



Review

Breast cancer in ethnic minority groups in developed nations: Case studies of the United Kingdom and Australia



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ABSTRACT

Recent research from the United Kingdom (UK) has highlighted some of the differences in breast cancer presentations between women of different ethnic groups. Analysis of a large database showed that Black women of African or Caribbean heritage living in England and Wales are more likely to present with stage 3 or 4 cancer than White British women and less likely to have their cancer detected through screening. In many countries around the world, migrant and cultural minority groups experience social and economic disadvantage and this is reflected in their health outcomes. With world migration at record levels, it is timely to reflect on ethnic disparities and to consider how developed nations can care for their minority groups, which are increasing in number and diversity. These issues and challenges are discussed, using the UK's migrant population and Australia's Indigenous and migrant populations as case studies.

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1. Introduction

The developed nations of the United Kingdom (UK) and Australia have among the highest incidence of breast cancer and the high-

est survival rates in the world [1]. However, these countries have minority groups for whom survival outcomes fall far below those of the general population. This article explores some of the disparities, using the migrant population in the UK and the Indigenous and migrant populations in Australia as examples. It discusses the challenges and some of the initiatives attempting to address them.

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2. United Kingdom

2.1. Recently published data

In England and Wales, Black African, Caribbean and British people make up 3.3% of the population (2011 census data) [2]. The largest ethnic group in the UK is White (86% of total population) followed by Asian (7.5%, including Pakistani/Bangladeshi 5.25%, Indian 2.5% and Chinese 0.75% subgroups). Breast cancer incidence is lower in South Asians (RR = 0.82) and Blacks (RR = 0.85) and this is almost completely explained by differences in known reproductive and lifestyle risk factors as well as socioeconomic factors [3,4].

Cancer Research UK recently released cancer data on 87,485 breast cancer diagnosed in England in 2012–2013. Analysis by ethnicity showed that Black African and Black Caribbean women are nearly twice as likely to be diagnosed with late stage breast cancer as white women in England [5].

Twenty-five per cent of Black African women and 22 per cent of Black Caribbean women with breast cancer are diagnosed at stage three or four, compared to 13% of White British women. Asian (Pakistani and Bangladeshi) and Chinese women have a similar stage profile to White British women [5]. Route-to-diagnosis data show that 20% of breast cancers in Black women are screen-detected, compared to 30% in White, Asian and Chinese women. Diagnosis via GP referral (outside of the two-week wait pathway) was more likely for Black women (14%, compared to 8% in White women). The proportion of diagnoses through the two week wait pathway was also higher in Black women (57% vs 52%). Emergency presentations were similar (around 4% in both groups) [5].

Diagnoses in Black women made up only 1.7% of breast cancer cases ($n = 1551$) and Asian/Chinese 3.1% ($n = 2719$) in the two-year study period. These proportions are small; however it is likely that they will increase due to increases in number of migrants as well as increased incidence due to changes in risk profile that often result as subsequent generations take on the reproductive and lifestyle behaviours of their adopted country.

The recent breast cancer findings from Cancer Research UK are consistent with previous research from England that showed lower incidence in Black, women compared to White women, but a higher likelihood of cancer being more advanced at diagnosis in Black women [4]. This study, published in 2009, also found that Asian and Chinese had worse outcomes compared to White women. Overall survival was similar in all groups when corrected for age, stage and treatment, but cancer-specific survival was still significantly lower for Black African women compared to the other groups [4]. In the UK, Breast screening is offered to all women aged 50 year and over (targeted to age 50–70) but uptake in minority groups is often lower [6,7].

2.2. Strategies to address disparities

Specific 'Black health' information is available on the NHS Choices website [8]. This focuses on key health issues including hypertension, diabetes and prostate cancer as these are the more common health conditions affecting the population [8]. Black women have noted that there is no specific information about breast cancer screening for Black African and Caribbean women, and many Black women do not feel engaged with the existing NHS screening information as they do not feel that the content and imagery represents them [9].

Several specific interventions to increase uptake of breast cancer screening in minority groups have been trialled in the UK. These have added other interventions to the standard letter of invitation sent by mail [6]. Text messages significantly increased first screening participation in an ethnically diverse group of women in London [10], and culturally/linguistically tailored telephone calls

increased uptake of screening in GP practices with a large South Asian population, but the effect was not seen in practices with a larger Black population. A follow-up postal letter is also an effective way to increase participation in screening in disadvantaged parts of England [11].

While these strategies may be effective in some minority and/or disadvantaged groups, there is no randomised evidence of effect specifically in Black women, and increasing screening participation is only one aspect of to consider. A comprehensive approach is required, and this must include education about symptoms of breast cancer to encourage earlier presentation when symptoms develop and reduce the proportion of later-stage presentations.

It is encouraging that screening participation and rate of later-stage presentations in Asian women in the UK (previously similar to Black women) [4] are now similar to those of White women. In Canada, the reverse is seen: the lowest rate of breast screening participation was found in immigrant women from South East Asia (48.5%) and the highest participation was in women from the Caribbean and Latin America (63.7%) [12]. This suggests that the lower participation rate in some immigrant women in the UK may be due to lack of awareness rather than being related to the cultural beliefs of their region of origin acting as barriers to screening.

3. Australia

3.1. Historical background

Aboriginal and Torres Strait Islander people have inhabited the Australian mainland and surrounding islands for around 60,000 years [13]. For most of this time, they lived an itinerate hunter-gatherer life with a very strong connection to the land and sea and they were the only inhabitants before the arrival of British colonists in 1788. There were approximately 700 languages spoken throughout Australia and there was an estimated population of 750,000 Aboriginal and Torres Strait Islander people before 1788. Today there are around 400,00 Indigenous people and they make up 2.5% of the Australian population [14]. The proportion is increasing as population growth in this group is higher than that of the general population [14]. Since the arrival of European settlers, Aboriginal and Torres Strait Islander people have suffered devastation due to introduced illness, violence, dispossession of their land and a series of controversial government policies, many of which have removed rights of control and self-determination. Aboriginal and Torres Strait Islanders now suffer shorter life expectancy, worse health outcomes, higher socio-economic disadvantage, higher incarceration rates, higher unemployment rates, lower literacy and a constellation of social justice issues compared to their non-Indigenous Australian counterparts [13].

3.2. Breast cancer statistics

The incidence of breast cancer is 30–50% lower among Aboriginal and Torres Strait Islander women than non-Indigenous Australian women [15,16]. This is likely due to more favourable reproductive and lifestyle risk factors inherent to cultural traditions. Cancer outcomes, however, are worse by every measure: compared to non-Indigenous Australians, cancer in Aboriginal and Torres Strait Islander women tends to be larger at diagnosis (43.4% vs 38.5% have a tumour size >15 mm), the mastectomy rate is higher (35 vs 28% for screen-detected invasive cancer), the mortality rate is higher (5-year survival 81% vs 90%) and the risk of death from breast cancer is 68% higher [17]. These outcomes are thought to be related to much lower participation in the national screening program (36.3% vs 57.5%), challenges of access to treatment in rural and remote areas, cultural beliefs and issues of trust that may affect

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