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A Narrative Engagement Framework to Understand HPV Vaccination Among Latina and Vietnamese Women in a Planned Parenthood Setting

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Abstract

Disparities in cervical cancer and human papillomavirus (HPV) vaccination persist among Vietnamese and Latina women. Through a partnership with Planned Parenthood of Orange and San Bernardino Counties (PPOSBC) in Southern California, we conducted in-depth interviews with young adult Latina ($n = 24$) and Vietnamese ($n = 24$) women, and PPOSBC staff ($n = 2$). We purposively sampled vaccinated women to elicit HPV vaccine decision narratives to uncover rich data on motivators, cultural values, and implicit vaccine attitudes. Unvaccinated women were interviewed to identify barriers. Women were also asked to discuss their observations of men's HPV vaccine attitudes. Narrative engagement theory guided the study privileging the meaning women ascribed to their experiences and conversations related to vaccine decision making. Vaccine decision narratives included (a) mother–daughter narratives, (b) practitioner recommendation of HPV vaccination, (c) independence narratives among Vietnamese women, (d) HPV (un)awareness narratives, and (d) school exposure to HPV knowledge. Barriers to vaccinating included trust in partner HPV status, and family silence and stigma about sexual health. Participants conveyed the importance of including messages aimed at reaching men. Practitioners described insurance barriers to offering same day vaccination at PPOSBC health center visits. Narrative communication theory and methodology address health equity by privileging how Vietnamese and Latina women ascribe meaning to their lived experiences and conversations about HPV vaccination. Identifying authentic and relatable vaccine decision narratives will be necessary to effectively engage Vietnamese and Latina women. These findings will guide the process of adapting an existing National Cancer Institute research-tested HPV vaccine intervention.

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Declaration of Conflicting Interests

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Keywords

health equity; HPV vaccine; Latina cancer disparities; narrative engagement; planned parenthood; Vietnamese cancer disparities

Cervical cancer rates among U.S. Latina women (10.0 per 100,000) remain one of the highest in the United States and are 44% higher than non-Latina Whites (American Cancer Society, 2015). Similarly, Vietnamese women also have high incidence rates of cervical cancer at 9.0 per 100,000 (Fang, Ma, & Tan, 2011; Gomez et al., 2013; Jin, Pinheiro, Xu, & Amei, 2016). This disproportionately higher cancer burden among Latina and Vietnamese women coincides with low human papillomavirus (HPV) vaccination rates. In 2014, the Surveillance of Vaccination Coverage among Adult Populations indicated Latina women (28.1%) and Asian women (22.8%) had lower HPV vaccination coverage compared with their White counterparts (46.3%; Williams et al., 2016). Health communication studies aimed at identifying indicators of health disparities are needed to develop appropriate interventions for reducing inequities in health and health care. Braveman et al. (2011) argue that progress toward health equity is best measured by evaluating advances in eliminating health disparities. By utilizing narrative communication theory, we aim to engage women to increase awareness about the availability of HPV vaccination among historically underserved Vietnamese and Latina young adult women.

A Narrative Communication Approach That Promotes Health Equity

Narratives as a human communication paradigm reflect how individuals recount and make meaning of their experiences (Fisher, 1987; Petraglia, 2009). Narrative communication has been proposed as a promising tool for promoting health behavior change because its form is particularly well suited to reflect culturally situated messages (Cappella & Hornik, 2009; Hinyard & Kreuter, 2007; Kreuter et al., 2007; Larkey et al., 2008). While narrative used in the health context has been defined a number of ways in the communication literature, in this exploratory study, we define narrative as linguistic construction of significant experiences, or talk organized around significant or consequential experiences with characters undertaking some kind of action (Miller-Day & Hecht, 2013). We use story and narrative interchangeably; story is generally considered a person’s account or testimony, while narrative is the created structure chosen by the storyteller (Parker & Wiltshire, 2003). Guided by narrative communication theory (Miller-Day & Hecht, 2013), we focus specifically on eliciting “decision” narratives to identify and understand cultural values and implicit attitudes that may be associated with women’s decisions to vaccinate (Hopfer & Clippard, 2011).

When experiences are framed as stories, their meaning and reality are revealed to the storyteller and audience. Narrative inquiry allows us to expand our understanding of the context and environment in which women’s vaccine decisions are made. Narrative communication theory emphasizes attending to how stories are told, what language is used by women in their decision stories, and what people, conversations, and experiences they include in their stories to explain the degree to which various determinants are weighted among young adults when making health decisions—in this case vaccinating. Vaccine

decision stories not only help in understanding what messages might resonate with young adult women but also inform how to adapt the content of an existing research-tested HPV vaccine intervention (National Cancer Institute [NCI], 2015). Including culturally grounded decision narratives derived from the target audience is more likely to effectively resonate with and engage, in this study, young adult Vietnamese and Latina women at a Planned Parenthood setting.

Collaboration With Planned Parenthood

Orange County (OC) consists of many immigrant communities, of which 35% are Latino (U.S. Census Bureau, 2010a). OC also houses the largest Vietnamese ethnic enclave in the United States (Vo, 2004). Vietnamese and Latina women have been disproportionately burdened by cervical cancer; therefore, it is appropriate to target these populations to continue decreasing the burden of disease. Given that we wanted to reach Vietnamese and Latina women in OC, we worked with Planned Parenthood of Orange and San Bernardino Counties (PPOSBC), at their Westminster and Santa Ana Planned Parenthood health centers, which serve a 40% Vietnamese population (U.S. Census Bureau, 2010b) and a 78% Latino population, respectively (“Facts and Figures: Santa Ana History and Population,” 2017).

Our collaboration with PPOSBC was intended to help us better understand factors that influence vaccination uptake in the populations attending these health centers. The partnership was meant to leverage our reach to economically disadvantaged populations who historically have had less access to cancer prevention. PPOSBC is one of the few community safety net providers in OC that serves socioeconomically disadvantaged populations. Consequently, the strategic placement of PPOSBC health centers within OC helps ensure equal access to preventive services to all who utilize their health centers. As Braveman (2014) noted, health equity means that all are given equal opportunity to be healthy regardless of their social or economic status and that reducing health disparities in turn, moves us toward health equity. By working with PPOSBC, the narratives that women conveyed when seeking vaccination services provided us a more comprehensive perspective of the barriers and motivators in receiving the HPV vaccination. This knowledge allows us to continue our work in diminishing cancer disparities and advance health equity.

The main purpose of this study was to elicit HPV vaccine decision narratives to understand how cultural values and implicit as well as explicit attitudes shape vaccine decision making among Latina and Vietnamese women attending Planned Parenthood health centers. Results inform the adaptation of an existing NCI research-tested HPV vaccine intervention program (RTIP; Hopfer, 2012; Hopfer et al., in press; NCI, 2015) originally developed to reach college women at student health centers.

Method

Setting

The value of gathering and analyzing health decision stories of racial and ethnic minority women with regard to HPV vaccination lies in stories providing rich data for understanding interpersonal interactions, social expectations, and implicit cultural values relevant to

vaccine decision making. Hispanic/Latinos comprise the second largest population in OC (34%), while Vietnamese Americans comprise the highest concentration (35%) of all Asian Americans in the country (U.S. Census Bureau, 2010a). The county mortality rates for cervical cancer among Hispanic women (3.47 per 100,000) are still much higher than the national mortality rate (2.3 per 100,000). County morality rates for Vietnamese in OC are not available. Nationally, although rates have improved, cervical cancer mortality rates still rank among the top 10 among Vietnamese women at 1.5 per 100,000 (NCI, 2014). Planned Parenthood health centers offer an ideal setting for reaching racial and ethnic minority women given that they serve this population.

Recruitment and Study Enrollment Criteria

Young adult women, ages 18 to 26 years, who self-identified as Latina or Vietnamese were recruited in PPOSBC waiting rooms between July 21 and August 20, 2016. All procedures received prior approval from the collaborating university review board and from Planned Parenthood Federation of America. Women were approached in the waiting room after check-in to ask if they would be willing to participate in a 30-minute interview after their clinic visit and to confirm they met eligibility criteria (ages 18 to 26 years, Vietnamese or Latina). Semistructured interviews were conducted in English at the Santa Ana health center by a trained Latina doctoral student and at the Westminster health center by a Vietnamese doctoral student. Vaccinated women ($n = 32$) were recruited to elicit their HPV vaccine decision stories, to collect data on the experiences and conversations women have had, and how women ascribe meaning to these conversations. Unvaccinated women ($n = 16$) were interviewed to understand barriers to vaccination. Additionally, women were asked to describe how their boyfriend, brother, or male friends would respond to HPV vaccine messages. One PPOSBC staff from each center was interviewed to understand HPV prevalence in the PPOSBC population, the target population's perceived susceptibility, and to understand how HPV vaccination is discussed with patients.

Interview Procedures

A narrative inquiry interview technique was used to elicit vaccine decision stories (Clandinin, 2006). The interview guide used questions framed to be conversational, encouraging women to talk about their experiences that led them to vaccinate. Vaccinated women were asked to talk about the conversations, people (family, partner, friend, practitioner), and experiences that led them to vaccinate. Questions to prompt decision narratives included "Tell me how that conversation went" and "What were your thoughts about e.g., what the practitioner said or what your mother said." All women were informed that the HPV vaccine is recommended for men and women. Interviewees were then asked to share their thoughts about how men they know (e.g., boyfriends, brothers, friends) might respond to HPV vaccine messages.

PPOSBC staff were interviewed by the same interviewers to share their experience with seeing patients with HPV (prevalence), the proportion of patients who vaccinate, how they discuss the HPV vaccine with patients, and their experience with logistic, insurance, or any structural barriers around making the vaccine more accessible to patients. All interviews were audiorecorded and informants were given $20 cash as compensation for their time.

Data Analysis

Interviews were transcribed verbatim with personal identifiers removed and replaced with pseudonyms. Data analysis was conducted using NVivo version 11 software. Three coders read and coded all transcripts independently using a grounded theory approach (Charmaz, 2012). Coding proceeded in two phases: initial coding of emerging themes and subsequent focused coding of more abstract, prototypical decision narratives. Authors read all transcripts line by line, categorizing and labeling segments of data with a code or short name (labeled as a “node” in NVivo). These nodes or initial codes described phenomena or accounts being observed in the data (e.g., practitioner interactions, family communication, partner language, protecting yourself, low awareness, Catholic upbringing, and premarital sex; Babtiste, 2001). Coders convened weekly to discuss how they had selected, organized, and sorted data into categories. Constant comparisons were made during the coding process, and discrepancies discussed (Strauss & Corbin, 1998). Memo writing was documented both during the initial transcribing of data (immediately following interviews) and during the coding process (Charmaz, 2012). The codes reflected feelings and thoughts related to motivations to vaccinate as well as barriers including any explicit or implicit stories, attitudes, or experiences that interviewees mentioned and or perceived that prevented them from vaccinating.

The second phase of coding aimed to identify the prototypical, higher level (abstract) decision narratives (e.g., mother–daughter narratives, independence narratives). At this stage, identified codes or nodes were repeatedly read and reviewed, organized, and analyzed for higher order, prototypical narratives emerging from the existing codes. The three coders compared and contrasted identified narratives discussing whether these narratives resonated with their interpretations of how women ascribed meaning to the messages they received and also whether the interviewers themselves felt the narratives resonated as authentic decision stories typical of experiences described by young women (two of the authors/coders were a similar age and ethnicity as the target population). Lastly, decision narratives by Vietnamese and Latina women were compared for similarities and differences.

Results

Participants

Fifty interviews (n = 24 Latina, n = 24 Vietnamese, n = 2 staff) were conducted. Table 1 summarizes demographics and health characteristics of participants. Latina women were primarily from Mexican American origin (n = 20) with one woman born in Mexico, one of Mexican Peruvian heritage, one from Guatemala, and one from Bolivia. Vietnamese women were second-generation, born in America. The two PPOSBC staff members interviewed were nurse practitioners who had been employed by the affiliate for 4 and 12 years, respectively.

The following prototypical decision narratives emerged from analyzing women’s interviews. The narratives reflect participants’ informal and formal influences that shape their awareness and attitudes about HPV vaccination.

Mother–Daughter Narratives

Mothers played a central role in many adult women's health decisions including HPV vaccination. When asked to describe their decision to vaccinate, 63% (n = 15) of Latina and 46% (n = 11) of Vietnamese women included conversations with their mothers and described ways in which their mother–daughter relationship influenced their vaccine decisions. Latina women mentioned their mother as vaccination decision maker, while Vietnamese women were more likely to mention their mother as decision maker only when they had vaccinated as an adolescent.

Mothers appeared to exert an influence on their young adult daughters in either direction—whether in support of or against vaccinating. Teresa, a Mexican-born 20-year-old vaccinated Latina, expressed her mother's acceptance of the vaccine as the primary reason why she vaccinated: "I really didn't have a choice because my mom was the one that wanted me to get [HPV shots]." Mothers' attitudes toward vaccinating frequently trumped doctor recommendations. Sandra, a 22-year-old unvaccinated Mexican American expressed skepticism about the vaccine: "My parents heard bad things about getting the shot. So I was kind of scared." When Sandra was asked to elaborate on what they heard, she was not certain. Although Sandra could not identify specific fears, the recommendation made by her parents to not vaccinate was the main reason she chose not to vaccinate. In some Vietnamese women's decision stories, their mother's vaccine attitudes influenced whether they vaccinated: Jessica, a 21-year-old Vietnamese woman said: "Honestly when I got the shot, I didn't know what it was. I wasn't really informed … I mean we had a conversation about it, but it was ultimately my mom's decision to get it …" When mothers' vaccine attitudes were supportive of vaccinating, mother–daughter conversations normalized HPV vaccination as routine and cancer protecting rather than as a stigmatized sexually transmitted disease (STD) vaccine to be unnecessary or avoided: " … Oh, all girls get it … so it's normal. You should get it too."

Mother–daughter conversations about HPV vaccination were also often initiated in the context of medical visits (69% of Vietnamese and 67% of Latina women). Examples included Andrea, a vaccinated 24-year-old, "I was getting a physical, and that's when my mom brought it up. The doctor told me about the vaccine and my mom recommended I get it." Ruth, a 21-year-old vaccinated woman told of how her mother wanted her to get vaccinated and accompanied her during a medical visit: "My mom wanted me to get it [HPV vaccine]. She was like, 'Yeah, you should get it!' She agreed with the nurse, as I am getting older."

Practitioner Recommendation of HPV Vaccination

Women's HPV vaccine decision stories included references to conversations with clinicians. Among vaccinated Latina women, 38% (n = 6) explicitly cited provider influence as the primary reason they chose to vaccinate, while 81% (n = 13) of the vaccinated Vietnamese women's decision stories included descriptions of conversations with a health care practitioner as the reason for vaccinating. Ashley, a 24-year-old vaccinated Vietnamese woman, described her interaction with her provider:

> The doctor asked me about it. I heard about it too, so when I came in for a check-up, I decided to get it since it's not anything harmful to me and it prevents cancer. Why not, right? That's why I got it. She [The doctor] explained it to me like about how I have to get it to prevent cancer. And it just made sense to me so I got it.

Similarly, a 20-year-old vaccinated Vietnamese woman, Judy, explained: "And then my doctor brought it up. He said, 'You know you should get it because you're a girl and it can help prevent you with all these types of things.'"

Among women's decision stories of vaccinating, descriptions of practitioner conversations presented vaccination in a normalized, nonstigmatizing way. Lily, a 24-year-old vaccinated woman said:

> … my doctor just went through my files and said, "you got this shot, this shot, and this shot." And then he asked, "Did you get the HPV shot?" And I asked him what it was … so he said, "Oh, the Gardasil shot that protects you from cancer down the line." He made it as basic as he could for me to understand at that age. And I told him I hadn't gotten it and he asked me if I was sexually active. And I told him no … And he implied that, "Oh, women around your age, 21 or so … in college" … and so I was like okay, might as well.

Daniela, a 26-year-old Latina recalled,

> I went to the doctor, they told me about it and if I wanted to get it, and I just said yes. They were suggesting it. I was like, "Ok, why not." There was also another vaccination, I don't know if it was the flu shot, or something else that they wanted to give me as well.

Among women's decision stories, vaccinating for HPV came up secondarily at the clinic visit. Even when vaccination was not the primary reason for the visit, a practitioner's explicit recommendation or encouragement was enough to convince many women to vaccinate.

Independence Narratives Among Vietnamese Women

Vietnamese women who vaccinated when they were young adults (38%) described making their own decision to vaccinate. Their vaccine decision stories expressed the motivation to adopt preventive care to protect themselves from disease and the possibility of rape. This view contrasted with their family's views. Lily, a 24-year-old vaccinated woman, contrasted her family's mentality toward health decision making with her own:

> Not a lot of people have the same mentality as me … I'm getting vaccinated to protect myself from not my partner, but from people who might take advantage of me. That's my mentality of always having a backup because you just never know … I don't think there is a connection about me getting the vaccine and my family because if I was more like how my family's beliefs are, I wouldn't have gotten the vaccine. But that's not my mentality so I want to protect myself. With their mentality, it's like they don't foresee anything bad that might happen. [thinking], "Oh she's just not going to have sex."

These expressions of self-protection were also expressions of independence to make health decisions alone for the first time as an emerging adult. Nancy, a 24-year-old vaccinated Vietnamese woman, described her decision to seek health information on her own:

> We don't even talk about [sex]. But I know my mom is very proactive in her checkups and everything, but I don't want to go with her…. Yeah, she offers like, "Do you want to go get a female exam or something?" but I'm like, "No, I want to go separately." I know she is proactive on her own terms and I am proactive on my own terms … but we don't really discuss that. It's not really a topic of conversation … because once she gets on this topic, she's going to ask me all these things. That's why I don't want her to go.

Several women believed in the value of protecting themselves, being accountable for their own health, and valuing their independence to make decisions about their own health.

HPV (Un)Awareness Narratives

Both vaccinated and unvaccinated women could not explain what the HPV vaccine protected against. While all vaccinated Latina women ($n = 16$) had heard of HPV, many were uncertain about its significance. Half of the unvaccinated Latina women had never heard of HPV ($n = 4$). The majority ($n = 23$) of all Vietnamese women were unable to elaborate on what HPV is or what the vaccine protects against. Two of eight unvaccinated Vietnamese women had never heard of HPV. These women's stories described either nonexistent or passive practitioner communication about the availability and importance of vaccinating against HPV, or their potential inability to understand the information, which PPOSBC provides all patients. The situation was similar for Latinas, as illustrated by Adriana, a 19-year-old unvaccinated Latina, who stated, "Honestly … this is the first time I have ever heard about it [HPV]."

Misconceptions and unawareness about HPV were evident in women's stories, including confusing HPV with HIV, not knowing that HPV is a sexually transmitted infection, and thinking that HPV testing is readily available. Mai, an 18-year-old Vietnamese unvaccinated woman said: " … I've never looked into that so I don't know much. But I know that it's not curable. Yeah, and leads to AIDS or something." Many women were unaware that HPV vaccination is recommended for young adult men. A 20-year-old vaccinated Vietnamese woman, Judy, stated, "My doctor brought it up but she didn't recommend it to my brother. So I didn't know it was for both men and women." Prototypical (un)awareness narratives described the varying knowledge and awareness levels of HPV in both communities that could hinder unvaccinated women from seeking vaccination and vaccinated women from promoting it among their own social networks.

School-Based HPV Knowledge

Women (33% of Vietnamese and 17% of Latina) included in their vaccine decision stories learning about HPV and the vaccine in school settings. Four Latina women attributed their own decision to vaccinate as a result of early exposure and learning about HPV at school settings. These four vaccinated women's stories included learning early on in middle or high school about HPV through a school class or after-school workshop. These women attributed

their early knowledge about HPV to making the decision to vaccinate even when family members were not supportive. Maria, a 24-year-old vaccinated Mexican American indicated she was in high school when she received the vaccine. After learning about the virus from an after-school workshop, she knew she wanted to vaccinate. Maria's mother, who disapproved of the vaccine, was with Maria in the doctor's office the day she was offered the vaccine. The nurse and Maria informed her mother about the benefits of the vaccine and addressed the mother's concerns. When the interviewer asked if Maria would have still received the vaccine if she was unsuccessful in convincing her mother, she responded, "I had already made up my mind because I had that workshop previously. I would've wanted to get it. So I think it just helped the nurse present it to my mother, that she was more approving of it." These stories indicate that school-based education are ways in which women received information about HPV that affects their decision-making processes regarding vaccination uptake later in life.

Barriers to Vaccinating

A number of themes emerged from young adult women's stories ranging from low perceived susceptibility to family silence about sexual health.

Trust in Partner HPV Status

When women described STD or safe sex conversations with their partners, they talked about asking each other whether they were "clean." Mai, a 19-year-old unvaccinated woman regarding her boyfriend stated:

> I asked him to get checked out and he did … and he's clean. So I'm not really worried about that so yeah … I'm not really motivated [to get the vaccine] because my partner told me he is clean so I don't think I feel the need to get the vaccine.

Vivian, a 21-year-old unvaccinated Vietnamese woman also said,

> I asked him if he ever had an STD before we had sex for the first time and he told me that he hadn't had a partner in like 3 years and so the answer was no for him. And I was a virgin at the time so I was definitely clean.

Relationship status influenced perceived susceptibility to acquiring HPV. Additionally, married Latina women feared their partners may interpret seeking vaccination as a potential signal about infidelity. Decision narratives not to vaccinate described feeling a sense of protection that accompanied being married or in a serious relationship. Maribel, an unvaccinated 22-year-old Latina woman stated, "It [HPV] kind of scares me. I haven't been with more than one person, and my partner hasn't either … well, that I know of …" Young married Latina women shared additional concerns that vaccinating could potentially send the wrong message to their husbands and might in fact signal mistrust.

Family Silence and Stigma About Sexual Health

Among both Latinas and Vietnamese, women's decision stories described family silence around discussing sex and sexual health. Family silence impeded women from taking preventive measures to ensure good reproductive health. Yesenia, a 22-year-old unvaccinated

Latina stated, “I feel like, for Hispanics, not all Hispanics but a lot, like, your parents don’t talk about that [stuff]. Like we just don’t talk about that. You just figure it out on your own.” Thao, a 24-year-old unvaccinated Vietnamese woman described this experience in her own family:

> Family wise … it’s hard to talk about sexual talk. We’re really reserved and we don’t really talk about that stuff. That’s why … it’s hard to get birth control because I don’t want my family to know and they’ll look down on me.

Lily, a vaccinated 24-year-old Vietnamese woman, expressed a similar family environment:

> Well, my family doesn’t have very open communication about sexual health. I’m Catholic and they’re Catholic. They’re super strict. And like, I do agree with religion and all that. I try to be the best I can, but like … it’s just some things that…. And maybe I’ll pay for it later, but if you know Catholics, we can’t have sex before marriage. It could be the whole cultural taboo like we talked about earlier or religious beliefs…. It’s just not a normalized topic of conversation …

Both Vietnamese and Latina young adult women acknowledged family silence and stigma around sexual health also mentioning having Catholic, conservative family cultures that precluded them from having family conversations around sexual health and HPV. Intergenerational conflict between adult women contemplating vaccination and their parents voicing disapproval came up in both groups.

Unplanned Pregnancy Prevention: The Primary Sexual Health Concern Among Latinos

Among Latina women’s decision stories, parental concerns about unplanned pregnancy were described as priority concerns over prevention of STDs, which was not discussed. Miriam, a 20-year-old vaccinated Latina discussed her frustrations about family silence around sexual health:

> Parents had their babies at a very young age and they are scared for us … at the same time, that’s the reason why a lot of teenagers end up being pregnant more from our culture … because our parents are scared and they think avoiding all that, they are helping you out. But they are not, because eventually everyone has to go through it. And once someone is in that position, they don’t know anything about it. And that’s why young teenagers end up pregnant instead of going to school and everything. They are staying home taking care of babies.

Consuelo, a 22-year-old unvaccinated Latina was asked why she felt HPV vaccine rates were low among young adult Latinas. She responded,

> I feel like HPV is the last thing they worry about. It’s like pregnancy is the first thing they worry about and I think a lot of Hispanic girls don’t use condoms that often. I noticed Hispanic girls get more pregnant at a young age, I think that’s why.

Latina women in our study recognized a gap in family communication about sexual health. Although they perceived high parental concern about unplanned pregnancies, they stated parents do not communicate appropriate prevention measures. Women also stated they

believe parents prioritize unplanned pregnancy prevention above HPV cancer prevention, another important health topic that is not discussed among family.

Promoting HPV Vaccination Among Men

Latina and Vietnamese women described their impressions of low HPV awareness among men, and their impressions that men would be unlikely to act on preventive health behaviors. Several Latina women referred to this as “machismo” values. When asked how to entice men into the clinic for prevention services, Julia, a 26-year-old Latina mentioned,

> Most machista men don’t really think about a doctor. I’m Mexican American and my dad’s Mexican, and when he has a cold or a flu he doesn’t say “oh I’m going to go to the doctor.” So I don’t see why they would come see a doctor for HPV or something like that.

Vietnamese women had similar perceptions of male preventive health values as being neglectful but one woman offered her thoughts that if a preventive behavior is normalized by having important others engage in the behavior, this would lead to young men contemplating and adopting the behavior themselves: Ashley, a 24-year-old vaccinated Vietnamese woman replied,

> That’s hard because guys are pretty stubborn. I think as long as they know their friends are getting it … within their little clique, then they’d get it. But they wouldn’t want to talk about it. It’s like a man-to-man thing.

Latina participants conveyed machismo values as influencing men’s decision to go to a clinic for health service. Both groups acknowledged the challenges in motivating men to adopt preventive health behaviors.

PPOSBC Practitioner Perspectives

Clinicians expressed hopes of HPV vaccination for their patients.

> I wish that regardless of their insurance that they can get it [HPV shot] here. Because I have some patients that are insured, but through their insurance they won’t let them get the vaccine here [at Planned Parenthood]. They make them go to their primary care doctor. So I feel like if we can just capture them and give it here, we can get more people on board. Because when they leave here, many times I’m sure they don’t call up their primary care to make the appointment and go wait for another visit and go through all of that. Even with Medi-Cal, which a lot of our patients have … it doesn’t cover it here unless they are a primary care patient for us.

Clinicians also described a program for the uninsured offered by the pharmaceutical company Merck, which allows patients to receive the vaccine at a nominal fee. However, this program can have an extensive, time-consuming application process, which is a barrier to vaccinating despite its intent to improve access. When asked to describe how HPV vaccination is talked about, one practitioner stated:

> The patients are usually willing to [receive the vaccine], but there is a time factor … that would make it difficult for a patient to get the vaccine right there and then. That's something we are working on and I know it's a big project that PP, at least this affiliate, is really gung ho about … making sure you can get all your services right there and then.

Since the time of this study, PPOSBC has streamlined the application process.

Discussion

This narrative exploratory study first and foremost identified HPV vaccine decision stories that are relevant for Vietnamese and Latina young adult women. The prototypical decision narratives have implications for adapting the content of an existing HPV vaccine intervention, for health and school policy, and for clinical practice.

Adapting an NCI Research-Tested HPV Vaccine Intervention Program

The identified prototypical narratives will shape the story scripts used for adapting the content of an NCI HPV vaccine RTIP (Hopfer, 2012; Hopfer et al., in press; NCI, 2015), to resonate and effectively reach Planned Parenthood clients at their health centers. Story scripts for the adapted intervention will include mother–daughter, independence, and practitioner–mother–daughter narratives. Reenacted composite stories derived from these culturally grounded and authentic decision stories will be developed. Language used in story scripts will be integrated into decision story scripts, for example, conversations about "being clean" and how this might be problematic or using Spanglish in mother–daughter scripts. Mother–daughter narratives may be multiple and range from supportive conversations, to conversations initiated in the context of a medical visit with a practitioner, to mother–daughter conversations expressing intergenerational conflict on the taboo subject of being proactive about prevention for sexual health. Family interactions played an important role in young adult women's vaccine decision stories similar to previous studies (Kim & Ward, 2007; Moran, Murphy, Chatterjee, Amezola de Herrera, & Baezconde-Garbanati, 2014; Niccolai, Hansen, Credle, & Shapiro, 2016; Rendle & Leskinen, 2016).

Among Vietnamese women, decision stories of independence would be important to include in the intervention. Vietnamese women expressed a desire to assert their own emerging young adult interpretation of HPV prevention messages and make their own health decisions independent of parents. By contrast, such stories were absent among Latina women in our sample, many of whom (46%) had children and whose stories expressed family unity rather than asserting independence. Integrating these prototypical decision stories combined with positive vaccine messages are likely to resonate with the Latina and Vietnamese young adult population attending PPOSBC for reproductive health services. Decision narratives perceived of as authentic and culturally derived are more likely to engage Latina and Vietnamese women to raise awareness about the importance of vaccinating to prevent cancer.

Implications for Health and School Policy

Planned Parenthood has a goal of delivering optimal preventive services. Practitioner interviews shed mainly light on health insurance and financial barriers to vaccinating. The Affordable Care Act requires coverage of a number of preventive care measures, including vaccines ("Are Immunizations Free," 2015). However, our study suggests that patients may not be aware of where and how they can receive these services, or even if they have coverage for them. Our qualitative inquiry with PPOSBC practitioners suggests that more patient education about covered services would be helpful, particularly if it were provided in a clear and culturally sensitive fashion. Such policies would have a health equity orientation to affect these communities in significant ways and at multiple levels (Hall, Graffunder, & Metzler, 2016).

In addition, school clinics may also be an additional source of education regarding vaccination services. Many of the women interviewed shared how they learned about HPV and the preventive vaccine through school curricula rather than at home through family discussions on the topic. Comprehensive school-based sexual health education policies, such as those enacted in California as recent as 2015 AB 329 in California (Burlingame, 2015; "CA Assembly Bill (AB) 329," 2015) are important to supporting widespread dissemination of HPV information. For Latina women, the experience of empowerment through sexual health education outside the home environment led them to utilize vaccine prevention services and vaccinate even when their parents disagreed or discouraged HPV vaccination. Continuing school-based programs may help mitigate the cultural barriers that can impede women from vaccinating, and policies supporting these types of programs inherently promote health equity by providing equal access to sexual health education (Calo, Gilkey, Shah, Moss, & Brewer, 2016; Grose, Grabe, & Kohlfeldt, 2014).

Implications for Clinical Practice

Similar to previous studies, in many of the Latina and Vietnamese women's vaccine decision stories, practitioners' HPV vaccine recommendation was the key reason why women vaccinated (Gilkey, Malo, Shah, Hall, & Brewer, 2015). Practitioners should be aware, however, that vaccine decisions may not only reflect a woman's individual values but may likely reflect also her family's attitudes about vaccination. Some families may know very little about HPV vaccination, or may associate it only with sexual activity, leading to potentially stigmatized discouragement. While we know from vaccine communication literature that a practitioners' explicit and strong recommendation about HPV plays an important role in HPV vaccine adoption (Dempsey, Cohn, Vanessa, & Mack, 2011; Gilkey et al., 2015; Yi, Lackey, Zahn, Castaneda, & Hwang, 2013), our findings suggest that if vaccine hesitancy is encountered by clinicians among especially mothers who accompany their daughters, clinicians may benefit from exploring in a discussion her family environment. Family views (e.g., parents of adult patient) or anticipated family approval may still play a deciding role in personal health decisions among young adult Latina and Vietnamese women, especially women with children, who make decisions in the larger context of their extended family. Although many Latino and Vietnamese families still perceive of the HPV vaccine as a taboo topic associated with sexual activity, discussing and recommending HPV

vaccination as cancer prevention and as a routine part of preventive care normalizes vaccination and lessens the potential for stigma associated with vaccinating.

Our participants conveyed the importance of including messages aimed at reaching men. Latina women raised the issue that machismo values may present as a critical cultural barrier preventing men from seeking HPV vaccination. Literature has shown that machismo values can either influence or deter Latino men from seeking cancer prevention services (Getrich et al., 2012). Vietnamese women also anticipated that Vietnamese men may deny or avoid seeking cancer prevention services such as HPV vaccination. Therefore, future research should include men to understand what messages can encourage them to seek preventive services, such as HPV vaccination.

Limitations

Limitations to the study included that we were not able to achieve prolonged engagement with informants rather, interviews consisted of a one-time discussion and interaction (Morse, 2015a). Second, although we cannot guarantee saturation of identified decision narratives, we strived toward the goal of saturating characteristics within decision narratives by having three coders independently analyze the data and repeatedly discuss and compare findings among authors (Morse, 2015b).

How Narrative Communication Contributes to Promoting Health Equity

Narrative communication theory and methodology, a unique qualitative approach, are particularly useful for addressing health equity given that the theory and method give voice to womens' lived experiences and conversations, and how they ascribe meaning to these experiences and conversations (Banks, 2012; Hecht & Miller-Day, 2009). The methodology gives the participant the power to define their identity and experience rather than have their reality shaped by the researcher. Opportunities to tell and reflect on stories related to health care decision making may be a crucial component of effective behavior change strategies. Narrative communication theory and methodology further inform how to design a prevention intervention to effectively engage and improve health behavior choices among socially and economically disadvantaged populations (Hecht & Miller-Day, 2009; Hopfer & Clippard, 2011).

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Table 1

Characteristics of Latina and Vietnamese Women.

Variable	Total Latina[a] (*n* = 24)	Total Vietnamese[a] (*n* = 24)	Total sample[b] (*N* = 48)
Age (years), *M* ± *SD*	23 ± 2.29	22 ± 4.95	22 ± 2.4
Human papillomavirus (HPV) vaccination status, *n* (%)			
One or more	16 (67)	16 (67)	32 (66)
Completed series	8 (33)	15 (63)	23 (48)
Currently sexually active, *n* (%)	20 (83)	23 (96)	43 (90)
Condom use, *n* (%)	11 (46)	12 (53)	23 (48)
Health insurance, *n* (%)	19 (53)	18 (75)	37 (77)
Ever received a pap smear, *n* (%)	12 (50)	13 (54)	25 (52)
Partner status, *n* (%)			
Married	3 (13)	0 (0)	3 (6)
Dating or engaged	13 (54)	22 (92)	35 (73)
Single	8 (33)	2 (8)	10 (21)
Has children, *n* (%)	11 (46)	0 (0)	11 (23)
HPV exposure, *n* (%)	2 (8)	1 (4)	3 (6)

[a] Percentages displayed out of total racial/ethnic sample (*n* = 24).

[b] Percentages displayed out of total sample (*N* = 48).