



“Money talks. And the society we live in is very harsh.” Cancer Care-Seeking from the Perspectives of Guam’s Chamorros

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Key Words

Chamorro • Guam • cancer • healthcare

Abstract

Cancer mortality is rising at an astonishing rate on the island of Guam compared to the US. The indigenous people of Guam, the Chamorro, suffer from the highest rates of cancer death compared to other ethnic groups. To better understand some of the factors underlying these mortality rates, in-depth interviews were conducted with 11 self-identified Chamorros of Guam to explore their experiences seeking screening and treatment for cancer. Respondent’s care-seeking was significantly influenced by their family’s wealth and their health insurance coverage. Informants who did not seek regular cancer screening reported financial barriers along with a lack of awareness of cancer screening. Immediate family members facilitated increased access to cancer care, but extended family members sometimes caused increased stress for participants with cancer. Public awareness campaigns promoting cancer screening need to be tied to structural changes to the health care system to make cancer care financially accessible for care-seekers.

INTRODUCTION

The National Cancer Institute’s Surveillance Epidemiology and End Results (or SEER) study shows that the United States has achieved declining overall rates of cancer mortality between the years of 2000 to 2009 (Howlander et al., 2012). Unfortunately, this has not been true for Guam, a Pacific island territory of the United States where annual cancer mortality rates have risen a little over 50%, from an average of 168.17 per 100,000 deaths between 1998 and 2002 to an average of 318 deaths per 100,000 between 2003 and 2007 (Mummert et al., 2011).

The ethnic group experiencing the highest rates of cancer deaths on the island is the Indigenous people of Guam, the Chamorro. On average, Chamorro experienced 247.2 cancer deaths per 100,000 population between 1998 and 2002, compared to Guam’s white population which had the second highest average mortality rate



at 204.6 during this same period (Haddock, Talon, Whippy, 2009). The Haddock, Rebecca, and Whippy (2009) study reported the major ethnic groups on Guam at that time were the Chamorro, making up 37% of Guam's population, followed by Filipinos at 26.3%, and Whites at 6.8%. This paper explores Chamorros' experiences seeking screening and treatment for cancer in order to uncover some of the factors that are leading to these higher cancer mortality outcomes.

Early cancer screening is an essential public health strategy for lowering the mortality rates of many kinds of cancer (Mummert et al., 2011). The earlier cancer is detected, the more likely it can be stopped before it spreads and metastasizes to other parts of the body where it is extremely difficult to treat successfully. Unfortunately, many cancers that can be detected early through cancer screenings are diagnosed at later stages in Chamorro (Mummert et al., 2011). Between 2003 and 2007, 48% of breast cancer cases, 46% of colorectal cancers, and 14% of prostate cancers were diagnosed at late stages of the disease when metastasis is distant from the cancer's origin point and less treatable.

Research suggests that higher rates of these particular types of cancer death on Guam are partially linked to difficulties accessing the health care system. A 2004 needs assessment argued that facilities for cancer treatment were inadequate on the island, with no radiation treatment available and only one oncologist (Tseng, Omphroy, Naval, & Haddock, 2004). While cancer care facilities on Guam have improved since this study, with the addition of a machine for radiation treatment (Island Cancer Center, 2013), and a second oncologist (Guam Cancer Care, 2013), a persistent problem is the fact that health care and private insurance options are much more limited on Guam compared to the US mainland because the island is geographically distant from other health care alternatives (Tseng et al., 2004). Since the island is located approximately 1,300 miles south of Tokyo, 1,500 miles east of the Philippines and 3,700 miles southwest of Hawaii, traveling to alternative off-island facilities for treatment can be quite expensive (Tsark, Cancer Council of the Pacific Islands, & Braun, 2007). Another problem is the high percentage of uninsured people living on the island. According to 2010 figures available from the US Census, over one-fifth of the island population is uninsured, a figure that is largely unchanged from the 2004 study (US Census, 2010b).

There are several kinds of insurance programs available on Guam. People who served in the military or National Guard are eligible for the military's Tri-care insurance, which also covers military dependents.¹ Four private health insurance companies serve the island's residents and there are also government-funded health insurance programs for people who are retired or have low incomes and are without

1 See: (see: <http://www.tricare.mil/>).

health insurance. Individuals over 65 can access Medicare without paying a monthly premium if they've worked long enough for an employer who has paid into the system. A special Guam Government program called the Medically Indigent Program (or MIP) serves low-income residents of Guam who are not eligible for Medicare or Medicaid.² To become eligible for MIP, applicants must have lived on Guam for at least six months, be refused eligibility for Medicare and Medicaid, have income at or below the poverty line and have assets of \$2,000 or below, excluding their primary residence and one vehicle.

These government-funded programs are critical for many of Guam's residents because overall poverty rates on the island are also high. The latest numbers from the 2010 US Census indicate that approximately 35,848 residents on Guam lived under the poverty line (US Census, 2010a; US Census, 2010b) which means that 22.49% of Guam's population, many of whom are Chamorro, were living in poverty in 2010. While these broad economic indicators are important in relation to the lack of accessibility for cancer care, there is still very little known about the concrete reasons leading to disparate cancer mortality outcomes among Chamorro. The existing scholarly work concerning cancer and Chamorro on the island of Guam encompasses just three research studies.

LITERATURE REVIEW

A knowledge, attitudes, and behavior (or KAB) study of a purposive sample of 266 Chamorro over age 50 from each village of Guam measured knowledge of cancer etiology and the frequency of screening for breast cancer, cervical cancer, colon-rectal-anal cancer and prostate cancer (Balajadia, Wenzel, Huh, Sweningson, & Hubble, 2008). A majority of this sample knew the main causes of cancer. Cervical cancer screening was pursued by 84% of Chamorro women in this sample in the previous five years before data collection, while about 83% had a mammogram in the last two years. The rate of mammograms in this sample exceeded the 2010 Healthy People Objectives of 70% but the cervical screening Pap tests were below these objectives, which were set at a 97% rate of screening over the previous 3 years (US Department of Health and Human Services, 2006). But the study reported that the males in the sample had much lower rates of screening for prostate cancer, with 38.9% having ever been screened. Low screening rates were also apparent for colon-rectal-anal cancer. Only 38.3% reported ever being screened through the fecal occult blood test, 15.5% for sigmoidoscopy and 33.1% for colonoscopy over their lifetimes, rates that are well below the recommendations of the American Cancer Society (Smith, Cokkinides,

2 No respondent I talked to had Medicaid. Eligibility for this program is based on whether individuals are near the poverty line and have children who live with them and none of my respondents met these criteria.

& Brawley, 2012). Accessibility to the medical system was a key reason for these low rates of cancer screening. Associated correlates with not being screened included: not having a regular physician, being poorer, unemployment, speaking Chamorro, and having a 30 minute or greater travel time to reach health care providers.

Adelaida Rosario (2010) conducted an interview study exploring the influence of cultural norms of Mamahlao, or modesty, on the attitudes of Chamorro women towards Pap tests, a common cervical cancer screening procedure. Studying a convenience sample of 15 Chamorro women, Rosario found that widespread misinformation about Pap tests led many women in her sample to assume these tests were for sexually transmitted infections rather than cancer screening. This study suggested that education about pap smears is needed and that cultural norms against women's expression of sexuality prevents many women from seeking this test.

Finally, Lisa Linda Natividad (2007) recruited a convenience sample of 15 breast cancer survivors who were interviewed about their experiences of social support while undergoing cancer treatment. Natividad found that the strong cultural norms among Chamorro of assisting people in need allowed her sample of breast cancer survivors to draw upon financial support from family, friends and mayors in their fight against breast cancer. Family and friends also tended to help these cancer patients with daily hygienic needs and assisted in arranging housing for off-island cancer treatment, while local mayors helped to offset some expenses. Many Chamorros in this sample drew on their Catholic faith to maintain optimism as they confronted their disease.

These studies examine correlates of cancer screening in older Chamorro, cultural explanations of why Chamorro women avoid Pap tests, and how Chamorro breast cancer survivors receive social support. This research study uncovers new ground, examining experiential care-seeking narratives of Chamorro as they seek screening and treatment of cancer to identify some problems this group has in accessing cancer care. This study asks, "What are the everyday experiences of Chamorros as they seek cancer screening and cancer treatment on the island of Guam?" This topic has yet to be addressed by other scholars.

METHODS

SAMPLE

The author conducted 11 interviews with self-identified Chamorros who had direct, first-hand experience with cancer screening or treatment on the island. This sample included three groups: (a) Chamorro who accompanied their spouses or parents in seeking cancer screening or treatment, (b) Chamorro who sought cancer screening, and (c) Chamorro who were currently undergoing or previously received cancer treatment.

Understanding the experiences of these three overlapping groups of Chamorro was essential. Cancer screening is a vital public health strategy for reducing cancer deaths, making the collection of verbal accounts of care-seekers for cancer screening important. Studying the accounts of caregivers and immediate family members who accompanied cancer patients to treatment is important because family members are key supporters of this group (Natividad, 2007). Studying Chamorro cancer survivors and Chamorro undergoing treatment were critical for firsthand understanding of care-seeking during the cancer treatment process.

The sample for this study included seven women and four men. Respondents ranged in age from their early 20s to their mid 70s, though most participants were in their 50s and 60s. Two participants in the sample were actively undergoing cancer treatment at the time of their interviews—one for breast cancer and another for colon cancer. Two participants were breast cancer survivors who completed cancer treatment and were currently in remission. Two interviewees were primary care-givers for their parents who had died of cancer—one from lung cancer and another from prostate cancer. One interviewee accompanied her mother for lung cancer surgery. Another participant supported his cancer-survivor spouse through successful breast cancer treatment. Three participants described their own experiences seeking cancer screening: one sought a colonoscopy and the other two sought Pap tests. Another participant cared for her mother on the US mainland and was excluded.

MEASURES

It was not possible for the author to directly observe Chamorro as they pursued care-seeking for cancer screening and cancer treatment; thus, in-depth interviews were conducted. In-depth interviewing is a research method designed to elicit detailed accounts of respondent's experiences (Weiss, 1995). In this method, just a few main open-ended questions are asked of respondents, followed by shorter follow-up questions developed from the context of the interview itself to elicit more details. Thus, our respondents were asked one open-ended main question, followed by probes and follow-up questions to capture detailed accounts of respondent's experiences seeking cancer care on the island. Those who sought only screening were asked:

Think back to your most recent cancer screening appointment. I'd like you to walk me through everything that happened as you made the appointment, how you got to the doctor's office, and everything you can remember about what happened during the appointment.

Chamorro cancer survivors and Chamorro who were currently undergoing treatment were asked a slightly different question,

Think back to the time when you first suspected you had cancer. I'd like you to walk me through everything that happened including when your health problem was first noticed, how you made your first appointment, how you got to the doctor's office where your cancer was first screened, and diagnosed and your thoughts, feelings and experiences as you underwent treatment.

Respondents who were caregivers of family members who had cancer were asked,

Think back to the time when you first realized your (spouse or parent) had been diagnosed with cancer. I'd like you to walk me through everything that happened including when you first found out your (spouse or parent) had cancer, how you helped your (spouse or parent) get to their first appointment, and everything you thought and felt and experienced as you assisted your (spouse or parent) through the cancer treatment process.

The author asked all respondents follow-up questions, encouraging them to share detailed descriptions of what the respondent did, felt and thought as they sought cancer screening or treatment process in as much detail as possible. Most of the interviews were 60 minutes long, but ranged from 45 minutes to 120 minutes. Participants were recruited through word-of-mouth and through snowball sampling, a technique where respondents are asked if they know of anyone who fits the sample criteria and would be willing to participate in the research project. All respondents were given \$30 fuel certificates to cover some of their transportation expenses.

ANALYSIS

Interviews were recorded, transcribed, and inductively studied through a process of coding. Coding is a method to identify common patterns or themes that are contained in interview transcripts (Weiss, 1995). After transcribing each interview, the author carefully read through each transcript to become familiar with each participant's narrative. The transcripts were read through additional times and recurrent themes related to the author's research question of care-seeking were identified. Examples of the themes were excerpted from interviews. These themes were refined into further sub-categories over time as codes accumulated. When interviews were coded to the author's satisfaction, the best example of each theme was selected to illustrate an example of the theme. Other themes were summarized in text for purposes of brevity. To protect participant confidentiality, all names in this study were changed and some identifying characteristics of respondents have been withheld.

FINDINGS

LACK OF AWARENESS AS A BARRIER TO CARE-SEEKING

While some respondents were well aware of the risks of cancer and sought screening regularly, many participants were unaware of the recommendations for cancer screening. Some participants in this latter group reported that unless they were pushed by family members to seek screening or were experiencing symptoms of illness that interfered with their daily functioning, they simply did not seek medical care. An example of this is reflected in the following interview excerpt. Diana was undergoing cancer treatment at the time of her interview and was diagnosed with colorectal cancer. She was especially concerned that Chamorro become more aware of the need for early cancer screening.

I didn't feel the need to go to the doctor for a pre-screening or anything like that because my parents never went either. Because if we [my family] were fine [and without health problems], I thought we were healthy. So I'm advising my children even before they get sick to get a physical, because if I had known ahead of time, then I don't think that my cancer that I had would have gone that far if I had taken precautions for that and gotten a physical. That's one of the regrets that I have.

Diana describes that she and her family lacked awareness around the need for cancer screening, but feels that she could have been much better off if she sought screening earlier.

Sandy, who was undergoing chemotherapy when she was interviewed, said she didn't seek screening for other reasons. Because she exercised regularly, ate right and followed all of her doctor's recommendations, she thought she was healthy and didn't need screening.

There was nothing ever wrong with me. I wasn't on any medication, there wasn't any high blood pressure, I didn't have diabetes. Sixty years, you know, nothing ever happens. And here I was, I didn't even get annual physicals like I should, because what for? Nothing was ever wrong.

In this excerpt we see an example of a widespread assumption: that only people with unhealthy habits are at risk for cancer.

One of the younger respondents, Cindy, who was in her 40s, described that she avoided screening unless her husband pushed her because she felt "invulnerable," preferring that her family's insurance co-pay be used by her asthmatic son and her husband, who were more likely to have health problems.

Another respondent, Jeff, who was the key caregiver of his father who died from cancer, described that while he needed more knowledge of cancer, he also needed more knowledge concerning how insurance companies operated. As a

young man, he knew very little about cancer and there were few public educational materials available on Guam when he cared for his father in the 1990s. When he began helping his father after diagnosis, he had difficulty understanding the complicated formularies and pre-authorizations, but eventually learned the system, as described in the following excerpt.

I learned how to work the system. I walk into the doctor's clinic, with a checklist and with a drug formulary, [and would tell] "Doctor so and so, that's not in the formulary. You need another medicine. That's not in the formulary." "What's in the formulary?" "These are." "Well, that's not going to work." "Well, you give me a pre-authorization before I leave this office."

This excerpt shows the need for greater patient education concerning the complexities of insurance systems of coverage.

Barriers of awareness were also evident in three respondents who reported that before they encountered cancer personally, they thought it always led to death. Both Diana and Jane, one a cancer survivor and another who was undergoing treatment, also described relatives who thought that death was preferable to the side effects of cancer treatments.

FAMILY AND FRIENDS AS BOTH A BARRIER AND FACILITATOR OF TREATMENT

Family reciprocity and support among Chamorro is a very strong *moré*. All caregivers and cancer sufferers were comforted and supported during treatment and care-seeking by networks of immediate and extended family members. Family support included help with everyday needs, such as cooking meals and cleaning, transportation, patient advocacy, and financial and emotional support. In the following excerpt, we can see how important family reciprocity is between parents and their children. At this point in the interview, Cindy describes a conversation she had with her mother when cancer treatment began.

I: I see, so [your mother] was worried that she was being a burden to all of you...

R: Yeah, and we told...[my mother], "You're not [a burden]." We were your burden when we were growing up, so now it's our turn to take care of you. Cause that's the mentality back then [when I was young] and I try to instill that in my kids. We as parents raise you [children] and we expect, when we get older for you to be there for us. That's why you don't see a lot of elders in senior housing or whatever you call it, cause most of those [elderly people] stay at home. Because the family structure is always there.

But it would be a mistake to think that family was "always" there for everyone in this sample. One participant described hearing the news about her cancer diagnosis as particularly stressful because her family and friends were absent at that time.

R: When they told me I had breast cancer I was all alone. And I had nobody to support me. And I cried myself out in that clinic. Nobody was around.

I: Wow, you were all alone.

R: Nothing, nothing, not even him (gestures towards husband), I was all alone.

Family and friends could also be a source of stress during the recovery process. Jane, a cancer survivor who sought treatment off-island in Hawaii, said that while she missed some aspects of having extended family nearby, she was also grateful she could avoid the large numbers of extended family members that customarily visit Chamorro in hospital. She thought these visits might have interfered with the rest she needed after treatment. Another participant, who was undergoing treatment when we spoke, complained of insensitive comments from friends, acquaintances and her sister. The excerpt below illustrates this theme.

My home is open to everybody and everybody comes over and dumps their problems on us. I have a [female family member] who just gets on the phone and even if I'm hurting, you know, I tell her I'm tired, and she just keeps on with her negativity, and it gets to me, but because of the type of person I am I listen.

While this respondent drew upon a loving relationship with her immediate family members she lived with, her female relative was not sensitive to her emotional needs. The Chamorro value of family reciprocity was not always a welcome obligation. Jeff, who was a Chamorro caregiver to his father who had cancer, even encountered openly hostile family members. Jeff's older siblings, who lived on the US mainland, were upset at virtually all of the decisions he made in caring for his ill father. Jeff was caught in the middle of a family firestorm.

The interview data suggests that the primacy of family among Chamorro was a double-edged sword. While immediate family members helped patients and caregivers, extended family members could also be a source of stress. The help that family provided cancer sufferers was at times accompanied by insensitivity, and in one case, even hostility. Interviews suggested that extended family members may not always be sensitive towards the needs of cancer sufferers and cancer caregivers.

FINANCIAL BARRIERS TO CARE-SEEKING

Cancer treatment in the United States is extraordinarily expensive, even for people with insurance coverage. Participants in this study represented a range of

insurance programs available on Guam that were described in the literature review, including the military's Tri-care Insurance, private insurers, Medicare and MIP. Respondents' experiences of care-seeking for cancer were vastly different depending on what type of insurance coverage was available to them when they were diagnosed and what financial resources respondents had at the time of their diagnosis. Even the cost of cancer screening was a financial hardship for some respondents. All respondents who did get screened regularly were insured, but not all people who were insured sought regular screening.

The author interviewed three women who were eligible for Tri-Care, two of whom were breast cancer survivors and were spouses of men who served in the military. One of these respondents, Carla, opted to be treated on-island, deciding on a mastectomy because she was told it would be the most permanent treatment. Carla described her experience being treated by her doctor on-island as a good one, with "no problems" until after surgery when she discovered that she was left with an unusual amount of scar tissue from her surgery, which left her uncomfortable. She could not afford the expense of breast reconstruction surgery.

Jane, the other respondent with Tri-care, complained that since the Naval Hospital was a teaching hospital, doctors were stationed there only temporarily and her continuity of care suffered. When she sought screening after finding a lump in her breast, she described being told by her doctor to come next month. But her concerns prompted her to call the hospital back and make an appointment for a mammogram for the next day. This mammogram led to a biopsy and a diagnosis of breast cancer. Jane's Tri-Care insurance referred her to the Hawaii-based Tripler Medical Center for treatment. Luckily, she was able to access almost-free military housing at a program for families who undergo long-term treatment in military hospitals. Jane counted herself lucky that her cancer care did not bankrupt her. As she said later in the interview, "Insurance here on Guam, it's very expensive, people go into debt! They become poor! They become impoverished! Really! Family members are standing on corners trying to raise money." Indeed, it is quite common on Guam to see people begging for money on the medians of major intersections on the island, trying to collect money in coffee cans from passing cars to pay for medical expenses and off-island travel.

Two other respondents who were actively undergoing treatment had private health insurance. Privately-insured patients did not have as much financial coverage as those with military benefits. My youngest participant described that her mother had no financial difficulties with travel or expenses for her lung cancer. But another respondent with insurance was forced to turn to family for financial help with deductibles, as the following excerpt demonstrates.

I: Do you mind if I ask about when it's hard, you mentioned just now there can be hard times when things are hard to manage.

R: OK, the hardest part is financial because even now with my insurance, [while] I have a great insurance package, [the] intravenous chemotherapy that I've been prescribed in the past now requires a co-payment, and the co-payment is 439 dollars, so ... the insurance company wasn't sending me any money, it's been very difficult, but my oldest daughter...she's been helping, so that's been a very big stress relief for me, so she told me not to worry about that just recently, so that's been a very very big help for me...

This respondent was receiving Chemotherapy every three weeks at the time of our interview. Her cancer made it impossible for her to work and the 439 dollars for each treatment was a major financial hardship.

Sandy, another respondent with private insurance, had no trouble with co-payments, but experienced repeated frustration with the front-line staff of the insurance company where she paid her bills and the nurses and front-line staff at her doctor's office. Sandy had to solve these problems on her own, through appeals to supervisors at these agencies as she underwent treatment. These experiences convinced Sandy the front-line staff of many medical and insurance companies on Guam was incompetent. She claimed that most Chamorro on Guam are passive in the face of such bad service, saying, "[Chamorro] don't want to be confrontational and they just take it."

Finally, two of my respondents cared for their retired parents who did not have insurance when they were diagnosed. Both applied for the Medically Indigent Program (or MIP) and were forced to transfer property from their parents to other family members to become eligible for this program. Sadly, both respondents' family members died from cancer.

Before his cancer was discovered in the mid-1990s, Jeff's father Rick suffered from diabetes. Since Rick had no health coverage, nor even a social security pension after he retired from his job, Jeff cashed out his personal pension and took his father off-island to a relatively inexpensive Philippine Hospital to seek care for his diabetes and get a check-up. It was during this check-up when his father's prostate cancer was discovered.

Jeff's father, Rick, who was a first generation Filipino immigrant,³ felt that asking doctors questions was a sign of disrespect, which put Jeff in a very difficult situation. Rick didn't allow Jeff to seek any financial assistance from his siblings nor from other non-profit groups on Guam, viewing any outside assistance as shameful. Jeff was finally able to convince his father to travel with him to Hawaii to seek chemotherapy,

³ Like all ethnic groups, many Chamorro are mixed race, but still identify as Chamorro.

but MIP did not pay for off-island care at the time.⁴ The only way Jeff could afford the trip was to sell land, which deeply angered his siblings. As Michael Perez (2002) notes, owning land on Guam is very important for maintaining Chamorro identity. But this money was still not enough for Rick's entire chemotherapy treatment. Jeff then took out a second mortgage on the home he shared with his father so he could care for Rick another year on Guam until he passed away.

After retiring from her Government job on Guam, Cindy's mother Frieda paid for COBRA coverage for some time, but eventually ended her insurance coverage before she got cancer because it was too expensive. As Cindy said in our interview,

When she had insurance, she didn't need it. And when she finally stopped [her insurance] because it got too costly and it was just her [alone], then she was like, "I don't need it." And then when she really did need it, it wasn't there.

Frieda's cancer was discovered at stage IV when it was already metastasizing to other regions in her body. To pay for her Chemotherapy treatments, which were \$3000 a month, Cindy and her other siblings pooled financial contributions together, but were still unable to afford the costs of all the recommended treatments and had to spread them out. While this was happening, family members diligently sought to transfer the mother's assets to Cindy and her siblings so that Frieda would be eligible for MIP. Frieda finally gained eligibility by January, but she passed away by the end of February.

DISCUSSION

The findings suggest that the Chamorro of Guam face enormous hurdles in their attempts to seek screening and treatment for cancer on Guam. Foremost among these are financial barriers, such as a lack of health insurance coverage, which inhibits timely cancer screening. Front-line workers of agencies involved in cancer care may make access difficult. Compounding these problems is a need for greater knowledge about cancer, the benefits of regular cancer screening, and insurance. While immediate family and extended family are extraordinarily helpful in assisting care-seekers, sometimes the close relationships within families can backfire, leading to insensitivity and even hostility between family members as cancer is treated.

This research supports conclusions from Natividad (2007), that Chamorro receive a great deal of help from family in accessing the cancer care system on Guam. However, because this study encompassed care-seeking instead of focusing solely on social support, it also diverges from Natividad's findings. We learned that extended relatives and family commitments may at times cause additional stress for Chamorro with cancer.

⁴ At this time, MIP does allow patients \$175,000 for off-island care.

These findings also support Balajadia et al.'s (2008) research that inequality is associated with decreased levels of cancer screening. However, more details were uncovered concerning how a lack of awareness of the need for screening is also a barrier to care-seeking. It also showed how respondents creatively managed to secure funding from family members for cancer care and the struggles that uninsured Chamorro face in gaining eligibility for MIP and navigating its complicated bureaucracy. Unlike Balajadia et al.'s (2008) study, no respondent reported difficulties securing transportation for cancer screening, which is likely a result of self-selection factors, since an incentive for participating in this research included certificates for fuel.

Unlike Rosario's (2010) study, no female respondent reported they experienced shame or cultural stigma for seeking out Pap tests with their gynecologist. Perhaps the cultural norm of "Mamahlaho" reported in Rosario's study is understood differently than it was three years ago when this earlier research was published. This is only speculative, given the fact that the current study addressed a different topic.

Depth interviewing relies on subject's memory of events, which are subject to respondent bias and, perhaps, social-desirability bias. Nevertheless, there would be no way to learn about respondents' past experiences without conducting interviews. Moreover, even if these recollections are inaccurate, they are likely to capture attitudes towards cancer and influence current understandings of the disease.

There is much research yet to be done in relation to care-seeking for cancer by Chamorro of Guam. As a first step, researchers might consider studying the themes of care-seeking uncovered here through in-person surveys or self-administered questionnaires so that scholars can know more about how widespread these problems in a larger sample of Chamorro. Understanding perspectives of Guam's health-care providers concerning Chamorro who seek cancer care is also needed. There are many gaps in basic knowledge concerning health care accessibility on Guam in relation to ethnicity. For example, there is no available data concerning rates of health care coverage by ethnicity and no data concerning income or wealth by ethnicity.

This study shows ways that Guam's community can lower cancer deaths. Awareness campaigns about cancer screening are needed and the public needs to be informed that cancer is not a death sentence like it used to be. More patient advocacy is needed for Chamorro with cancer to help navigate the many bureaucracies they encounter as they seek cancer care. Encouraging regular cancer screening regardless of how healthy people feel would help, as would making cancer screenings more available to communities around the island. Additional funds should also be made available for cancer screening and cancer treatment for those individuals who need financial help. As one of my respondents said, "I know that money talks. And the society that we live in is very harsh."

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