European Journal of Oncology Nursing 15 (2011) 173–177

Contents lists available at ScienceDirect

European Journal of Oncology Nursing

journal homepage: www.elsevier.com/locate/ejon

Perceptions of breast health awareness in Black British women

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Keywords:
Breast health
Black British women
Perception
Health education
Breast cancer

A B S T R A C T

Purpose: Breast cancer is a global concern. Published studies indicate that 43% of Black and ethnic minority women interviewed have reported that they did not practice breast awareness because they did not know the relevant breast changes that occur in breast cancer. Black women are also more likely to receive a diagnosis of breast cancer when it is in an advanced stage. This pilot study aimed to address the views of Black British women on breast health awareness and breast health screening practices.
Methods and sample: In this qualitative study I used semi-structured interviews were used to investigate breast health perceptions, practices and education in a pilot sample of ten women.
Key Results: Women held numerous perceptions of breast cancer which ranged from no knowledge to well informed through receiving extensive education. Two out of ten women were relatively uneducated with regard to breast self examination (BSE). The remaining eight women participated in a variety of screening routines which varied from undertaking BSE everyday to once every few months. Women's experience of breast health education was also variable. One woman, younger woman, had not received any health education advice in relation to breast health awareness or BSE. The remaining nine women had received some health advice following visit to their General Practitioners, Medical consultant, media information or as a result of participating in mammographic screening.
Conclusions: Black British women require health education that focuses on breast cancer and its associated risk factors, technique of BSE, and national breast cancer screening recommendations.

Introduction

Breast cancer is a global disease and represents not a single disease but a group of tumour subtypes which predominantly affects women (Cancer Research UK, 2010). Women have one in nine chances of developing breast cancer at some time in their lives (Cancer Research UK, 2010). The development of breast cancer is independent of race, ethnicity, religious belief and social status. Breast cancer is not only a multi-ethnic disease but is also the most common form of cancer in ethnic women from first generation immigrants such as Black women (Breast Cancer Research Campaign, 1997).

Although recent data from the US and the UK suggest that Black women have a lower incidence of breast cancer compared to Caucasian women (Grann et al., 2006; Smigal et al., 2006; Jack et al., 2009), the stage of the breast cancer on diagnosis may differ. Li et al. (2003), Grann et al. (2006) and Morris et al. (2007) found that on diagnosis, Black women were more likely to present with an advanced stage of breast cancer. In many cases an aggressive form of disease may be present such as triple-negative breast cancer (Jack et al., 2009). This form of the breast cancer may not respond to chemotherapy and hormonal therapy (Cleator et al., 2007). In contrast, Hahn et al. (2007) reported that Black and Caucasian women presented with a similar stage of breast cancer on diagnosis. Comparisons were made in relation to demographic details, method of detection and breast cancer characteristics. However, Black women differed from Caucasian women with respect to survival characteristics. Reports suggest that Black women have poorer survival data than Caucasian women even when taking in to account the cancer characteristics in terms of stage and size as well as age and demographic details (Li et al., 2003; Grann et al., 2006). In such cases women require earlier detection (Jack et al., 2009).

Although England has a national breast screening programme, the uptake of screening among ethnic minority women is low (DH, 2003), particularly in inner city areas. (Pfeffer, 2004). This may be due to failure to associate mammography with breast cancer (Kernohan, 1996); reduced referrals by physicians (Ansell et al., 1994), reluctance to undertake breast cancer screening (BCS) due to previous negative mammogram screening experience (Thomas, 2004); deficient support from partners and spouses (Facione and Katapodi, 2000) or economic factors that impede travel (Moser et al., 2009). Poor uptake of mammography may also be associated

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doi:10.1016/j.ejon.2010.07.007

with inadequate knowledge about the aetiology risk factors of breast cancer (White, 1997; Breast Cancer Care, 2005; Scanlon and Wood, 2005). A recent study identified that up to 43% of Black and ethnic minority women had a limited knowledge of breast health awareness and did not know what to look for in terms of breast cancer changes (Scanlon and Wood, 2005). This finding concurs with previous reports (Breast Cancer Care, 2004).

Current state of research

Five studies have examined the experiences of Black women and ethnic minority women in relation to breast self examination (BSE), breast cancer and BCS in England. One study found that investment in breast health awareness at a community level could improve understanding (Kernohan, 1996). In recent studies, black women and ethnic minority women had less knowledge of breast cancer, associated risk factors or participated in BSE compared to Caucasian women which may have been related to deficient family history (Breast Cancer Care, 2004, 2005, Scanlon and Wood, 2005). The limitations of these studies infer that there is a need to examine breast health awareness in Black British women in order to provide an accurate account of their impressions about the disease and current BCS practices.

More recently Waller et al. (2009) investigated individual ability to recognise cancer symptoms and reasons for not investigating abnormal symptoms. Black African women demonstrated poorer recognition, understanding and awareness of abnormal symptoms. Findings indicate a need for greater understanding of how cancer is conceptualised by various ethnic groups of women particularly in Black women.

The aim of this pilot study was two-fold. First to explore the views and attitudes of Black British women in relation to breast health awareness and breast cancer screening practice. Second to examine Black British women's experience and exposure to breast health education.

Methods

This exploratory, descriptive qualitative study used qualitative procedures to collect and analyse pilot data using individual semi-structured individual face-to-face interviews with ten women. Interviews were undertaken by the author at a convenient time and location for each participant. The questions used in the interviews were developed from the available literature on breast health awareness and breast cancer in relation to Black women. This literature is predominantly US based, therefore questions were carefully developed to ensure relevance to Black British women. The interview guide was also informed by relevant experience of interviewing ethnic minority women with cultural sensitivities towards breast health awareness and breast cancer. The interview guide was assessed internally by a relevant cancer nurse specialist prior to the commencement of the study. The interview questions included series of questions that included the following: When did you first become aware of breast health awareness? Do you know of any risk factors associated with breast cancer? What do you understand by the term breast cancer screening? How often do you undertake breast self examination? Have you received any breast health education? If yes can you describe what advice you received and who provided the advice?

Interviews were tape recorded and transcribed verbatim. Ten interviews were undertaken with Black British women from a variety of health and social care professions. Interviews lasted up to 30 min with a mean time of 20 min.

All women were provided with a participant information sheet outlining the ethics of participation and the right to withdraw at any time (DH, 2000). Prior to the interview, participants were asked to complete and sign an ethics consent form which provided their permission for interviews to be audio tape recorded. Participants were assured that all data received would remain confidential and identities would not be revealed in all presentations and publications developed from the study. The interviews were coded for identification purposes and the taped interview files were kept in the author's personal computer with restricted access and an encrypted password. The author undertook all interviews and has sole access to the interview files. Individuals were informed that all interviews would be digitally recorded and transcribed verbatim. All participants were informed that the study was approved by the University Research Ethics Committee (DH, 2004).

Sampling procedure

Initially the study was advertised in gyms, relevant churches, mosques and Black ladies hairdressers and Black women's groups. However these approaches were unsuccessful and failed to generate interest. Snowball sampling was therefore used to recruit a sample of Black British women employed in schools, universities, local industry and health and social care environments. Snowball or networking method is used when target groups are either difficult to reach or where subjects are sensitive (Boeije, 2010). The researcher approached a University lecturer who developed an interest in the study and encouraged a work colleague to participate in the study. Following this initial contact, the interviewee encouraged friends and relatives to also participate in the study. The sampling frame included women aged between 27 and 58 years of age with no personal history of breast cancer, who could speak fluent English, who were the resident in the UK for at least five years to ensure that they access to health promotion/health education provided by General Practitioners and the Department of health, but also to include Black British women with an age range and socio-demographic variables to obtain a representative sample of Black British women. See Table 1.

The sample involved ten Black British women with no personal history of breast cancer. When no new codes were being developed from the interview data questions a sample of ten women was thought to be sufficient.

Framework for analysis

Thematic analysis was used to analyse the interview data (Miles and Huberman, 1994). This is a tried and tested approach that is used to analyse qualitative data and involves "the process of segmentation, categorisation, relinking of aspects of the data base prior to final interpretation" (Gbrich, 2007, p. 16). During thematic analysis, data is reduced to illustrate repeated words, phrases and evidence of answers to research questions. This process involved both file and block (to categorise data) and conceptual mapping approaches which allowed data to be reduced into meaningful groupings. Conceptual mapping allows the researcher to summarise the data and provide a neat visual display of the data. These approaches enhance the development of conceptual units of meaning, categories, concepts, repeating patterns and clusters that influenced the development of emerging themes.

All participants received a copy of the transcribed interview and were asked to verify the interview transcription.

Numerous verification strategies were employed to help to attain the reliability and validity of the data and rigour of the study and assist the direction of analysis. The first strategy involved methodological coherence. This aimed to ensure that there was cohesion between the methods chosen and the research question but also that the sampling strategy ensured that the sample