me that it is a test that women need to have done to see how they’re doing, how healthy are their reproductive organs.

Similarly, women relied on older relatives for information. Another woman shared her knowledge construction through conversations with older family members.

Well, generally when one needs, for example, a question to ask anyone about health, generally one asks older adults. Many times, they have knowledge and know about different types of diseases. Although sometimes they also, maybe they tell us more because sometimes those people are healers (curanderos) that suddenly give you some medication. Home medications [home remedies], to cure the person or something like that. So then generally, one rather asks our parents, or grandparents, an older person who has more knowledge. Generally these diseases occur during their lifetime.

Regularly I speak with my family, with my parents. And they always tell us that we need to take care of ourselves. That we need to eat this. That if you are sick you need to eat that or that we shouldn’t do that. Well, my mother has told me about the Pap test, my aunts, my sisters all of us women that live in the house talk about that disease.

Reference to healers during the study rarely occurred and did not influence screening behavior. However, the respect depicted toward older adults by referring to them for health information was strongly evident. The previous narrative reflected those experienced within the female social network as an influential source of health information. Much of women’s understanding was constructed by experiences and knowledge learned from other women regardless of age, SES, or screening behavior.
The Mother Factor

Panamanian society depicts a matriarchal society, where the older mother in the family tends to guide the rest of female family members. A majority of the women who had never been screened spoke about sharing health information with other women. Within the female social network of women who had never been screened, mothers were the most influential female figure. Other female family members such as sisters and daughters were influential as well. However, the influence mothers had on knowledge construction was considerable.

Mothers influence on women’s understandings of health was twofold. First, mothers provided guidance about professional health assistance needed. Second, mothers shared their own experiences, both positive and negative, with their daughters. Many women reported behavior based on the information provided by their mothers, especially non-screeners. A young woman, married with children, who had never been screened shared her experiences of interactions with her mother while visiting at a friend’s home.

I speak with my mother sometimes about those topics [about health topics] because she has more experience with check-ups, and more experience in life. I speak with her and also with other women, professionals. With my mom, we talk sometimes about, about those diseases that I mentioned earlier.

Who else do you talk to? Nobody else because I spend most of the time with my mom. I talk about health primarily. I discuss it with my mother and then she recommends where should I go, if to a general practitioner or to a specialist. Yes, my mother tells us that when we feel something uncomfortable down there, sometimes we talk about a mild itching. Immediately she says for us to go to the doctor because one never knows if it is a fungus that it will spread, that it will become an infection and all of that. Above all I speak with my mother she is very important, I ask her and she responds immediately. I talk about any type of disease with her.
Women talked about fear of the test results, of the shame they felt during the examination and of the pain of the test. Some of this fear is socially constructed. Women who had a negative experience at a health care facility shared it with other women. Hence, women might have shared these beliefs even without ever having been tested.

Another young woman shares her interactions with her mother and how her mother influenced her screening behavior.

How did I learn that I have to do the Pap test? Well, yes, they told me when I went to be tested for my pregnancy, it was pretty advanced [the pregnancy]. Then the doctor who was treating me told me I had to do it. And since this was my first pregnancy, I didn’t have experience or anything like that. Although I have knowledge from books I had read and because of that one also has doubts and fears. My mother told me, don’t do it, because that is going to harm the baby. So I listened to her, I didn’t do it. I think that sometimes it is very necessary to do the Pap. Now that I’ve had the baby, now I will do it. I have also been hearing at the health center, actually today I took the baby [to the health center]. There was a doctor [female doctor] saying that there were a lot of women being screened. She was saying that when women go get the Pap they realize that they have an advanced cancer and it is very hard to treat an advanced cancer because it has no cure.

I always ask my mother first, and since she is a mature woman, she can more or less guide me. Then I go to a doctor afterward.

As in other matriarchal societies, mothers in Panama are strong influences on women’s behavior. Women’s narratives suggested that women shared with one another information about pain, embarrassment, and fear of screening. This information might interfere in women’s screening behaviors. Many women acted based on the information they received from other women, especially their mothers. Mother’s influence was most saliently depicted among non-screeners.
Male Influence

Since Latino culture generally is considered a machista society, I was interested in exploring male influence on women’s screening behavior. Across all subgroups of women, regardless of screening history, SES and marital status, a majority of women agreed that men were positive influences for screening behavior. Husbands and boyfriends promoted screening behavior among women.

Women were asked if their partner objected to them getting a Pap test done. Among regular, irregular and non-screeners, overwhelmingly the women spoke positively of men’s influence on screening behavior. Men actively encouraged women to get tested. Some women received their health information from men and also discussed their health questions with their partner (husband, boyfriend). Men were another important factor in the construction of women’s health understandings.

Another related factor is that some women who were not in a relationship with a man felt no need for getting a Pap test because of lack of sexual activity. Many women related sexual activity to disease. Women believed that if they were not sexually active, there was no reason to go to the gynecologist. Homosexual beliefs, attitudes, and risks, among men or women, were not explored in this study.

I talked to several men in an effort to confirm the information presented by women. The men confirmed that they wanted their partner to get tested. Even if they did not understand the relationship between HPV and cervical cancer or about other STIs men wanted women to get tested. A young woman, 24 years of age, from middle SES background, who cohabitated with her partner shared the experiences she had with him.
He doesn’t mind at all. On the contrary, when I get the Pap test done, he feels more confident about me. He tells me it is good for me. **What does he say?** Well, he tells me that it is a check-up that I have to do always. He has never been upset that I do this exam, much to the contrary. He tells me that I need to keep always, I mean take care of myself, because this is the only way in which I can stay healthy, so I can offer something better to my children.

Now, I just tell him, I’m going to the gynecologist, I’m going to my doctor, to the gynecologist, that’s it. He doesn’t mind, he even reminds me. He says did you get your Pap test yet, he helps me with that.

Men also helped shape the information women received and encouraged women into seeking screening services. Women were asked who they spoke with regards to health. Most married women responded that they spoke with their husbands regarding health. **I speak with my husband.** Well we talk about health, that health is good and that you should seek treatment. Go to the doctor to see how we are doing. **Do you speak with another person about health?** No, just with him.

Women in relationships tended to discuss health information with their partner. According to most of the women in the study, Panamanian men encouraged screening behavior and were not deterrents to women seeking screening services.

**Key Messages**

Information available to women at the community level was scarce. The modest print information in the form of pamphlets was poor, hard to read, un-engaging and culturally irrelevant (Appendix I-Samples of Local Brochures). Rarely, there were television health programs or newscasts where physicians or health care providers talked about cervical cancer and screening. When information was available it was often unclear, complex, and contained medical terminology.
Women in the study obtained health information from local and international media. Knowledge from media in the form of television, radio, magazines and newspapers continued to be important sources of health information for women. Although women received health information from public media sources, increased relevant information is necessary. All the women participating in the study offered extensive ideas and suggestions on delivering health messages. A regularly screened woman explained where she received health information. She believed that group sessions or talks at the community level would be most relevant. She also offered suggestions on appropriate information channels and spokesperson.

*I receive health information from what I read in newspapers, from talks given by doctors, from magazines, from the books I read and what I learned in school.*

*I think they should give talks at community health centers of hard to reach areas, because there are a lot of people who don’t know about this. So, well, I suggest that they are done at community health centers to prevent any disease.*

She also believed that popular media were important health information channels for women in Panama. However, she agreed that the health information offered on local television should have positive and targeted messages.

*The information should also be by television at a given moment on the local news during a health segment about the topic of the Pap test. Why through television? Well because it is a communication medium that nowadays in our country everyone watches every single day. I think you should propose that to local television channels in this country. Because they show things that they shouldn’t and they aren’t good sources. They give negative messages and what they should do is share positive information like about cancer on a programmed period on all television channels in this country.*
She also discussed the use of other popular media, specifically radio. She suggested specific content for the program(s).

Also, regarding telecommunications, the radio should also have information about cancer. That all women should do the Pap test and what the test means. The Pap test, what consequences this test brings. If we do this test and in reality the fatal consequence is that us, well me as a woman, we do not want to reach that fatal consequence which is that fatal disease, which is cancer.

Culturally relevant health information delivered at the community level by other women or health care providers in the form of group sessions would be most engaging to women. Community health centers can be useful points of information for women. Information from the Ministry of Health was usually regarded as a trustworthy source of information. Women in the study viewed health care practitioners such as doctors and nurses as sources of trustworthy information. However, more health education material is needed at the health centers. Material is poor in presentation and content. Printed material tends to be unappealing. Nonetheless, health care providers were often regarded as knowledgeable and women trusted them to present health information.

Women suggested the following health education opportunities to increase awareness among women (concientizar a la mujer) at a community level.

1. Go to communities themselves and talk at community and health centers.

2. Increase awareness with campaigns deep within communities in secluded areas, such as rural areas through free informative sessions or talks.


4. Work in partnerships with community groups and health centers.
5. Hand deliver information door-to-door.

6. Have a gynecologist talk on television.

7. Deliver information through newspaper and the Internet.

The women also offered suggestions on how screening programs should be delivered at the community level.

_They should have a specific day for Pap tests at the health center, at least every Thursday at the health center._

_They should have a mobile unit to visit the distant communities to do a complete check-up, including the Pap test._

Women offered possible key messages to present in health education programs or interventions. Specifically, they were asked what would they tell women who have never been tested about the Pap test. Women believed that the following positive messages were most appropriate.

- It is a test that takes between three to five minutes and it can prolong your life (_es un examen que le va a tomar de cinco a tres minutos y eso le puede prolongar más su vida_).

- I would tell her, motivate her to get her Pap test done because it is very important; and also tell her that it won’t hurt her, that it won’t make her feel uncomfortable, so she becomes inspired and gets her test (_yo le diría que se lo haga, la motivo para que ella se haga su examen porque es muy importante y le diría que no le va a doler, que no le va a molestar, para que ella se anime y se haga su examen_).
• I would tell women to get the Pap test, because it is not embarrassing and it doesn’t hurt, or make them feel uncomfortable (Yo le diría que se hagan el Papanicolaou, porque eso no da pena y es algo que no duele, ni molesta).

• …not to be afraid and have their test done every time they can (…que no tengan miedo y que se hagan su examen cada vez que puedan).

Summary

A total of 132 women were interviewed in this study through individual semi-structured and group interviews. Women were stratified, following a sample matrix, into regularly, irregularly and never screened, as well as, by age and marital status. Freelisting, although a simple process offered powerful information (Bernard, 1994); this was borne out by the data gathered from women in Panama. The pile sorting exercise assisted in understanding how women categorize in the Panamanian culture and how this might affect health beliefs. Semi-structured individual interviews offered insight into sociocultural and structural factors that affected women’s screening practices. Sociocultural factors that affected screening behavior included family responsibilities, fear and embarrassment. Structural factors such as cost and experiences with the Panamanian health care system might have deterred some women from getting a Pap test. However, these were not strong determinants of screening behavior. Women voiced the need for a more humanistic approach to health care delivery.

Women in Panama understood that sexual behavior related to health in general. Women viewed women and men who have multiple sexual partners at increased risk of infection, focusing on morality issues. Cancer was seen as a death sentence, signifying
death to women. Preventive care, including cervical cancer screening was important. However, the Pap test was often misunderstood as a manner in which women can prevent female diseases, instead of a test for early detection of cervical cancer. Vaginal hygiene was another manner in which women prevented female diseases through the use of vaginal douches, creams and suppositories.

The social construction process was observed among women in group discussions as they reacted to information in local newspapers. Women, especially mothers, within female social networks are strong positive and negative influences on knowledge formation and understandings of screening behavior. However, male partners also were a positive influence.

A dearth of information existed at the community level. More directed culturally relevant health information programs are needed. Women who were not screened tended to have less social interactions to receive information from other women or men, or if they receive the information they sometimes rejected this information. However, mothers tended to be strong influencers among this subgroup of women. Media was an important source of information for the development of popular knowledge about women’s health, cervical cancer and Pap tests. Health education messages that are culturally relevant, delivered at the community level by women or health professionals would enhance the health care experience of women in Panama. Chapter V offers a thorough discussion, implications for health education and recommendations for future research and practice.
CHAPTER V-SUMMARY, DISCUSSION AND RECOMMENDATIONS

Chapter V presents the summary, discussion of findings, strengths and weaknesses, implications and recommendations for health care professionals, health education interventions and future research. In this chapter, the interpretations of the data collected are discussed based on the research questions and current literature. Some similarities with current literature exist, such as cancer signifying death. However, contradictions with literature exist as well, such as cervical cancer being mostly associated with poverty and structural barriers. Health beliefs of women in the study are analyzed and compared to current literature. Social construction processes and the manner in which women in Panama understand cervical cancer and screening are discussed. Societal influences are an important aspect of constructionist processes, especially among female networks. Health education recommendations are offered for health care providers and policy makers. Recommendations for further research and health care practitioners are presented followed by strengths and weaknesses of the study. This final chapter closes with a section on platform for future research.

Summary of the Study

The data collection phase of the study was conducted between January and May 2003 in Panama City, Panama among Mestizo women 20-40 years of age. This population has the highest incidence of human papillomavirus in the country and the highest risk of cervical cancer (Reeves, 1982; Reeves, et al., 1994; Reeves, et al, 1985;
In this qualitative study, 117 women were interviewed through in-depth semi-structured individual interviews using an interview guide (Appendix F). In addition, four group interviews (N=15) were conducted among Panamanian women. All interviews were conducted in Spanish, the native language of the women in the study, tape recorded with women’s permission and transcribed verbatim. Data organization for analysis was accomplished using the qualitative data analysis tool *Ethnograph V 5.0*. During data analysis, patterns observed in the interviews were coded and key messages were identified. Emergent themes surfaced from the interviews and narratives of women were used to support these themes. Results and findings of the study were presented in Chapter IV, where interview quotes in their English translations were included to ensure validity and reliability of qualitative data. During the individual interviews, a freelisting and pile sorting exercise was conducted among 36 women to assure that the researcher’s beliefs were not imposed upon study subjects. Women provided a list of beliefs on how a woman can stay healthy. This list, categorized by groups of women, assisted in understanding how women’s beliefs regarding health in general were structured within cultural domains.
Once individual interviews were conducted and data was transcribed and organized, four group sessions were conducted. Group interviews were conducted following individual interviews so individual interview data could be used to facilitate the discussions during the group sessions. The groups were small with 3-4 women so we could observe the construction of meaning process for cervical cancer and Pap test information from local newspapers. During planning, data collection, data analysis and reporting phases of the study, I communicated with colleagues in the U.S. and Panama discussing observations and personal experiences. This generated a series of field notes which support data presented by women. Detailed results were presented thematically in Chapter IV.

Discussion of Findings

This section discusses the finding of the research results presented in Chapter IV. Results are discussed in the following subsections: structural factors, sociocultural factors, health beliefs and practices, cervical cancer awareness, construction of health, cervical cancer and screening and health education preferences.

Structural Factors

Current literature suggests that Latina women face structural problems that affect screening behavior (Jennings, 1997). Kagawa-Singer (1997) notes that many community groups in the U.S. have held free screening days for underserved groups and no one came to be screened. In many of these efforts, the product itself (screening) usually is not as important as the mode of delivery or style of the deliverers. A similar situation occurs in Panama where access to health care is relatively straightforward, free or low-cost, and accessible. Nonetheless, women in the study reported a lack of sensitivity, compassion,
and nurturing treatment received by physicians and nurses as a deterrent. The lack of confidentiality was exemplified by the list of women’s names with abnormal test results posted on the wall of a local health center. Long waiting periods, especially at the social security clinics, and limited information available to women on screening related topics might deter women from being tested. Regardless of these factors, women in the study tended to deny structural factors such as cost and long waiting periods as reasons for avoiding screening. This is supported by regularly screened women interviewed during their waiting period who expressed previous negative experiences with the health care system including practitioners’ conduct.

Contrary to the literature on cervical cancer, Panamanian women of all SES do not encounter structural problems such as cost and transportation (Coughlin & Uhler, 2002; Diaz, 2002). The incidence of cervical cancer cuts across socioeconomic boundaries and affects many Panamanian women. Unfortunately, many studies link structural factors to decreased participation in cervical cancer screening services and conclude that Latina women need to have increased access to cancer screening services to increase early detection (Massood, 1999). However, in Panama sociocultural factors seem to have the greatest impact on screening behavior, since Pap tests are available to women regardless of SES, through tests free of charge at community health centers and clinics or at low cost (approximately 3.00 U.S. Dollars) at other health care facilities.

Contrary to Latino literature (Aguirre-Molina & Molina, 1994; National Alliance for Hispanic Health, 2001), folk knowledge, in the form of shamans or healers, was not observed among the Mestizo women in the study, except for one woman who mentioned curanderos (healers). This form of folk medicine in Panama is mostly delineated among
indigenous populations, such as the Kuna, Ngobe Buglé and Guaymi Indians, groups who were not included in this study. Through informal observation and individual interviews, self-medication is commonly practiced in Panama since most medication is available from pharmacists. However, when women in the study were asked if they self-medicated few women said they did. Women denied going to the pharmacy for medication other than for mild health problems (e.g., headache, cold). Interestingly, women did not view purchasing and using vaginal cleansing products as self-medication. Rather, they considered vaginal cleansing as a way in which they prevented vaginal problems. Most women said they went to the doctor when they felt sick. Informal observations and conversations with other community members and health care providers confirmed the local practice of self-medication through pharmacies.

Sociocultural Factors Important in Women’s Lives

Family

Latina women play an important role in the entire family’s health (Lambert, 1995). Most women overlook their own health concerns and focus on their family health needs instead. In this study, a few women mentioned sociocultural factors such as family responsibilities, as reasons for not getting a Pap test. Most family responsibilities are taken care of by women. Women go to school, work, and hold many responsibilities that might deter them from seeking regular screening services. At the same time, family is a focal point of Panamanian women’s lives. During interviews, women mentioned family within the top three important things in their lives. Responsibility coupled with family focus deters women from taking care of their own health.
Religion

Religion and faith are significant in Panamanian women’s lives. The majority of people in Panama are Catholic; however, religion was not mentioned as a reason for not getting a Pap test. Younger women who are not married do not have an understanding of the Pap test and its importance as a screening method for cervical cancer. Working with religious groups could assist health educators and other public health professionals to deliver screening messages to communities, especially among young unmarried women. Partnering with community churches has increased screening participation among Hispanics in the U.S. living in Florida, Texas and California (Brown, Villaruel, Oakley & Eribes, 2003; Derose, Duan, & Fox, 2002; Giachello, Arrom, Davis, Sayad, Ramirez, Nandi & Ramos, 2003).

Health Beliefs and Practices

Women conceptualized cancer as a death sentence. Almost every woman participating in the study identified cancer with death. This belief is consistent with Latina health literature (Chavez, et al., 1995a; Meade & Calvo, 2001; Reynolds, 2004). Researchers often regard this observation as fatalism (fatalismo), where nothing can be done to prevent death due to cancer. Fatalismo is common among Hispanic cultures and it is reported frequently in the literature (Borroyo & Rae Jenkins, 2001; Lantz, et al., 1994; Mathews et al., 1994; Peragallo, et al., 1998; Perez-Stable, et al., 1992; Reynolds, 2004). Fatalismo reinforces the beliefs that cancer is a death sentence, something to avoid talking about, and a form of punishment from God (Perez-Stable, et al., 1992). Fatalismo is also described in the literature as a form of extreme fear (Reynolds, 2004). Chavez, Hubbell, Mishra & Valdez (1997) conclude that fatalistic beliefs are among the
factors that negatively influence Latinas use of Pap tests. This fear was also expressed by women participating in the study, as cancer is considered a death sentence with no cure.

Avoidance of screening to evade test results, fear of the test itself (e.g., fear of pain or the unknown), and fear of disease generally are factors that help explain the screening behavior of women in Panama. Similarly, a recent study among young Hispanic women in the U.S.-Mexico border depicts women’s perception that the Pap test is painful and this is negatively associated with ever having had a Pap test (Byrd, Peterson, Chavez & Heckert, 2004). Non-screeners in this study also perceived the Pap test as being painful, as derived from information shared by women who had been screened.

During the freelisting exercise and individual interviews women mentioned going to the doctor to prevent diseases as important. However, differences among sub-groups of women exist. Women who are regularly and irregularly screened talked about preventive care in the form of a Pap test. These were women who had received a Pap test sometime in their lives. Women who had never been screened talked about preventive care in the context of going to the doctor to get general check-ups, such as blood pressure, but did not mention getting Pap tests as preventive care. Comparable to this notion, some Hispanic groups of women feel less susceptible to cancer and attribute this as a reason for lack of screening (Austin, Ahmad, McNally, & Stewart, 2002).

In addition, how a woman perceives her own health influences screening, because a woman might believe that she has no health issues and avoids going for screening tests (Borrayo and Rae Jenkins, 2001). Some women in the study said they saw no reason for
going to the doctor if they did not feel sick or have any symptoms. If they felt healthy, women did not see a reason for participating in screening.

*Cancer, Cervical Cancer and Screening Awareness*

Information about cervical cancer, Human papillomavirus (HPV) and screening is not readily available to Panamanian women regardless of their socioeconomic level. Current literature suggests a need for culturally and linguistically relevant information delivered at the community level working with community partners and delivered by lay community outreach workers to reach Hispanic women with cervical cancer screening messages (Austin, et al., 2002; Meade & Calvo, 2001; Meade, Calvo & Cuthbertson, 2002).

Women understand the importance of sexual health; however, it is troublesome that most women have never heard of HPV, even when infected. Unlike health care providers, women do not associate HPV to cervical cancer, and in turn to sexual health. Despite the fact that women link sexual behavior to health and vaginal diseases, the association between sexual behavior and cervical cancer is not present. In comparison, women from the Dominican Republic and from Puerto Rico residing in Rhode Island, U.S., attribute cervical cancer risks to carelessness about health care and sexual behaviors (Goldman & Risica, 2004). Women in Panama do not differentiate between different types of female cancers. Increasing education about female anatomy may help Panamanian women understand cervical cancer and the association with sexual behavior. Related to this matter, Martinez, Chavez & Hubell (1997) conclude that physicians and Latina immigrants converge on their beliefs that sexual behavior is a predominant risk factor for cervical cancer or vaginal infections. Nonetheless, physicians and Latinas
diverge on the reasons of the sexual behavior risk. Physicians focus on the clinical aspect of cervical cancer etiology, while Latinas focus on cultural values of gender relations, sexuality and morality. Similar observations were made among Panamanian women in the present study.

Current HPV research in Latin America focuses on developing HPV prophylactic vaccines (Kulasingam & Myers, 2003; Sanders and Taira, 2003; Taira, Neukermans & Sanders, 2004). Consequently, all sociocultural aspects that might influence cervical cancer screening are largely ignored. Even if women are never exposed to biomedical concepts of HPV and cervical cancer by health practitioners, the importance of screening as a form of early detection should be explained. In 1988 Latour made the observation that “there is not a significant difference among social sciences and exact or natural sciences, because science does not exist without society” (page 34). If we were to follow Eisenberg and Kleinman’s (1981) observation where the biomedical model would be complemented with applications of social sciences similar to those of medicine, an enhanced understanding of disease would occur. Thus, involving social sciences in public health approaches to cervical cancer control would lead to better understanding of the disease and the disease processes. For example, women in the study relate promiscuity with sexual health problems. Current literature maintains that the number of sex partners is a risk factor for an increase in HPV infection rates (Taira, et al., 2004). Therefore, popular and folk knowledge of sexual health could enhance biomedical knowledge. By combining both models, stronger sexual health programs and cervical cancer prevention and control programs could be developed, implemented and evaluated.
A clearly delineated problem in Panama is the communication between health care providers and women in the study. Health care providers attempt to communicate with women using advanced medical terminology and expect women to come for Pap tests regularly without offering adequate culturally relevant information. Challenges in provider-patient communication for cervical cancer screening are also observed among other Latino populations in the U.S. (Hunt, et al., 2002).

Although screening programs exist, most women are not aware these programs are offered in their communities. The lack of culturally relevant information and awareness about screening programs available to women is consistent with current literature on Latina health (Chavez, et al., 1999; Frank-Stromborg, et al., 1998; Perez-Stable, et al., 1992). Although local and national health programs are offered in the U.S. and Panama for cervical cancer screening and treatment, women, in general, are not aware of services available to them at health centers, clinics or hospitals.

Cultural Beliefs and Cervical Cancer

Chavez and colleagues describe a Latina model of cervical cancer. This group of researchers in California identified several themes among Mexican immigrant women. Similar to Panamanian women, the Mexican women had limited knowledge about cervical cancer and no knowledge about human papillomavirus (HPV); believed that infections are caused by sexual activities and poor vaginal hygiene; believed that a Pap smear was only needed when symptomatic; and that women who engage in risky sexual behavior should receive a Pap test (McMullin, De Alba, Chavez & Hubbell, 2005). The authors conclude that culturally related beliefs about the etiology of cervical cancer affect screening behavior decision making among Latina immigrants. Similar themes were
identified among Panamanian women in the present study. Women in Panama from

different SES also identified certain risk factors associated with health such as cigarette

smoking, alcohol and illegal drug consumption. This observation is similar to Chavez’s et

al., (1995b) *Latina model* of beliefs about cancer risk factors that emphasizes *bad

behaviors*, including drinking alcohol and using illegal drugs. Although Latino women

from different Latin American countries and backgrounds present important distinctions

their culture is similar (Goyan Kittler & Sucher, 2001).

Additional cultural beliefs are shared among Latinas. Some women in Panama

also mentioned embarrassment as a reason for not getting a Pap test. Women feel

embarrassed about being examined and seen naked by a physician. Some of the regularly

screened women suggested that embarrassed women should go to a female doctor to

avoid embarrassment. In a qualitative study conducted by Jennings (1997) Latinas in

focus groups mentioned embarrassment, use of a cold or unclean speculum and

discomfort as the most salient beliefs regarding cervical cancer screening. Some of these

fears where also shared by Panamanian women in this study. Lantz (1994) observed

similar beliefs among Hispanic women in Texas, where women’s cultural barriers to

screening included attitudes of embarrassment and shame associated with physical

examinations and women’s strong discomfort with male clinicians. Another form of

embarrassment refers to worrying about what other people might think of them if they are

seen going to the gynecologist.

Some Panamanian women associated the need for a Pap test with having multiple

sexual partners. Since women do not want to be thought of as being *promiscuous*, they

will avoid getting a Pap test. Hunt (1998) conducted a study on the meaning of cancer in
Mexico, where results show that causal models incorporate local constructs about what constitutes a *virtuous* life, especially in terms of class- and gender-based values. In addition, Hunt’s study illustrates how biomedical culture articulates with the local moral constructs of the community. Morality and loss of confidentiality issues are factors that might affect Panamanian women’s screening behavior. Although women may understand the seriousness of cancer, perceptions about the Pap test and a moral framework may affect screening behavior (Byrd, et al., 2004; Hubbell, Chavez, Mishra & Valdez, 1996).

*Societal Influences in Panamanian Women’s Understandings of Health*

In this study, strong social influence observed among Panamanian women provides the basis for studying understandings of cervical cancer screening decisions. Women agreed that all women are at risk for developing cancer; however, women related increased risk with women with multiple sexual partners. This is a social norm that is socially constructed among women, family members, and friends.

Although all sexually active women are at risk of developing sexually transmitted infections and women agreed with this premise in theory, many women also considered women with multiple sexual partners at greatest risk of developing female problems. Some women also believed if they are in a relationship there is no need for being tested. Although women believed men transmit sexual diseases, they do not take into account their partner’s previous sexual experiences. In addition, social influence in Panama prevents most women from being tested before being married and becoming pregnant. Chavez et al. (1997) similarly identified that married Latinas are more likely than unmarried women to get a Pap test. Women understand that if being tested before marriage they would be considered *promiscuous*. Society does not approve of sexual
relations before marriage, so many women might not be tested before marriage or becoming pregnant. Chavez et al. (2001) made a similar observation among Latinas in California.

Frequent transmission of HPV infection occurs mostly among young Panamanian women, 20-40 years of age (Garrido, 1996a). In addition, the Ministry of Health (2004) recently reported that the incidence of HPV is increasing among teenagers younger than 19 years of age. Women in Panama usually get married in their twenties and mothers tend to assume their daughters are not sexually active until marriage. The younger groups of women need to be targeted with screening programs and adequate information.

Similarly, vaginal cleansing is a common folk practice which is socially constructed. As in Wood et al. (1997) study in South Africa, women in Panama associated the Pap test with cleaning the vaginal area. In Woods’ study, South African women associated the Pap test with cleansing the womb. Panamanian women in this study identified vaginal cleansing through the use of creams, suppositories and douches as an important component of female health. Women [mis]understand the purpose of a Pap test is to prevent, treat, or cure a vaginal problem, rather than a diagnostic test for detection of cervical abnormalities.

Current literature suggests that Hispanic cultures in the U.S. tend to be patriarchal and this societal system affects women’s screening. For example, Bechtel, Shepherd and Rogers (1995) describe Hispanic migrant culture in the U.S. as patriarchal, with men playing the dominant role in decision making and income allocation. The authors explain that the patriarchal system contributes to limiting access to family, health and social service needs for women and children. In this study, men’s influence on women’s
screening behavior in Panama was explored. In contrast, Latina women’s health literature, Panamanian society is a *matriarchal* one (Salles & Noejovich, 2004) and in Panama men are perceived to be positive influences on women’s screening behavior. Women were asked if their husband or boyfriends said anything to them regarding going to the doctor. Their responses were positive regarding men’s influence on their screening behavior. Some women mentioned that their significant other urged them to go to the doctor. Within a matriarchal family, mothers tend to play a dominant role. In Panama, mothers of many women in the study influenced screening behavior, especially among non-screeners.

*How Panamanian Women Construct Understandings About Health, Cervical Cancer, and Screening*

Women in Panama construct most of their screening knowledge and behavior from sociocultural and media influences. The social construction of cervical cancer screening among women in Panama comes mostly from other women. Health behavior and health care among women resulted from social construction and understanding of health mostly from conversations among women. Usually, mothers, sisters and female friends and neighbors talked amongst themselves about health, mothers being the most influential female figure. Women approach other women with questions about health problems. Other women respond with their already formed knowledge of health, health services and treatment options. Study participants reported sharing information regarding screening from their own experiences as well as understandings from other women’s experiences. Depending on the information being shared, the understanding becomes positive or negative toward screening behavior.

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Regularly screened and irregularly screened women from different SES tended to share knowledge with other women, mostly friends, coworkers and neighbors. Among regularly screened women who are married or cohabitating with a partner, the man also becomes a source of health communication and interactions. This group of women tended to accept responsibility for their own health and to have increased knowledge of women’s health. Women who had never been screened received most of their health information from their mothers. This group of women seems to have a need for further education regarding women’s health including cervical cancer screening. Non-screeners reported the most misconceptions about cervical cancer, Pap tests and women’s health issues.

In the process of social construction, Panamanian women participating in the study negotiate cultural/folk, popular and biomedical knowledge to develop their own understanding of cervical cancer screening. Chavez et al. (2001) and Mathews et al. (1994) made similar observations about knowledge construction among Latina and African-American women, respectively. Construction of cervical cancer screening knowledge is an amalgamation of knowledge from different sources. Based on literature and the current study, consistent observations in beliefs about cervical cancer knowledge and behavior across Latina women subgroups suggest generalizability of ethnographic findings on beliefs to larger populations (Chavez et al., 2001).

Social construction processes were pragmatic among women in Panama. Social construction processes emerge from women’s interactions. When women look to other women to gather health information and receive answers that help them form new knowledge, the process of construction occurs. This information can positively or negatively affect cervical cancer screening. The acceptance of this new knowledge
promotes the diffusion of the information among other women. Sexual aspects of health are sensitive issues among Panamanian women and this might deter some women from being screened. Hanson (2001) studied the social construction of femaleness in writing about cancer. He suggests a holistic approach to female cancer rather than just focusing on a specific anatomical part affected by cancer. Women in the study also viewed female cancers in general rather than understanding different types of female cancers, including cervical cancer.

Sociocultural aspects of cervical cancer and sexually transmitted infections have received little attention in Panama. Most of the studies in Panama focus on clinical and epidemiological aspects of the disease. We must not negate the importance of clinical and epidemiological research in presenting and analyzing public health issues (Krieger & Zierler, 1996). However, researchers’ focus on biomedicine neglects women’s health needs, because women focus on their social lives. The epistemology of science focuses on rationalism and empiricism which tend to negate the sociocultural aspects that influence the incidence of cervical cancer in Panama (Testa, 1997).

To understand and explain epidemiological and clinical problems in public health, an interdisciplinary approach that includes sociocultural analysis must be present. By focusing solely on clinical and epidemiological studies, researchers emphasize the objective nature of reality and ignore the importance of human sense-making (Slife & Williams, 1995), such as through social construction. Equally important is the analysis of sociocultural aspects that influence models of behavior and population health (McMichael, 1995), not just focus on biomedical aspects.
Influence of Media on Panamanian Women

Local and international media also play a strong influence on the formation of popular knowledge. Women obtain health information from the television, radio, newspapers and magazines. Women discuss health information among themselves and accept or reject this new knowledge. Acceptance or rejection of the new knowledge influences screening practices.

Recent studies suggest that working with local media (television, newspapers, radio) is also an effective manner to recruit Latina women into participating in cervical cancer screening programs (Brewster, Anton-Culver, Ziogas, Largent, Howe, Hubbell & Manetta, 2002). Similarly, Panamanian women in the study received health information from local media. However, knowledge reported by women in the study reflects limited and sometimes inaccurate information regarding cervical cancer screening. For example, most women in the study were not aware of the annual Pap test screening guidelines. Other studies discuss Latina women’s difficulty learning and following screening guidelines even after abnormal test results (Hunt, De Voogd, Soucy & Longworth, 2002). This behavior of not returning for further testing after abnormal test results was also reported by women in this study.

Popular knowledge about health topics is shaped by local and international media available to women. However, there is little cervical cancer and HPV information available to Panamanian women. During 2004 only one cervical cancer public service announcement aired on local television. Local media and health education campaigns do not provide updated and current information on cervical cancer, HPV, Pap tests and/or reproductive health topics. Although cervical cancer continues to be the number one
cause of cancer death among women in Panama, and HPV affects a majority of the population (Barés, 2001), public health campaigns do not address these important topics. Instead, we observe campaigns on Hantavirus, SARS and other diseases that do not impact the Panamanian population as much as cervical cancer and HPV. Even a recent AIDS television campaign sponsored by an AIDS Foundation (PROBIDSIDA) and supported by the government, focused on testing for HIV/AIDS, but failed to mention prevention. An emphasis on prevention should be sought in the provision of information about sexually transmitted infections.

Women responded to health information, particularly information related to cervical cancer, positively and welcomed new information. In the group discussions, women openly discussed cervical cancer screening information gathered from the media and from personal experiences. Women in Panama obtained health information from local and international media. The phenomenon of globalization has greatly influenced the availability of information to women, and the North American influence in Latin America has grown considerably in recent years.

Women in group discussions reacted to local newspaper articles on cervical cancer screening information. Women welcomed the new information and mentioned the need for women’s health information to be disseminated in Panama. Women were not shy or embarrassed to talk about reproductive health topics even if they were not previously acquainted with one another. This group exercise allowed for the live construction of the meaning of cervical cancer screening among women in Panama. The women participating in the group sessions were eager to receive new knowledge that is culturally relevant. Group sessions at the community level in health centers, women’s
homes or other community groups are viable formats to deliver health information. Group interactions among women depicted the construction of meaning of health knowledge at the popular level.

In recent years, due to globalization, the influence of media in Panama created a more open model of sexuality among younger generations. Girls are becoming sexually active at younger ages. In Panama, the average age of sexual activity initiation is 14.5 years of age (Guerrero, personal communication, 2004). Younger women’s understanding of sexuality might differ from that of older women. Therefore, older women who influence screening might be providing messages based on their previous experiences and understanding, which may not be applicable to the reality of younger generations today.

*Construction of Cervical Cancer Screening Among Panamanian Women*

Women who participated in this study in Panama City constructed an understanding of cervical cancer screening as a form of prevention of sexually transmitted diseases or infections. Women did not understand cervical cancer screening as a form of detection of cervical cancer. Rather, women understood the Pap test as a form of prevention of disease. Women in the study, who were aware of the Pap test, believed it was a form of vaginal cleansing and prevention of vaginal diseases. Similar observations were made by Wood et al. (1997) in South Africa.

Screening guidelines were not reported by women. The periodicity of the test was understood in another context. According to the women, the cleansing effect of the Pap test lasted a certain period (e.g., six months). After the period elapsed it was necessary for
women to have a Pap test again to once again cleanse their vagina. Prevention through the Pap test was widely understood among women in the study.

Panamanian Women’s Health Education Preferences

Women are open to learning about health individually and in group settings. Participatory activities at the community level involving groups of women would be most engaging and result in new knowledge acceptance. Culturally relevant information delivered by other women would also prove beneficial. Women should be taught from a young age about sexuality and health, and about the importance of getting a regular Pap test. Information on low-cost and accessible health services available to women should be widely promoted.

Women in the study mentioned the need for community-based services and delivery of information. Health educators could benefit from the interest women and men share for reproductive health information and working in group processes. Action-based community activities and participatory research that involves community members would provide useful and directed campaigns (De Salazar, 2005). Panamanian communities present an ideal environment to generate participatory and social processes such as prevention research, social marketing, community development, diffusion of innovations, organizational change, media advocacy, and empowerment. In September 2004, the new Minister of Health established community groups for health, where community members are asked to participate in group discussions about the health problems in their communities. This forum provides an ideal setting to develop health education and promotion interventions based on participatory research tenets.
Messages for screening could include cancer prevention, early detection, association with sexual health, family involvement, address pain and discomfort concerns and time factors. Women expressed a preference for group interventions to promote health messages. This is consistent with preferences reported for other Hispanic populations (Meade, Calvo, & Cuthbertson, 2002; Meade, Calvo, Rivera, & Baer, 2003).

During visits to private clinics, I observed that Pap test brochures were available and were primarily developed by pharmaceutical companies intended to reach Caucasian audiences. Images depicting Panamanian women would increase local identification with the messages. Cancer control education materials could be improved by addressing culturally based beliefs that differ from those of the Anglo population, for whom materials are commonly prepared (Chavez, Hubbell & Mishra, 1999).

Strengths and Weaknesses of the Study

Strengths

A strength of the study was the use of multiple methods of qualitative data collection to understand the construction of cervical cancer screening meaning among Panamanian women. Local public health researchers and myself identified the need for qualitative research development in Panama since most research is conducted in the form of surveys (Dr. Manuel Escala and Aida Libia Rivera, personal communications). The use of social constructionism to study Panamanian women’s understanding of cervical cancer, screening and HPV is innovative in current literature. Integrating a social constructionist approach with qualitative methods of data collection provides a robust study design which can be used to develop policy and public health interventions.
Findings offer useful information to develop public health solutions to a serious public health problem in Panama.

The use of in-depth semi-structured individual and group interviews enabled me to describe the women’s worldview regarding cervical cancer screening, family and health information. Group interviews provided an opportunity to observe social dynamics in interpretation and reaction to local media information on cervical cancer. The observation of *live construction* behaviors is an innovative form of conducting research on cervical cancer screening, especially in Panama and other countries in Latin America. Freelisting and pile sorting provided information without imposing a set of beliefs on the interviewees (Chavez et al., 2001). The women provided information the researcher would not have thought of asking before the women offered this new information. The use of qualitative methodology provided for rich contextual data necessary to understand the cultural and social impact of interactions among women’s social networks to develop popular and folk knowledge about cervical cancer.

Selection bias was minimal in this study because almost all women approached participated in this study. This offers new insight into Panamanian women’s desire to be heard and to share their thoughts and ideas to others. Certainly some of the findings are specific to women in Panama City, Panama. Nonetheless, some of the women’s understandings are culturally specific to Latino culture and consistent with the literature. This offers the opportunity to transfer the knowledge to other Latinas.

Weaknesses

The study is based on self-reported data, with the assumption that women interviewed were truthful in their responses. Although this is a potential weakness, social
construction assumes subjectivity as a part of understanding our reality. Also, building rapport between researcher and interviewee increased trust and in turn high quality data was obtained (McDermott & Sarvela, 1999).

Although some of the findings might be transferable to Latina women in similar situations, the results of the study are not generalizable to a larger population. Social constructionism viewed from a strict standpoint does not assess truth. However, this study follows a moderate form of constructionism where biological realities are taken into consideration. During the process of data collection daily discussions of observations occurred. This helped shape interviews as data collection progressed. Nonetheless, adequate iterations of continual data analysis did not occur between interviews.

Recommendations for Health Care Practitioners

Based on the women’s observations of health care practitioners and the health care system in Panama, several structural and behavioral recommendations can be offered. First, regarding structural factors, it is recommended that appointment times be set within shorter waiting times (e.g., change to a week for appointment period, rather than the usual two months). Second, use interactions with women as an opportunity to communicate the importance of the Pap test and to explain the nature of the test. This includes explaining the purpose of a Pap test (e.g., for early detection), the procedures involved, and the possibility of experiencing some discomfort but not extreme pain. In addition, women yearn for a kinder, more humane treatment during interactions with health care practitioners.
Recommendations for Public Health Education Interventions

The National Institutes of Health (NIH) presented in their 2004-2009 Strategic Plan as their first goal, a need for translation and dissemination of research. Within this strategic plan, the NIH recommends that we examine factors that influence, and [develop] methods to increase, the dissemination and implementation of preventive interventions in community and public health settings. Working with community members and practitioners at the community level is an important facet of this endeavor.

This study documented the need to develop culturally and linguistically relevant and tailored health education programs and interventions for cervical cancer, HPV and cervical cancer screening in Panama. Cancer communications for ethnic minority women can be enhanced by tailoring sociocultural constructs (Kreuter, Skinner, Steger-May, Holt, Bucholtz, Clark, Haire-Joshu, 2004). Health educators in Panama should consider developing relevant cancer messages for women based both on epidemiological data and the sociocultural needs of the population. Group discussions led by peers at health and community centers would be an appropriate and cost-effective channel for health education interventions.

As described by women in the study, successful health education interventions for cervical cancer screening among Panamanian women should incorporate the following principles:

- Place: Community-based intervention at health centers, community centers, and schools;

- Focus: Specific priority populations, e.g., women in rural areas, young, unmarried, older women.
• Format: Group talks/group sessions and through popular media, such as television, radio and newspapers;

• Spokespersons:
  o A female physician showing care and understanding.
  o An older woman (mother) showing care and compassion while speaking to her daughter about her health issues.

• Tone: Upbeat and positive.

• Key Messages:
  o What is the Pap test? Women need to know what the Pap test is. Women did not have sufficient information on the test itself, how it is performed, what it entails and the purpose of the test. Women need to understand that the test is for early detection of cervical cancer and not for prevention of vaginal diseases or cervical cancer. Women also need to be assured that the Pap test is not extremely painful;
  o Link between HPV and cervical cancer. Further information on female anatomy and biomedical information on HPV and how this sexually transmitted infection leads to cervical cancer.

**Using Social Construction in Health Education**

Social construction is a theory that is seldom used in practical applications, especially in the development of health education intervention. Nonetheless, health educators can benefit from the practical applications of social constructionism. Studying constructionists processes among populations that have strong societal influences may
assist health educators in developing acceptable and relevant health education interventions.

Health education programs and interventions based on a theoretical framework prove to be most effective. Social construction may assist health educators in identifying media influences on intended population as well as social networks. These identified social influences can then be incorporated into health education interventions. The information presented to the audience will be more relevant and perhaps more acceptability of the information will occur.

Recommendations for Future Research

Research opportunities on women’s health issues abound in Panama. Sociocultural, structural and policy issues need greater attention. This study represents the foundation for future quantitative and qualitative studies in Panama not only cervical cancer studies but also reproductive health in general. The richness of the qualitative data collected in this study allows us to observe a complex web of beliefs, knowledge and other sociocultural and structural concepts that affect women in Panama. Future studies can build on the existing information provided in this study by focusing on specific relationships (e.g., mother-daughter) that enable the social construction of women’s health knowledge in Panama.

Opportunities for future research regarding cervical cancer, HPV and screening behavior in Panama include:

1. Quantitative explorations of knowledge and beliefs on cervical cancer, HPV and screening behavior. Studying how cognitive factors relate to cancer screening in well-defined minority groups can inform interventions suited to the knowledge
and belief deficits that characterize populations of diverse women (Consedine, Magai, Spiller, Neugut, & Conway, 2004). A lack of knowledge and presence of misunderstandings could greatly impede the prospects for effective HPV screening (Pitts & Clarke, 2002).

2. Epidemiologic analysis of cervical cancer and HPV patterns in the country should be conducted using a mapping technique. This analysis would enable researchers to determine the population subgroups and communities that should be the focus of future research and interventions.

3. Men’s influence on women’s health practices should be further explored.

4. Risk perception of women and sexually transmitted infections. Although women in the study said that all women are at risk of developing cervical cancer, the perception was that the risk is somehow distant. Since many women only go to the doctor when feeling ill, the concept of prevention is not well developed. Discounting future consequences and evaluating one’s present state to indicate future vulnerability may become important in making decisions about taking risks, especially when situational indicators of risk are not obvious (Hunt, Tinoco Ojanguren, Schwart & Halperin, 1999).

5. Further explore the behavioral experiences of women during interactions with health care professionals at social security clinics as compared to health centers. Also, there is a need to further study provider-patient communications.

6. Study Panamanian women’s relationship between vaginal cleansing and perceived risk of vaginal diseases.
Platform for Future Research

This study serves as a foundation for future studies and assists future researchers in philosophical and methodological aspects (Byrne, 2001e) and political complexities (Bettcher & Wipfli, 2001) of conducting qualitative research among women in Latin American countries, specifically in Panama. The qualitative information gathered in this study assists with global aims of research during this era of globalization in public health and other fields. Unfortunately, the World Health Organization’s goals identified in the *Health for All by the Year 2000* report are yet to be fulfilled, such as addressing health disparities among women who are more likely to suffer early death from all causes worldwide (Feachem, 2001; Grange, 2001).

Public health scientists are still at an early stage of gathering research information and must be equipped with the knowledge and skills to engage with partners across sectors and across borders to achieve health and other social goals (Drager & Beaglehole, 2001). The expectation is that this type of transnational research will assist in alleviating the increasing unequal access to health care by different social groups (Sitthi-Amorn et al., 2001; Thankappan, 2001), addressing global social and cultural factors that are affected by globalization (Owen, 2001), and dealing with high concentrations of diseases, such as cervical cancer, in developing countries (Dollar, 2001). Development of effective and relevant health education interventions can best be achieved by hearing the voices of those who are mostly in need (Grange, 2001). In Panama this can now be done more easily by applying the information gathered in this study. This study helps us understand the social and cultural facets of constructing health seeking behaviors and advances
knowledge that can help us address national and international inequalities of health, namely cervical cancer.
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Appendix A: World Facts and Panama Map
### Panama

<table>
<thead>
<tr>
<th>People</th>
<th>3,000,463 (July 2004 est.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age structure:</strong></td>
<td></td>
</tr>
<tr>
<td>0-14 years:</td>
<td>30.2% (male 461,427; female 443,932)</td>
</tr>
<tr>
<td>15-64 years:</td>
<td>63.6% (male 967,490; female 940,344)</td>
</tr>
<tr>
<td>65 years and over:</td>
<td>6.2% (male 88,611; female 98,659) (2004 est.)</td>
</tr>
<tr>
<td><strong>Median age:</strong></td>
<td></td>
</tr>
<tr>
<td>total:</td>
<td>25.9 years</td>
</tr>
<tr>
<td>male:</td>
<td>25.6 years</td>
</tr>
<tr>
<td>female:</td>
<td>26.2 years (2004 est.)</td>
</tr>
<tr>
<td><strong>Population growth rate:</strong></td>
<td>1.31% (2004 est.)</td>
</tr>
<tr>
<td><strong>Birth rate:</strong></td>
<td>20.36 births/1,000 population (2004 est.)</td>
</tr>
<tr>
<td><strong>Death rate:</strong></td>
<td>6.39 deaths/1,000 population (2004 est.)</td>
</tr>
<tr>
<td><strong>Net migration rate:</strong></td>
<td>-0.91 migrant(s)/1,000 population (2004 est.)</td>
</tr>
<tr>
<td><strong>Sex ratio:</strong></td>
<td></td>
</tr>
<tr>
<td>at birth:</td>
<td>1.05 male(s)/female</td>
</tr>
<tr>
<td>under 15 years:</td>
<td>1.04 male(s)/female</td>
</tr>
<tr>
<td>15-64 years:</td>
<td>1.03 male(s)/female</td>
</tr>
<tr>
<td>65 years and over:</td>
<td>0.9 male(s)/female</td>
</tr>
<tr>
<td>total population:</td>
<td>1.02 male(s)/female</td>
</tr>
<tr>
<td><strong>Infant mortality rate:</strong></td>
<td>20.95 deaths/1,000 live births</td>
</tr>
<tr>
<td>male:</td>
<td>23.08 deaths/1,000 live births</td>
</tr>
<tr>
<td>female:</td>
<td>18.72 deaths/1,000 live births (2004 est.)</td>
</tr>
<tr>
<td><strong>Life expectancy at birth:</strong></td>
<td>total population: 72.14 years</td>
</tr>
<tr>
<td>male:</td>
<td>69.82 years</td>
</tr>
<tr>
<td>female:</td>
<td>74.56 years (2004 est.)</td>
</tr>
<tr>
<td><strong>Total fertility rate:</strong></td>
<td>2.49 children born/woman (2004 est.)</td>
</tr>
<tr>
<td><strong>HIV/AIDS - adult prevalence rate:</strong></td>
<td>0.9% (2003 est.)</td>
</tr>
<tr>
<td>HIV/AIDS - people living with HIV/AIDS:</td>
<td>16,000 (2003 est.)</td>
</tr>
<tr>
<td>HIV/AIDS - deaths:</td>
<td>less than 500 (2003 est.)</td>
</tr>
<tr>
<td><strong>Nationality:</strong></td>
<td>noun: Panamanian(s)</td>
</tr>
<tr>
<td></td>
<td>adjective: Panamanian</td>
</tr>
<tr>
<td><strong>Ethnic groups:</strong></td>
<td>mestizo (mixed Amerindian and white) 70%, Amerindian and mixed</td>
</tr>
</tbody>
</table>
(West Indian) 14%, white 10%, Amerindian 6%

Religions: Roman Catholic 85%, Protestant 15%

Languages: Spanish (official), English 14%

note: many Panamanians bilingual

Literacy: definition: age 15 and over can read and write

total population: 92.6%

male: 93.2%

female: 91.9% (2003 est.)

Figure 1. Map of Panama
Appendix B: IRB Letter of Approval
July 15, 2002
Arlene Calvo
College of Public Health MDC 56
Dear Ms. Calvo:

Your continuing review for the protocol (IRB #99.774) entitled, "Social Construction of Cervical Cancer and Reproductive Health Among Women in Panama" English and Spanish Adult Informed Consents with Waiver of Written Documentation was approved under Expedited review categories numbers six and seven (6,7). Therefore, your approval period is from the date of this letter through the date stamped below. Approval is for up to a twelve-month period, after date of initial review. A Research Progress Report to request renewed approval must be submitted to this office by the submission deadline in the eleventh month of this approval period. A final report must be submitted if the study was never initiated, or you or the sponsor closed the study.

Waiver of Written Documentation has been approved having met the following four criteria: the research will not involve greater than "minimal risk" to the subject; it is not practicable to conduct research without a waiver; waiving will not adversely affect subject's rights; and if appropriate, information will be provided to subject later.

Any changes in the above referenced study may not be initiated without IRB approval except in the event of a life-threatening situation where there has not been sufficient time to obtain IRB approval. All changes in the protocol must be reported to the IRB. If there are any adverse events, the Chairperson of the IRB must be notified immediately in writing.

This action will be reported at the next convened IRB-02 meeting on August 16, 2002. If you have any questions regarding this matter please do not hesitate to call my office at (813) 974-5638.

Sincerely,

Louis Penner, Chairperson

USF Institutional Review Board-02

APPROVED THRU

JUN 2003

USFW--IstitTUTIONAL REVIEw BOARD FWA00001669

cc: Dr. Kelli McCormack Brown

Submit your Research Progress Report by the submission deadline one month prior to the date above. Failure to meet this deadline will result in closure of the study.
Appendix C: Interview Inclusion-Exclusion Criteria Tool
INTERVIEW INCLUSION-EXCLUSION CRITERIA TOOL

Address criteria below to determine inclusion or exclusion of women into study.

1. ¿Se considera usted Mestiza?/ Do you consider yourself from Mestizo background?
   □ Yes      □ No

2. ¿Está usted entre los 20 y 40 años de edad? /Are you between the ages of 20-40 years?
   □ Yes      □ No

3. ¿Ha vivido en la ciudad de Panamá, la capital, toda su vida?/ Have you lived in Panama City all your life?
   □ Yes      □ No

4. ¿Alguna vez se ha hecho el Papanicolaou?
   □ Yes      □ No

If answered yes to all above, then the woman can be included in study as screened woman.

If answered yes to all above and no to question #4, then woman can be included in the study as an unscreened woman.
Appendix D: Demographics Information Instrument
DEMOGRAPHIC INFORMATION INSTRUMENT

Acerca de Usted/ About you:

Queremos saber mas de usted. Por favor conteste estas preguntas. Recuerde que toda información es completamente confidencial y su nombre no es necesario. / We would like to learn more about you. Please answer these questions. Remember that all information is completely confidential and your name is not needed.

Edad/age:

- □ 20-25
- □ 26-30
- □ 31-35
- □ 36-40
- □ Otro/other: ________

Estado civil / marital status:

Nivel educativo / education:

¿Habla inglés? / Do you speak English?

Se ha hecho usted un papanicolaou antes? / Have you ever had a Pap test done?

Si contestó que sí, ¿Cuándo fue la ultima vez que se lo hizo? / if you answered yes, when was the last time you had it done?

¿Cada cuanto tiempo se hace usted el Papnicolaou? / How often do you get your Pap test done?

Notas del encuestador / Interviewer notes:
Appendix E: Sample of Local Newspaper Article
Por sus hijos, ¡hágase el PAP!

Rosalina Orocú Mojica (rorocu@epasa.com)
El Panamá América

Unir a la comunidad en un haz de voluntades en la lucha contra el cáncer cérvico-uterino en Panamá, se ha propuesto la Asociación Nacional Contra el Cáncer, ANCEC y hace un llamado de ayuda a las mujeres prominentes del país, para que presten su rostro y capacidad de persuasión para que pidan a las mujeres que se hagan su examen anual de cáncer y eviten sufrimiento y muertes que se pueden prevenir.

Puesto que el cáncer cérvico-uterino es la principal causal de muerte en mujeres en Panamá, hay que cambiar la actitud de temor por una de responsabilidad y de interés por cuidar de su salud y su vida, planteó el Presidente de ANCEC, Dr. Juan A. Monterrey P., quien les pide a mujeres lideresas en todos los campos y sectores del país, quienes tienen influencia en otras, que sin afectar la actividad a la que se dediquen o a su organización, paralelamente formen parte de esta cruzada a favor de la vida.

"No queremos interferir con, ni opacar su actividad. Queremos que comprendan que nada tiene sentido si la gente no está sana, que sin mujeres saludables la familia está en peligro. Panamá necesita a todas sus mujeres", puntualizó el Dr. Monterrey, quien expresó su preocupación ante el incremento en la morbi-mortalidad producto del cáncer cérvico-uterino en el país.

Panamá, planteó el galeno, tiene uno de los índices más altos de cáncer cérvico-uterino del área y en más de la mitad de los alrededor de 600 casos que se detectan las pacientes tienen cáncer ya avanzado con muy pocas posibilidades de curarlo. Y, esa detección tardía, producto del temor a un diagnóstico positivo está llevando a la tumba a mujeres en edad productiva y dejando huérfanos/as a niños/as en el país.

Llamó la atención sobre el hecho de que no hay conciencia entre la mujer panameña respecto a la importancia de estar saludable, tanto por sí misma como ser humano como por sus hijos. Resulta paradójico que ella vela por la salud de la familia y descuida la suya.

"Las mujeres van al médico sólo hasta que paren los hijos", manifestó y dijo que habría que considerar en nuestro país la necesidad de implementar medidas más efectivas que hagan que las mujeres estén al tanto de hacerse sus exámenes anuales preventivos de enfermedades que deterioran su salud y ponen en peligro su vida, como lo es el cáncer.

Explicó que recientemente fue a Cuba y observó que abundaban las vallas de carretera con mensajes sobre salud preventiva y educación. Asimismo, dijo que las mujeres no pueden matricular a sus hijos ni en primaria ni secundaria si no llevan el último PAP que
ellas se han hecho. "El concepto es: usted tiene que estar bien para poder serle útil y ayudar en el crecimiento y desarrollo a sus hijos".

Expresó que ANCEC trabaja en la elaboración de un Plan Quinquenal y analiza estrategias y alianzas con otros sectores del país para ganarle terreno a la parca que está matando a las mujeres panameñas vía el cáncer cérvico-uterino.
Appendix F: Interview Guide
GUIA DEL SONDEO PARA ENTREVISTAS
SEMI-STRUCTURED INTERVIEW GUIDE

Siga las siguientes preguntas para guiar las entrevistas con las mujeres. Vaya de lo general a lo relacionado con salud y más adelante a lo relacionado con el cancer cervico-uterino./ Use the following questions to help guide in-depth interviews with women. Go from general topics to health related, and then cancer related topics.

Ice-breaker:
1. ¿Qué hizo/va a hacer para las Navidades?
   What did you do/will do for the holidays?
   [or talk about clothes, the weather, children][Start a conversation]

General:
2. ¿Cuáles son las cosas más importantes para usted en su vida?
   What are the most important things for you in your life?

Family:
[Hablemos de su familia/ Let’s talk about your family].
3. ¿Qué anhela para su familia?
   What are your wishes/desires for your family?
   [PROBE: ¿Cómo qué?/ Like what?
   Por ejemplo: la educación, trabajo, etc./ For example: education, work, etc.]

Religion:
4. ¿Qué papel juega la religion o la fe en su vida?
   What role does religion or faith play in your life?
   [PROBE: ¿En qué sentido? / In what sense?]

Health:
5. ¿Qué se debe hacer para llevar una vida saludable?
   What should people do to live healthy lives?
   5-a. ¿Cuáles sigue usted?
      Which do you follow?
      [PROBE: ¿Qué más hace usted para mantenerse saludable?
      What else do you do to stay healthy?]

6. ¿En qué piensa usted cuando piensa en enfermedades?
   What do you think of when you think of disease?
7. ¿Cuándo piensa en enfermedades, cómo se siente?
   When you think of disease, how do you feel?

8. ¿Usted le teme a alguna enfermedad?
   Are you afraid or fear any disease?

   8.a. ¿Qué es miedo o temor [o palabra usada por las mujeres]?
       What is fear or afraid [or word used by women]?

9. ¿Cuándo usted tiene una pregunta de salud con quién habla? (Soc. Const.)
   When you have a question about health, who do you talk to?

   [PROBE: ¿De qué hablan? / What do you talk about?]

10. ¿Cuándo usted tiene un problema de salud qué hace?
    When you have a health problem, what do you do?

    [PROBE: ¿A dónde va usted para tratamiento? / Where do you go for treatment?]

   10.a. ¿Usted va a la farmacia para tratamiento o cura de sus problemas de salud?
       ¿Cuándo se siente mal?
       Do you go to the pharmacy for treatment or cure of your health problems?
       When you don’t feel good?

**Health Care Experiences**

11. ¿Cómo han sido sus experiencias previas con el sistema de salud en Panamá?
    How have your previous experiences with the Panamanian health care system been?

    [PROBE: Con los médicos? Con las enfermeras? Las esperas?
     With the physicians? With the nurses? With waiting?]

**Preventive Care and Screening:**

12. ¿Cómo las mujeres pueden prevenir algun problema feminino, allá abajo?
    How do women prevent any female problems?

13. ¿Cómo las mujeres se mantienen saludables? Y, allá abajo?
    How do women stay healthy? And, down there?

14. ¿Alguna vez algun médico le ha dicho que se tiene que examinar?
    ¿Qué le dijo?
    Has a physician ever told you to go get tested?
    What did he/she say?
Media:
15. ¿De dónde recibe información? Where do you get your information? 
¿Dónde aprende usted sobre temas de salud? 
Where do you learn about health? 

[PROBE: ¿Dónde lee, escucha, o ve sobre la salud? 
Where do you see, listen or read about health?]

16. ¿Usted sigue los consejos de salud que lee en el periódico, escucha en la radio o ve en la televisión? 
Do you follow the health advices you read in the newspaper, listen on the radio, or watch on television?

Cancer:
17. ¿Cuándo escucha la palabra cancer, qué es lo primero que le viene a la mente? 
When you hear the word cancer, what is the first thing that comes to your mind?

Cervical Cancer:
18. ¿Ha escuchado alguna vez sobre el cáncer cervical o cervico-uterino? ¿Qué ha escuchado? 
Have you ever heard about cervical cancer? What have you heard?

19. ¿Ha escuchado alguna vez sobre el virus del papilloma humano y las verrugas genitales? ¿Qué ha escuchado? 
Have you ever heard about the human papilloma virus and genital warts? What have you heard?

[Explain what is the cervix, where is it found in the body, about cervical cancer, and human papilloma virus/genital warts. Use pictures and drawings if necessary.]

20. ¿Alguna vez se ha hecho el Papanicolaou? 
Have you ever had the Pap test done?

21. ¿Qué tipo de mujer necesita un chequeo? 
What type of woman needs a check-up?

22. ¿Qué tipo de mujer está a riesgo de contraer cáncer de la mujer? 
What type of woman is at-risk for female cancer?
SCREENED WOMEN ONLY [DETERMINE MARITAL STATUS]

Cervical Cancer Screening:
23. ¿Cuándo fue la última vez que se hizo el Papanicolaou? When was the last time you had a Pap test done?

24. ¿Cada cuánto tiempo se hace el Papanicolaou? How often do you have the Pap test done?

25. ¿Cómo aprendió sobre hacerse el Papanicolaou? ¿Alguién se lo dijo? ¿Quién? How did you learn about getting the Pap test done? Did someone tell you about it? Who?

26. ¿Usted habla con otras mujeres sobre la importancia de hacerse el Papanicolaou? ¿Qué les dice? Do you talk to other women about the importance of having the Pap test done? What do you tell them?

27. ¿Porqué cree usted que algunas mujeres no se hacen el Papanicolaou? Why do you think some women don’t get the Pap test done?

28. ¿A su esposo/novio le molesta que se haga el examen? ¿Qué le dice? Does your husband/boyfriend mind that you have the Pap test done? What does he say?

EXIT INTERVIEW FOR SCREENED WOMEN

29. ¿Cuáles fueron sus experiencias durante su exámen? What were your experiences when tested?

29.a. Imaginese que le tiene que contar a una mujer que nunca se ha examinado, sobre sus experiencias con el examen. ¿Qué le diría? Imagine you had to tell a woman who has never been screened (never has had a Pap test done) about your experiences with the Pap test. What would you tell her?

29.b. ¿Qué les diría sobre los médicos? What would you tell them about the doctors?

30. ¿Qué le diría usted a otras mujeres sobre su experiencia con el Papanicoalou? Especialmente mujeres que nunca se han examinado. What would you tell other women about your experience with screening? Especially, women who have never been screened.

30.a. ¿Qué les recomendaría usted sobre ir a examinarse? What would you recommend women about being tested?
UNSCREENED WOMEN ONLY

Cervical Cancer Screening:

31. Have you ever considered getting a Pap test? What were the reasons you decided against it?

[PROBE: el examen de allá abajo / the test down there.
¿Qué se siente? What do you feel?
Por ejemplo: miedo, dolor, pena, etc.
For example: fear/scared, pain, embarrassed, etc.]

32. Has anyone (friend/relative) ever talked to you about the Pap test? Who? What did she/he say?

33. Does your husband/boyfriend mind that you have the Pap test done? What does he say?

FOR BOTH SCREENED & UNSCREENED WOMEN

¿Tiene usted una sugerencia de cómo podemos hacer llegar información sobre salud a otras mujeres? Y del Papanicolaou? / Do you have any suggestions of how can we get information about health to other women? And about the Pap test?

FINAL DEL SONDEO \ END OF INTERVIEW

Si las mujeres están interesadas en obtener información sobre cancer cervico-uterino, responda las preguntas que ellas tengas. Explíquelles sobre cuándo deben examinarse (una vez al año, cada año, a partir de los 18 años, y antes si tienen relaciones sexuales). Déles panfletos y su regalo por participar. Déle las gracias por su tiempo y por participar en el estudio.

If women are interested in cervical cancer information, discuss questions women might have about cervical cancer. Explain screening guidelines to them. Give women brochures and gifts. Thank them for their time and effort helping with the study. Hand women their incentives.

¡Muchas gracias por su tiempo!
Thank you very much for your time!

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Appendix G: Certification of Professional Translation
THE SUBSCRIBED,


HEREBY CERTIFIES

That the English translation of the document titled “Chapter IV - Results”, was reviewed and conserves the adequate grammar regarding shape and contents.

Signed in Panama City, Republic of Panama, on May the sixth, two-thousand five.

Dr. Humberto López Castillo, MD
Appendix H: Codebook for Analysis
CODE BOOK

Regularly Screened Women

Health
- Nutrition
- Exercise
- Doctor
- No alcohol
- No drugs
- No smoking
- Spiritual & mental
- Dance
- Go out
- Friends
- Education
- Financial
- Sleep
- Sexual health
- Drink water

Fear of Disease
- Fear
- Depressed (feel depressed about disease)

Diseases feared
- AIDS
- STDs
- Cancer
- Diabetes
- Heart disease

Panamanian Health Care system
- Long waits
- Treatment
- Positive experience
- Negative experience
  - Both types of experiences
- Self-medication
• Yes self-medicate
  ▪ Only with minor problems
• No self-medicate

Vaginal cleansing/vaginal health
• Douche
• Ovum/suppository
• Go to doctor
• Self-medicate

• Condom use

Information received
• From older people
• Reading
• Magazines
• Newspapers
• Television
• Husband/boyfriend/significant other
• Doctor and health practitioners
• Radio
• Learn about sexual health in school

Knowledge on cervical cancer
• No knowledge
• Some knowledge/awareness
• Cervical cancer occurs in the womb

• Knowledge of HPV
• No knowledge
• Some knowledge
  ▪ Transmitted by men
  ▪ Transmitted by women

Risk
• Risk for women who do not go the gynecologist
  ▪ Women too busy
• Women with multiple sexual partners
• All women
• Sexually active
• Pregnancy-1st Pap
• Sexual activity-1st Pap

Timing-Pap
• Every 6 months
• Once a year
• Monthly

Social influence
• Sisters
• Daughters
• Mothers
  ▪ First to mother then doctor
• Friends
• Family (general family members)
• Neighbors
• Co-workers
• Cousin
• Husband
• Aunt
• Elderly
• Doctor
• Media
• Male influence
  ▪ Positive
  ▪ Negative
  ▪ None

Reasons for not screening
• Embarrassment
• Fear
• Lack of knowledge
• Don’t care
• Laziness
• Fear of pain
• Male doctor
• Fear of results

Prevention
• Pap
  ▪ Early detection
• One sex partner

Experience
• Pre-test
  ▪ Positive
  ▪ Negative
  ▪ Fear of pain before the exam
• Post-test
  ▪ Positive
  ▪ Negative

Health education
• Flyers
• Radio
• Television
• Brochures
• Campaigns
• Video
• Group talks/ group sessions
• Reach low special populations
• Spokesperson
  ▪ Physician
  ▪ Woman who has been screened
  ▪ Cancer patient/survivor
Irregularly Screened Women

Media information
- Radio
- Newspapers
- Television
- Internet

Health education
- Talks, seminars
  - Health centers
  - Schools
- Printed-magazines
- Television
- Pamphlets
- Community
  - Homes
  - Personalized
  - Supermarkets
  - Church
  - Already existing groups

Staying healthy
- Nutrition
- Exercise
- More than physical health
  - Spiritual health
  - Mental (clear the mind, release stress)
    - Communication
    - Beach
    - Movies
    - Hair salon
    - Bingo
    - Play cards
    - Dancing

Vaginal cleansing
- Family values
- No alcohol
- No tobacco
- No drugs

Social influence
- Female
- Mother
- Daughter
- Aunts
- Neighbors (female)
- Girlfriends
- Sisters
- Older women

Male
- Husbands
- Brothers

Doctor’s advice followed
- Listen to the doctor (general practitioner)
- Don’t listen

HPV knowledge
- No knowledge about HPV
- Some knowledge about HPV
- Transmitted by men

Misconceptions about Pap
- To cure
- Against cancer
- All types of STDs
- Every six months-to cure disease, because of so many STDs
  - Weekly
  - Three months

Cervical cancer
- Smells
- Stains
- Sterile-take out organs, womb/ovaries

Most feared disease
- Cancer
- AIDS

Risk
- Everyone-all women
- Multiple sexual partners

Self-medication
- Minor problems-only
- Go to doctor
Sexual health
- Not having multiple sexual partners
- Transmitted by men-infections

Reasons for not going back to Pap
- Fear
- Embarrassment
- Lack of motivation
- Do to doctor only if sick
- Fear of pain
- Normal Pap-no need to go back
- Do other things to stay healthy
  - Nutrition
  - Vaginal cleansing
- Children’s health comes first
- Women responsible for everything, too busy

Prevention
- Condom use

Cervical cancer knowledge
- Womb-anatomy

Experience with health care system
- Positive
- Negative
Never been Screened

Health
- Nutrition
- Exercise
- Reading
- Mental health
- Doctor
- Self-esteem
- No alcohol
- No smoking
- No drugs
- Drink water
- General check-ups
- Go out
  - Release stress
  - Dancing
- Lifestyle
  - Sleep well
  - Be good

Diseases feared
- Cancer
- AIDS
- STDs
- Diabetes

Social influence
- Older persons
- Curanderos
- Doctor
- Mother
- Friends
- Family-general
- Grandmother
- Sister
- Cousin
- Neighbor
- Husband

Media
- Newspapers
- Television
- Radio
• Magazines
• Reading
• Church
• Internet

Self-medication
• Yes-slight health problem
  ▪ Home
  ▪ Healers
• No

Health care System
• Positive experience
• Negative experience

Vaginal health
• Doctor-gynecologist
• Cleansing
  ▪ Douching
  ▪ Ovum
  ▪ Creams
• Underwear
• Condom

Cervical cancer
• No knowledge
• Some knowledge-awareness

HPV
• No knowledge
• Some knowledge-awareness

Risk
• All women
• Multiple sexual partners
• Sexually active

Reasons for not screening
• Cost/money
• Fear
• Embarrassment
• Fear of pain
• Man/partner
• No interest
• Lack of knowledge
• Pregnancy
• Take children to doctor only
• Only one sexual partner-no need
• Feel healthy
• No sexual partner-currently

Learn about Pap
• Pregnancy

Male influence-partner/significant other
• Positive
• Negative

Health education
• Talks/group sessions
• Television
• Radio
• Newspapers
• Flyers

• Setting
  ▪ Health centers
  ▪ Community
  ▪ Schools

• Audience
  ▪ Hard to reach areas
  ▪ Younger girls

• Spokesperson
  ▪ Doctor
  ▪ A mother

• Message
  ▪ Information about the Pap—What is the Pap?
Appendix I: Sample of Local Brochure
GUÍA LATINOAMERICANA CONTRA EL CANCER

ALGUNOS TIPOS DE CANCER Pueden Evitarse

MAS TIPOS DE CANCER Podrían Curarse si se Detectaran Antes

ALICC
ABOUT THE AUTHOR

Arlene Calvo received her Bachelors in Arts degree in Interdisciplinary Natural Sciences with concentration in Chemistry in 1994 and her Master in Public Health with concentration in Community and Family Health and emphasis in Health Education in 1998, both from the University of South Florida. She is also a Certified Health Education Specialist. Ms. Calvo research experience focuses on Latino women’s health issues in the U.S. and in Latin America regarding cancer control and sexually transmitted diseases. Most of her public health education work concentrates on social marketing, prevention research, and research-based health education and promotion interventions. She has been involved in coordinating systematic clinical trials and epidemiological studies among Latino populations in Latin America. Ms. Calvo currently resides in Panama, Central America.