

# **Barriers to Breast Health Practices in Ethnocultural Women**

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Halifax, Nova Scotia  
March 17, 2009**

# Project Team

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# Acknowledgments

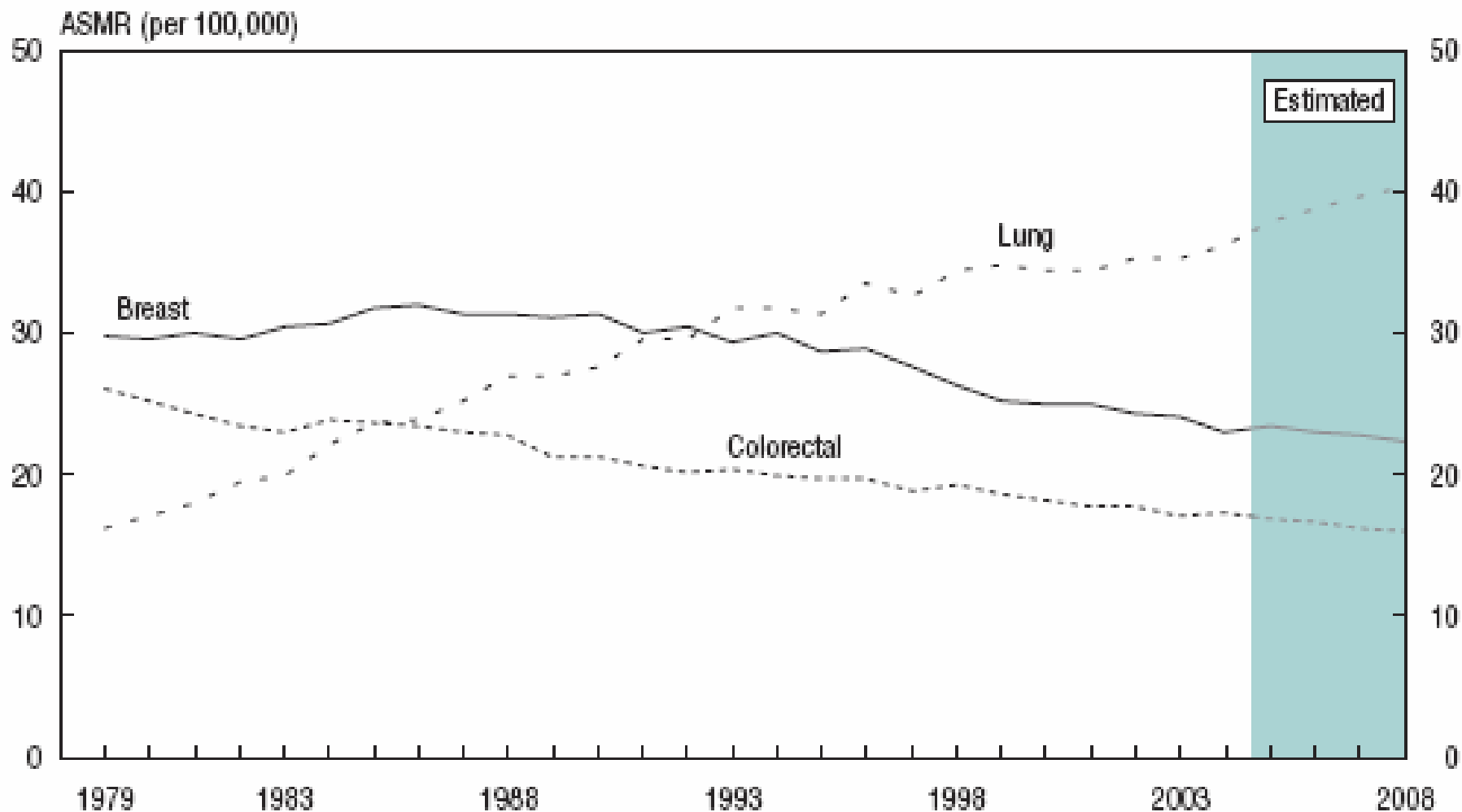
- Canadian Breast Cancer Foundation (ON. Chapter)
- Community Partners for Multicultural Health
- The Multicultural Council
- Project Advisory Committee Members
- Community Liaisons/Co-Facilitators
- Workshop Co-Hosts



# Objectives

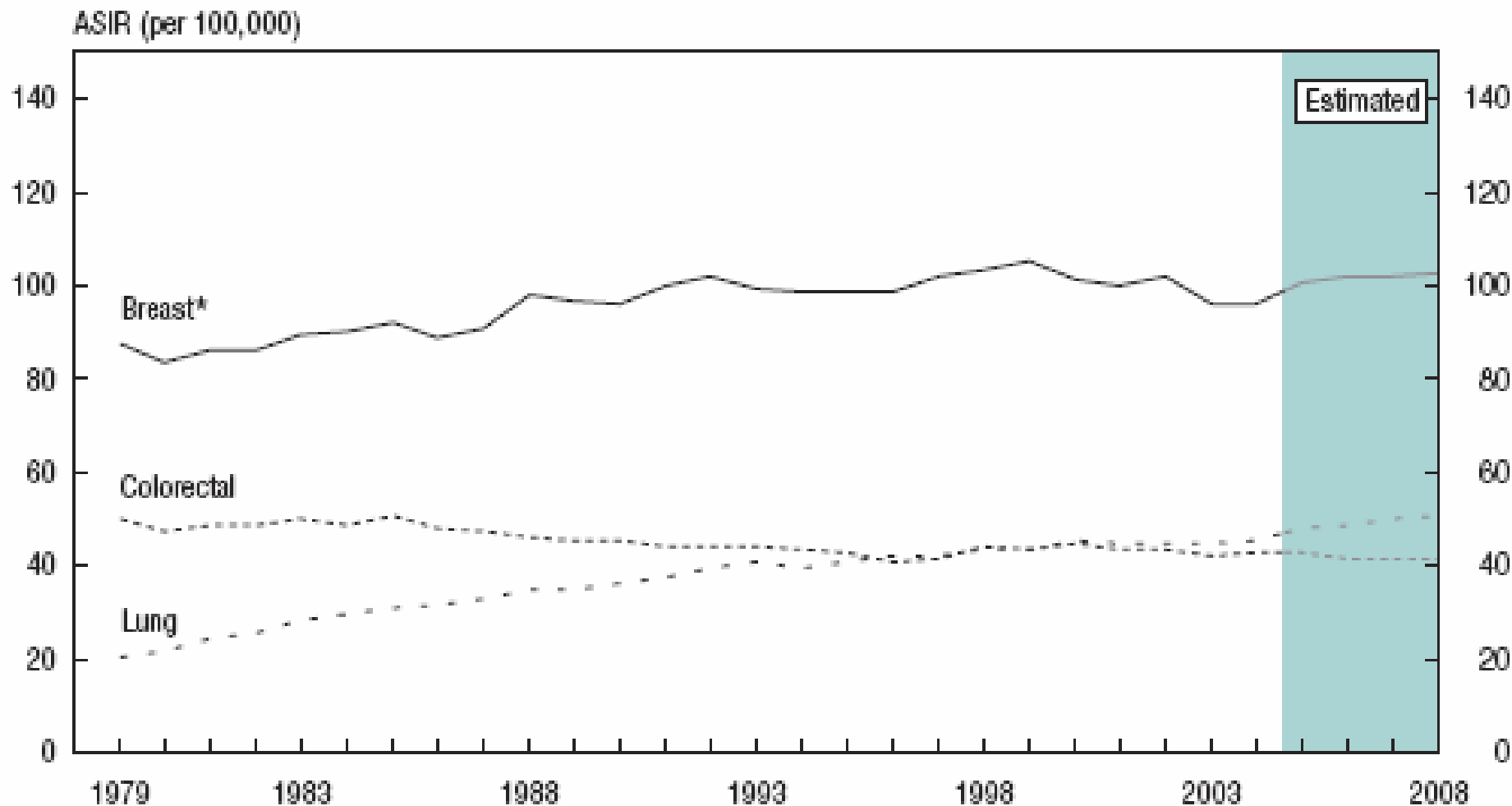
1. Literature review related to breast health practices in ethnocultural women
2. Project summary findings including facilitating and hindering factors for breast health practices among ethnocultural women in Windsor-Essex County
3. Implications for policy, education, and practice related to breast health promotion for ethnocultural women

# Age-Standardized Mortality Rates (ASMR) for Selected Cancers, Females, Canada, 1979-2008



Canadian Cancer Society/National Cancer Institute of Canada: *Canadian Cancer Statistics 2008*, p. 37

# Age-Standardized Incidence Rates (ASIR) for Selected Cancers, Females, Canada, 1979-2008



Canadian Cancer Society/National Cancer Institute of Canada: *Canadian Cancer Statistics 2008*, p. 36

# Why Breast Health?

Mortality and incident rates (CCS/NCIC, 2008, pp. 1, 22)

- Men - prostate, lung, and colorectal cancer
- Women - breast, lung, and colorectal cancer
- Breast cancer deaths in Canada declining since 1990
- >70yrs: 42% of new cases and 60% cancer deaths
- 20-59yrs: 30% new cases, 8% cancer deaths
- Cancer incidence rising in women aged 20-39

# Some Breast Cancer Facts... CCS/NCIC, 2008 estimates

## Canada

- 22,400 women will be diagnosed or 431 cases/wk
- 170 (1%) men diagnosed
- 5,300 women and 50 men will die of it

## Ontario

- 8,500 new cases of breast cancer in Ontario
- 2,000 women in Ontario die from breast cancer
- Breast cancer death rates in women aged 50-69 yrs have fallen 25% since 1986 (due to early detection, better treatment, healthier lifestyles)

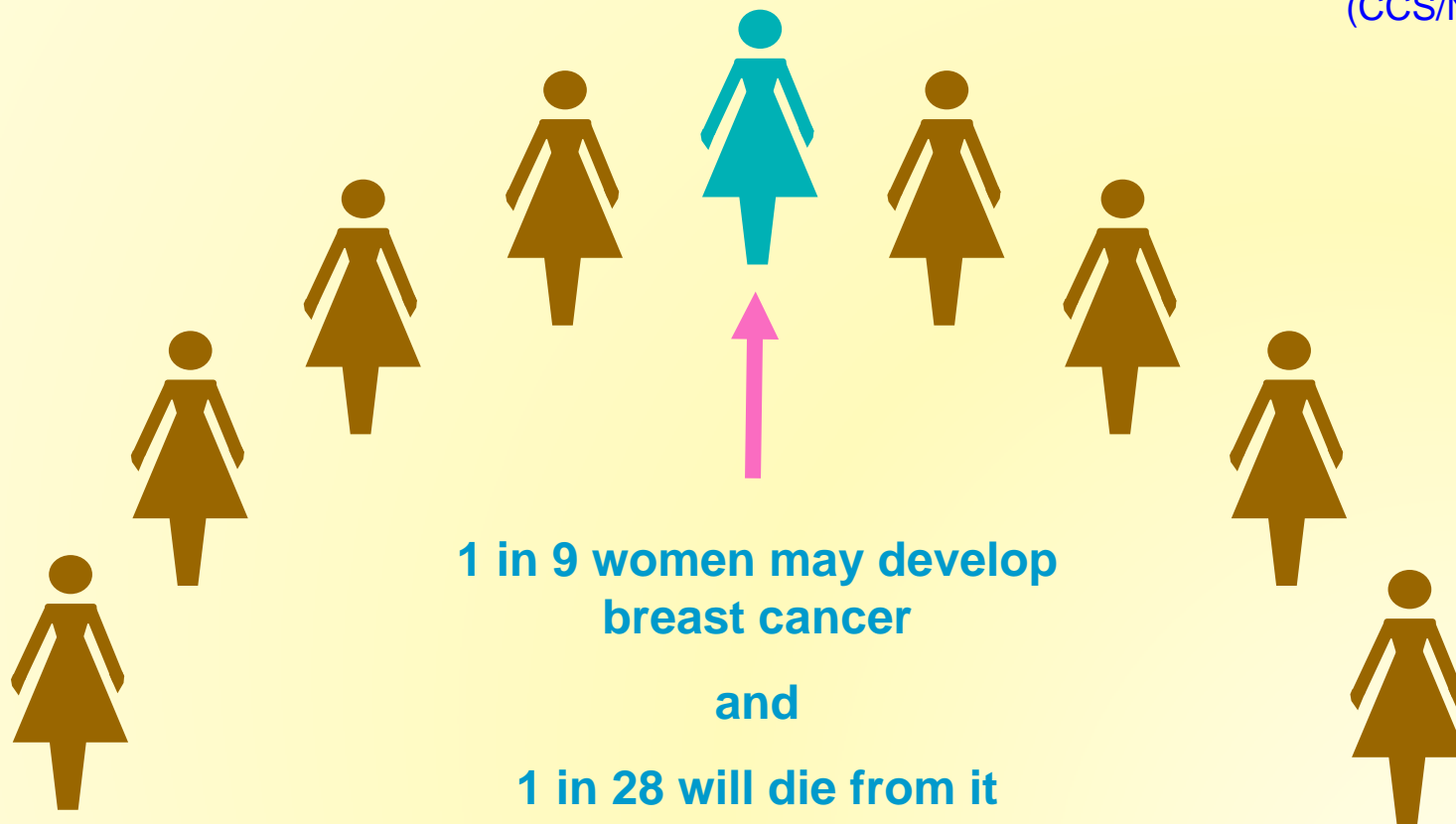
## Windsor-Essex County

- 10-12 women diagnosed with breast cancer every week



# Some Breast Cancer Facts

(CCS/NCIC, 2008)



# Immigrant Stats (Ontario Immigration, 2005)

- Community demographic profile
  - Windsor-Essex County 4<sup>th</sup> most ethnically diverse community in Canada
- 1 in 5 Canadian foreign born.
  - Highest ethnic groups: Asian, Middle East, & Black
- Shift in immigration profile since 1960's
  - newcomers face language and cultural barriers

## Immigrant Stats (Cont'd)

- Breast cancer - leading cause of death among women regardless of ethnicity & country (CCS, 2008)
- Limited research and data on ethnicity (Bottoroff et al., 1998, Rajaram & Rashidi, 2000)
- New cases of Breast cancer low in communities with high No. immigrants (CCO, 2008)
- Diagnosed at late stages → higher mortality rate (Gany et al., 2006; Hubbell et al., 1996)

# Screening programs

- Early cancer detection → ↑ survival rate (CCS, 2008)
- Screening program is underused (Bottoroff et al., 1998)
  - Lower screening rates for those in US < 10 yr (ACS, 2004; Scanlon, 2004, Watts et al., 2004) ).
  - low participation rate (34%-60%) women aged 50-69 (CCS, 2006)
  - 1/3 women practice BSE. Not all do BSE proficiently (Baines, 1994; Baxter, 2001)
  - Most lumps (80%) detected by women themselves who do not do BSE. Better to be breast aware (Love & Lindsey, 2005; Thornton & Pillarisetti, 2008)

# Ethnocultural Women & Breast Health

- Limited research; Incidence rate & mortality rates increasing. Women had cancer at lower ages (<50yr) (Petro-Bustas & Mikhail, 2006)
- In US, rate for first mammogram higher, but not for repeat screenings (Greene, Torio, & Klassen, 2005).
  - Only 10% had regular screening (Danigelis et al. 2005)
- Has info, but tend not to do BSE, not having CBE, & low rates of mammogram in F > 40 yrs (Ahmad & Stewar, 2004; Bottoroff et al., 1998; Choudry, 1998; Hiatt et al., 1996; Nakamura, 2001; Rashidi & Rajaram, 1999).

# ***Barriers for Breast Health***

- Accessibility - rural areas, transportation (CCSS, 2006)
- Beliefs
  - God's will/punishment (Bottoroff et al., 1998)
  - Not breastfeeding (Scanlon, 2004)
  - Trauma to breasts - caused by mammogram (Scanlon, 2004)
  - Lack of lifestyle, environmental factors
  - Hereditary (Scanlon, 2004)
  - Acute vs. preventive care (Yiu, 2008; Yiu & Ruggirello, 2007)

# ***Barriers for Breast Health*** (cont'd)

- **Emotional - fear** (Bailey et al., 2000; Baron-Epel et al., 2004; Cohen & Aziza, 2005, Consedine et al., 2004; Phillips, et al., 1999)
  - of diagnosis
  - of medical system
  - of level of embarrassment:
    - breast = taboo
    - Religion → need for female doctor
  - of burdening family members
  - of not able to carry on with family responsibilities

## ***Barriers for Breast Health*** (cont'd)

- Language/low literacy
  - had to rely on others (Bell et al., 1999)
- Income
  - major barrier in US, not in Canada
- Higher education
  - at least 1 screening only - but not for regular screening (Leong-Wu & Fernandez, 2006)
- Age
  - Older women more likely to participate in screening (Petro-Nustas, 2001, Straughan & Seow, 2000).



# What Facilitates Breast Health?

- **Physician** (Alpteter & Pennell, 2005; Consedine et al, 2004; Jackson et al., 2003; Greene, Torio, & Klassen, 2005; Petro-Nustus, 2001)
  - gender, ethnicity/culture/language, role
- **Transportation** (Bottorff et al., 1998)
- **Health promotion activities**
  - educational workshops  
(Gany et al, 2006; Rajaram & Rashidi, 1999; Watts et al., 2004)
  - Outreach, reminder letters  
(Bell et al, 1999; Brenner, 1997)

# Project Overview & Key Research Findings



# Research Questions

1. What are the ethnocultural women's experiences with breast health (e.g., BSE, CBE, mammography, and cancer treatment)?
2. What are effective education and awareness practice models for ethnocultural women to access breast health care?

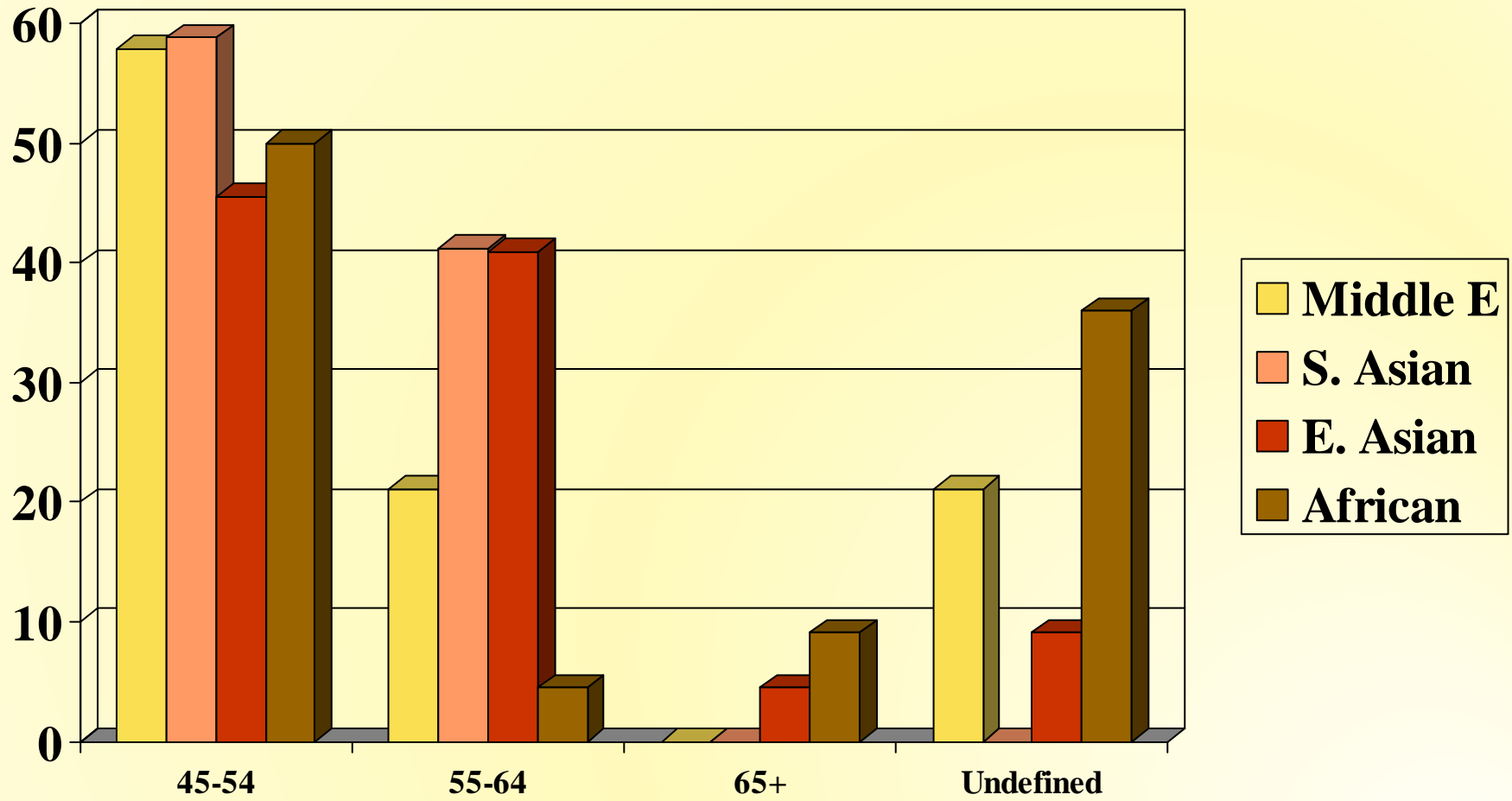
# Methodology/Samples

1. Qualitative study – 80 interviews
  - 22 East Asian
  - 19 Middle-Eastern & W. Asian
  - 17 South Asian
  - 22 African
2. Quantitative study
  - 18 workshops, 256 women

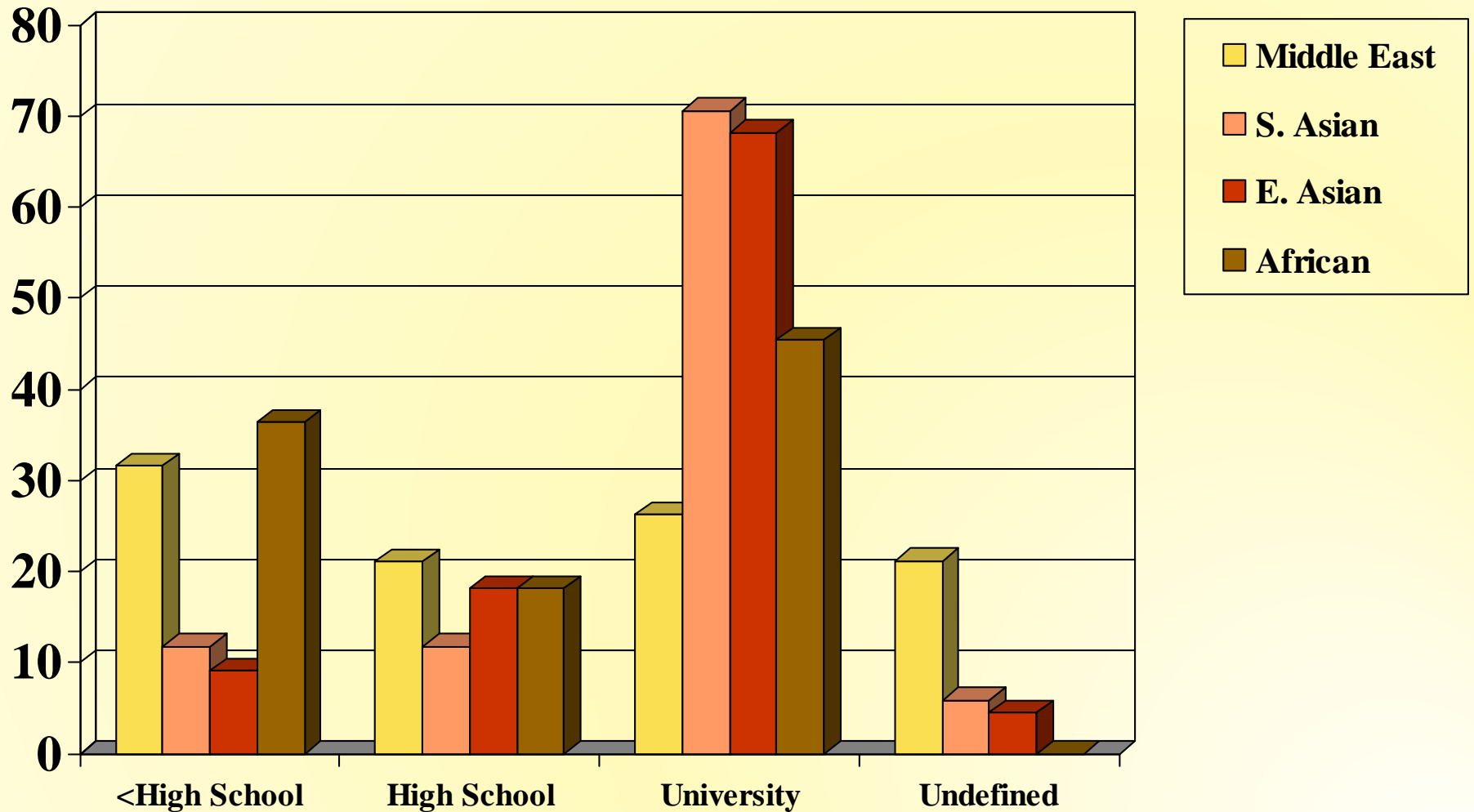
# Interviews

- Recruit participants and train research assistants
- Interviews in homes - 2006
  - used primary language of clients
  - audio-taped, transcribed, back translation
  - co-coded by 2 research assistants for validation

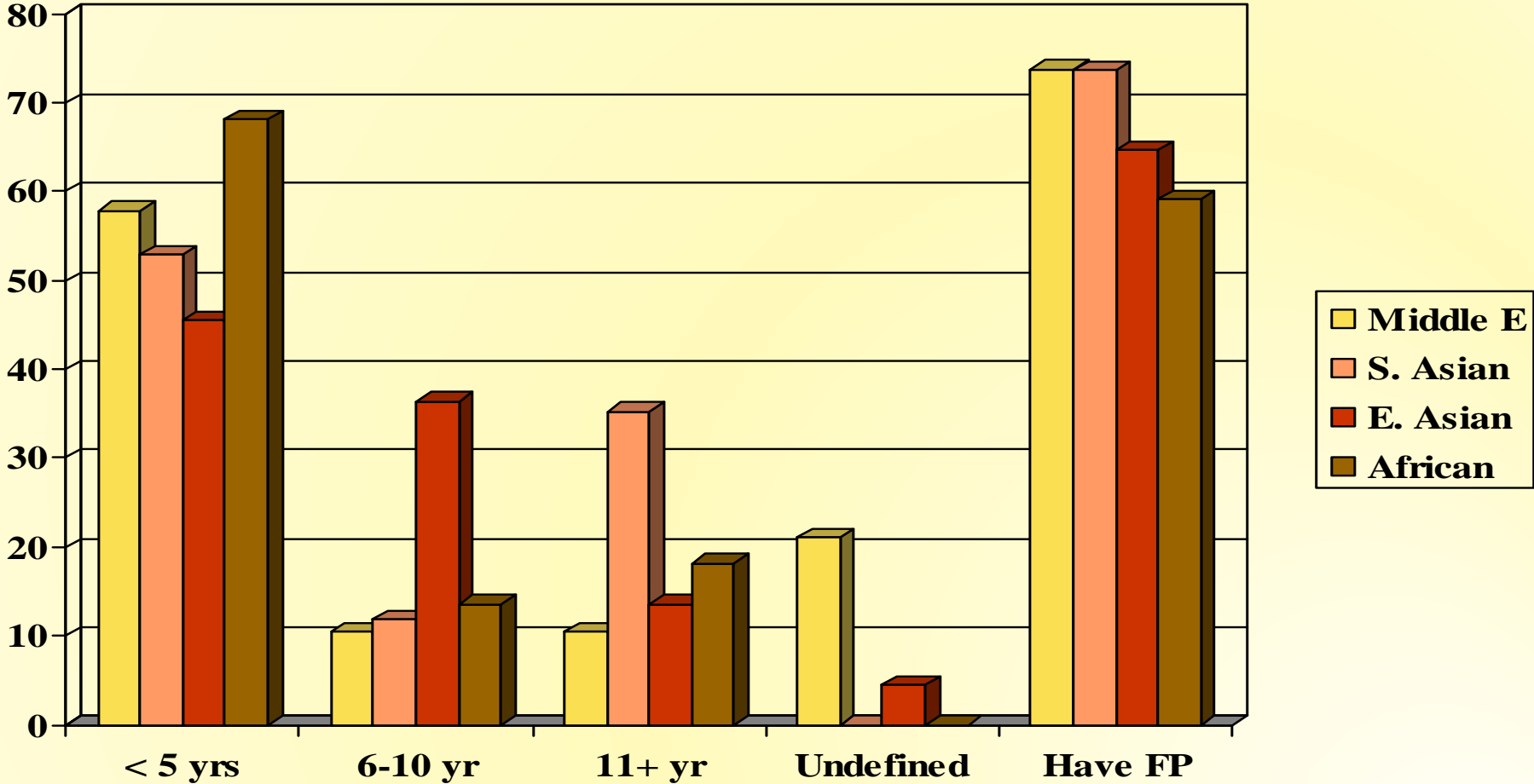
## Participants by Age (%)



# Participants by Education (%)



# Participants - Years in Canada + Have doctors (%)





# Findings: Barriers to Practice Breast Health

- Psychosocial-cultural
- Organizational
- Systemic

# Psychosocial: *Lack of knowledge*

- Information sources: friends/families, doctors, readings
- Knowledge of risk factors (lowest in African women)
  - Genetic factors
  - Diet – fresh fruits
  - Physical activities & environmental pollution
  - Mental health
    - E. Asian women: balance of energy and positive thinking
  - Breastfeeding can lower cancer
  - Why no/low rate of Breast awareness/mammogram/CBE
    - View self exam important but few did the breast exam
    - Fear, embarrassment (modesty)
    - Feels healthy, I am OK.

# Psychosocial: *Health seeking behaviours*

- View important for one to take control of life & is one's responsibility (in E. Asian/higher educated women)
  - yet followed FPs' advice
- Reliance on medical profession's advice
  - Do not do BSE but will do so if told by MDs or done for them
- Hindered by chronic illness/age/stress
- No transportation

## Psychosocial: *Cultural barriers* (cont'd)

- **Gender roles** that encourage women to prioritize other roles above caring for their health:

*“My health is not my priority. I (cannot think of doing) my exercises first and later think of other household stuff. If I had time, I would think of doing exercises; otherwise it is not important. I am okay. ...my health (is) not important. ..*

- No time (work/family), immigration adaptation
- Embarrassment and fear, prefer female physicians

*“Impossible, impossible to speak to a doctor, to a man, impossible”*

*“If the doctor is a man, I don’t go”. (Middle Eastern woman)*

## Psychosocial: *Cultural barriers* (cont'd)

- The **culture of silence and secrecy** about breast cancer:

*“Since birth, our society teaches us that these things are not to be talked about, that they are private. .... We think these things (are) dirty or wrong. So we run away from this information instead of acquiring it. We don't know how beneficial it is for us. This is missing from our culture..... the knowledge of breast health”*

## Psychosocial: *Cultural barriers* (cont'd)

- God's will - Belief that **fate/God** determines the risk and prognosis of breast cancer:

*"This is Allah's (God's) will. You can't get angry or complain about God's will; you have to live with it. In our religion (Islam), people think that God tests the person through illness, to see whether the person is patient and a strong believer with unshaken faith at times of hardship".*

## Psychosocial: *Cultural barriers* (cont'd)

- A **false sense of security** from cultural and religious practices that are deemed to offer:

*“I knew that this disease strikes women who are unmarried, don’t have a lot of children, don’t breast feed, or take hormones. So I was happy that our religion always encourages us to get married, have children, and breast feed. So to be honest, yes, I was happy, because of this“.*

- **Valuing** - much needed for others, but “I am OK”

# Organizational Barriers

- Lack of translation services to bridge language issues:

*“It is very frustrating when you have difficulty with communication”.*

*“... We cannot find out about things. ... our problem is not understanding or knowing English well enough. We all know what x-ray is; but women do not know what these other terms (mammogram, etc.) mean. If our women knew the details, then I am sure no woman would hesitate to go for tests or check up”*



# Systemic Barriers

- Lack of accessible transportation to breast screening centres
  - “we have to depend on our children to take us around”*
- doctor’s shortage
- Cultural and language barriers
  - Unfamiliarity with the health system, not knowing enough about breast health and where to learn it
  - Satisfaction & comfort level with own FPs are mixed.
- Treatment vs. prevention medicine
  - “If my family doctor told me I have to go this way, I go.”*
  - “The family doctor should at least start telling his patients ‘it is time for you to do it [mammogram]’”.*

# Systemic Barriers (cont'd)

- Insufficient female health care providers

*“After I came here, I know it is time to have a [mammogram]....  
But, once I went to my family doctor, it was a male doctor who  
was to examine me. I refused it.... I don't want male doctors to  
examine me. I want a female doctor. I don't know where the  
female doctors are.*

*“ Even with lady doctors, we feel shy when they check our ...you  
know...our private things... ”*

# Systemic Barriers (cont'd)

- Doctors' shortage
  - Inability to access a doctor for screening
- Referral system is too complicated
- Need for effective cultural competent health promotion strategies
  - Doctors/nurses need to advise patients for screening or referral
  - Inadequate translated materials
  - Inadequate cultural oriented/based health promotion workshops
    - *“Since this is a multicultural country, it should equip some special organization and units according to each individual culture. We do not want some strange male doctors to touch us, to see my private area” (E Asian)*

# What Facilitate Breast Health?

- Information/awareness/promotion/“propaganda”

*“Why are there so many people in churches? Because they come door to door, distributing flyers and contact no. so that we can call them. If we ask them to come, they come to our house every week, giving us the Bible, and explaining it to you. They even invite you to their houses. Very effective! If we can do the same for breast cancer prevention, it will be very good.” (E. Asian woman)*

- Physician referrals & reminders
- Social support (family, friends, & community)
- Universal and mandatory screening program

# Summary of Sample Characteristic at Baseline (based on 249 of 256 women)

Sample Characteristics	%	Sample Characteristics	%
<b>Age</b>		<b>Citizenship status</b>	
Under 19 years	3.6	Landed immigrant	44.6
20-39 years	48.2	Citizen	41.8
40-49 years	25.7	Refugee claimant	5.6
50-69 years	19.3	Other	3.6
70 years or older	0.4	<b>Importance of religion</b>	
<b>Marital Status</b>		Very	73.9
Married/Common law	63.9	Somewhat	12.0
Separated/divorced	4.8	Not at all	4.8
Widowed	6.0	<b>Employment Status</b>	
<b>Education</b>		Not employed	68.7
Elementary school	11.6	Full-time	10.4
High school	30.5	Part-time	11.2
University/college	51.8	<b>Household income</b>	
<b>Children</b>		Less than \$30,000	50.2
Yes	90.4	\$30,000-50,000	12.0
No	8.4	\$50,000 or more	10.8
<b>Family Physician</b>			
Yes	80.3		
No	14.1		

# Breast Cancer Screening Practices at Baseline

Had mammogram done	36.5%
Mammogram within last yr	19.7%
Had CBE	35.7%
❖ Within 2 yrs	7.6%
Awareness of BSE	71.9%
❖ Doing BSE	41.8%
❖ Doing BSE monthly	24.1%

# Pre and Post Test Findings

(Comparison of mean responses on all outcome scale scores based on the language in which the workshop was conducted)

	<u>Baseline</u>		<u>Follow-up</u>	
	<u>English</u> n=87	<u>other</u> n=162	<u>English</u> n=87	<u>Other</u> n=162
<b>Knowledge (Mean scale score)</b>				
<b>Range (0-13)</b>	<b>9.75</b>	<b>9.00 *</b>	<b>10.94</b>	<b>10.33*</b>
<b>CBE benefits (Mean Scale score)</b>				
<b>Range (0-5)</b>	<b>3.93</b>	<b>3.83</b>	<b>4.28</b>	<b>4.27</b>
<b>CBE barriers (Mean Scale score)</b>				
<b>Range (0-8)</b>	<b>4.6</b>	<b>4.49</b>	<b>6.49</b>	<b>6.24</b>
<b>Mammogram benefits (Mean scale score)</b>				
<b>Range (0-5)</b>	<b>4.10</b>	<b>4.02</b>	<b>4.54</b>	<b>4.25</b>
<b>Mammogram barriers (Mean scale score)</b>				
<b>Range (0-9)</b>	<b>5.12</b>	<b>5.11</b>	<b>7.53</b>	<b>7.32</b>

\* Denotes significant difference between the means at the .05 level.

\*\* Denotes significant difference between the means at the .01 level or better

# Knowledge... *At Post-test*

- Participants had an average scale score that was significantly higher than at baseline (indicating a higher level of breast cancer and screening knowledge overall following their participation in the HPW).
- Significant difference is concentrated in specific areas; specifically:
  - Women 50+ should have mammogram
  - Bruising and bumps do not cause breast cancer
  - Self-breast examination should be performed once-a-month
  - Breast cancer cannot spread from person to person
  - Radiation from mammogram not a serious health risk
  - Non-pregnant women should see a doctor if there is a discharge from the nipple.



# Language

- Language used in HPWs had no impact on outcome measures except on knowledge scale scores.

- Women in “non-English language” workshops:

## **At pre-test**

- had lower overall knowledge scale scores than their counterparts in English workshops

## **At post-test**

- showed a very marginal non-significant greater improvement in knowledge at follow-up,

# Conclusions

- Limitations - Bias in translation, sample, research assistants
- Findings similar to previous studies in literature
- Link education to practice
- Address health equity
- Promote women's health
- Need for cultural-based and competent breast health services
  - overcome language and cultural barriers
  - equity in health

# Conclusions (cont'd)

- Continued service improvement (Education and Practice)
  - Focus on the needs of ethno-cultural women
  - Engage all partners in breast health promotion
- Knowledge is power to influence policy change
  - Women need information about breast cancer prevention
  - Breast awareness and BSE controversy (see Baxter, 2001)
- Women's health is important & family roles
  - consider own health as seriously as other priorities
- Ongoing promotion and dialogue to translate ideas to action



**Thank you  
&  
Questions**

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