

Breast cancer and breast screening: perceptions of Chinese migrant women living in New Zealand

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ABSTRACT

INTRODUCTION: Migrant Chinese constitute a significant and increasing proportion of New Zealand women. They have lower rates of participation in breast cancer screening than other New Zealanders, but reasons for this are unknown. The aim of this study was to investigate factors affecting Chinese women's understanding of, and access to, breast health services, to better understand reasons for low participation in screening and their experiences of breast cancer clinic care.

METHODS: The participants were 26 Chinese migrant women—19 recruited in the community and seven recruited from 17 eligible women attending a breast clinic between 2008 and 2010 in Wellington, New Zealand. The design was that of a qualitative study, using semi-structured interviews and thematic content analysis.

FINDINGS: There were low levels of awareness about the national breast screening programme and limited engagement with preventive primary care services. Concerns about privacy and a range of communication difficulties were identified that related to oral language, lack of written information in Chinese, and limited understanding about Chinese perceptions of ill health and traditional Chinese medicine by New Zealand health professionals.

CONCLUSION: Addressing communication barriers for Chinese migrant women has the potential to raise awareness about breast cancer and breast health, and to increase successful participation in breast cancer screening. Greater efforts are needed to ensure this group has an understanding of, and is engaged with a primary care provider. Such efforts are key to improving health for this growing sector of the New Zealand population.

KEYWORDS: Breast cancer; Chinese; mammography; mass screening; New Zealand

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Introduction

Breast cancer is the most prevalent female cancer in New Zealand and currently accounts for more than a quarter of all cancer diagnoses in women.¹ Although Asian women in New Zealand have a lower, although increasing, rate of breast cancer registrations than the New Zealand population as a whole,^{2,3} they also have a lower uptake of mammography screening (57% vs 69%).^{3,4} Chinese (migrant and New Zealand-born) make up almost half of the fast-growing population of Asian people in New Zealand, which increased to 11.8% in the 2013 census.⁵⁻⁷

Internationally, immigrant Asian women appear to access cancer control services less often than local populations. For example, South-East Asian women in California have been shown to have lower cancer rates and lower access to both breast and cervical screening services, due to such factors as lack of knowledge about cancer symptoms, lack of transportation and facilities, language barriers and issues relating to cultural modesty.⁸ People have different attitudes towards mammography and those with better communication skills have been shown to have a higher rate of uptake.⁹⁻¹² A systematic review of mammography screening utilisation confirmed that past

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screening experience was closely linked with the uptake of mammography.¹³ Lack of a primary health provider or recommendation by a physician reduced the likelihood of seeking screening, and minority ethnic women usually had lower utilisation of these services compared to resident white women.¹³

Little research has been conducted in New Zealand to explore factors determining understanding of, and access to, breast screening and breast cancer services by Chinese women. With increasing numbers of Chinese women coming to and living in New Zealand, it is important to identify and address their health needs, including appropriate access to health services.

This study used a qualitative approach to investigate factors affecting Chinese women's access to, and use of, breast health services (breast screening diagnostic services treatments for breast cancer and other support services) in the Wellington region. By gaining a better understanding of Chinese women's beliefs about breast health and breast cancer, reasons for low participation in screening and experiences of breast cancer clinic care will be better understood.

Methods

A qualitative approach using individual interviews (conducted in a preferred language) and thematic content analysis¹⁴ was employed as an appropriate way to explore views of Chinese women living in New Zealand about breast cancer, screening and breast health services. Ethics approval for the study was granted by the Central Regional Ethics Committee (Ref. CEN/10/12/058).

Participants

Participants were recruited in two ways. Chinese women who had attended a public hospital breast clinic with suspected or confirmed cancer between 2008 and 2011 were identified from the hospital database and sent a letter of invitation to the study. The invitation included an information sheet describing the study, a consent form and the offer of a supermarket voucher as a token of thanks to participants. Reminder letters were

sent four weeks later to non-responders. Chinese women aged 40–70 years were also recruited through community settings, local Chinese newspapers and the use of 'snowballing'¹⁵ via other participants. All written materials relating to the study were provided to potential participants in both English and Chinese.

Data collection

Interviews were conducted face-to-face in a private consultation room, or at a place convenient to the participant. The interviews were conducted in either Chinese (Mandarin) or English according to the participant's preference, by one female, bilingual interviewer with experience living in both New Zealand and China. With the participant's consent, interviews were audio-recorded and later translated and/or transcribed by two experienced transcribers (both fluent in Mandarin) to ensure accurate and unbiased representation of conversations.

Demographic data collection included age, ethnicity (using the 2001 New Zealand Census question), country of birth, time in New Zealand, education, English proficiency, and employment status. To enable flexibility of questioning based on participants' responses, a semi-structured interview schedule was used to enquire about culture and health beliefs, knowledge of risk factors for breast cancer, awareness and experience of breast cancer and screening, incentive to use screening or reasons for non-use, and sources of information about breast health services. Breast clinic patients were also asked about their experiences with breast health services and treatments they had received. Recommendations for improvements in access to information and services were sought. Interview questions were informed by discussions with key informants, including staff working in primary care, breast screening services and the public hospital breast clinic.

Analysis

Interviews with Chinese participants were transcribed verbatim (and translated if required), and transcripts read and re-read to establish familiarity with content. Thematic content analysis¹⁴ was undertaken by the interviewer, with preliminary

coding notes made prior to discussions among the authors to develop themes from interpretation of the data.

Findings

Participation

Twenty-six Chinese women (all migrants) took part. Of the 17 Chinese women who attended the Wellington breast clinic from 2008 to 2011, seven agreed to be interviewed (three had been diagnosed and recovered from breast cancer). Nineteen women were recruited and interviewed from the Chinese community; 15 were in the eligible age-range for free mammography screening. The women's ages ranged from 34 to 74 years. Twelve of the women had lived in New Zealand less than five years, five between five and nine years, and nine for more than 10 years. Fifteen participants had some tertiary education, nine worked full-time, and 13 spoke reasonably fluent English (as assessed by the interviewer, and via self-reported information provided on the demographic data collection form).

Themes

Data from the transcripts of all 26 women were used in the analysis and coding was undertaken manually. Key points identified in the analysis are presented as themes identified from reading and re-reading the transcripts and coding of the data. Illustrative quotes are used to provide insight into women's views, including those that were unique to an individual and others that were common to several participants. Key findings relating to health care in New Zealand, perceptions of breast cancer and breast health, breast screening, investigation of breast abnormality, and communication barriers to care are presented below.

Health care in New Zealand

For most participants, their general practitioner (GP) was the first point of contact if they were unwell, although six women were not registered with a GP. Most had participated in cervical smear testing, but few had otherwise sought regular health check-ups or had consultations for

WHAT GAP THIS FILLS

What we already know: Asian women in New Zealand have lower than expected participation rates in breast cancer screening, perhaps consistent with international trends for immigrant Asian women elsewhere. Explanatory factors, such as perception of lower cancer risk, lack of knowledge about cancer symptoms, poor access to services, language barriers and differing health beliefs, have been suggested in the international literature but we have little knowledge about possible such factors in a New Zealand context.

What this study adds: Chinese migrant women had variable knowledge about breast cancer and the role of breast cancer screening in New Zealand. A range of communication barriers were identified, as well as important differences between health services in Asia and New Zealand. Some participants had no primary care provider or saw little need to engage with primary care, being more familiar with wholly hospital-based health care for serious health problems, such as cancer.

breast health. Interviewees had generally positive views towards New Zealand health services, stating that they were easy to access; had friendly, respectful and helpful staff; and were clean, less crowded facilities than in home countries.

She [the doctor] is very patient. ... It was the first time in my life that I got such a thorough check. I don't think it's possible that I get such [a] check in China. ... I was really satisfied with their service. (#1; community interviewee)

Women said that they generally felt comfortable if they had to talk with their GP about breast health, as it was all part of the process.

You are seeing a doctor, not chatting gossips. It's doctor's duty to treat a patient. (#2; community interviewee)

The 'medical experience' though, was noted to be different to that in China. Participants wanted comprehensive advice. They were not used to being given as many choices regarding care and treatment, and sometimes found the lack of direction from New Zealand doctors unsatisfactory.

I hope the doctors here can learn from the Chinese counterparts and tell patients clearly their own professional judgment and provide sound advice. It seems ridiculous to let the patient decide what to do since patients have no professional knowledge... I

think doctors should not only consider the psychological impact and your beauty/image, but tell you everything. (#3; breast clinic interviewee)

Concerns were also expressed by some about the competency and level of experience of doctors in New Zealand when compared with their counterparts in China.

Both doctors and nurses are very considerate and nice to patients. But compared with the doctors in China, they are not as experienced. They haven't seen many difficult or rare cases, so it is challenging for them. (#4; community interviewee)

Perceptions of breast cancer and breast health

Although Chinese women are considered to have a low rate of breast cancer, participants mentioned breast cancer among friends and colleagues in China. All community participants had known someone with breast cancer (extended family members, friends, or colleagues), so had second-hand experience of others' situations. Women recognised that breast cancer was serious and

problems, and Chinese medicines to recuperate. (#2; community interviewee)

We all know that chemo treatment... causes very strong side effects... common knowledge now. In contrast, Chinese medicine treatment causes much less harmful side effects because it aims at the whole body and at [repairing] the immune system... so that the good cells of our body can conquer the bad cells. (#5; community interviewee)

When asked what they would do if they found a breast lump, most participants said they would visit their doctor immediately. A few said they would not take any action for reasons that included waiting until it became more troublesome, having had a bad past experience with her doctor, and having had success in self-massaging lumps in other parts of the body until they disappeared. Most women said they would not necessarily equate detection of a lump with cancer.

Major risk factors for breast cancer mentioned were emotional factors (mood, stress), dietary factors, family history or genetics. Most women said that they lacked knowledge and information about breast health and the availability of services. They were keen to know more about breast cancer prevention, self-examination, and eligibility criteria for mammography.

Breast screening

Most participants understood that the purpose of a mammogram is to detect breast lumps that could be cancer. Friends, GPs and television advertisements were their main sources of information. Two participants said the mobile breast screening bus was their first contact with screening information. Of those recruited from the community, half in the eligible age range for mammography screening had never had a mammogram in New Zealand. Four were not aware of the national screening programme. Three who were aware of the New Zealand programme had undergone past screening in China, but not in New Zealand. One woman felt that self-examination was enough, so had not sought a mammogram.

It's good to have a combination of both Chinese and Western medicine: Western medicines to treat acute

We cannot see what happens in the cervical part, but we can touch and see what happens in our

Participants acknowledged that Western treatments play an important role in diagnosing and treating disease, but reported that traditional Chinese medicine could help in maintaining general health, and in recovery from illness

knew that early diagnosis could mean longer survival. Surgery, chemotherapy, and radiotherapy were all recognised as key treatment options.

Participants acknowledged that Western treatments play an important role in diagnosing and treating disease, but reported that traditional Chinese medicine could help in maintaining general health, and in recovery from illness. Participants reported using traditional Chinese medicine and Western medicine in different situations.

breast. You can feel it if there is some change there, like swelling or pain. The breasts are like big lymph nodes. I think when there is no symptom, there is no need to do medical checks. (#2; community interviewee)

Of those women who had participated in the screening programme, most were happy with the service, although lack of staff continuity and breast pain during the procedure were concerning to some. One woman had concerns because she had been diagnosed with breast cancer soon after a normal mammogram.

They didn't pay enough attention to details. Otherwise, I should have known my disease earlier... I wonder how come the doctor who did the screening test could not find it. (#6; breast clinic interviewee)

Although a few said they would not seek breast screening in the future because they saw little need, most of the community participants said they intended to have a mammogram when next due.

Investigation of breast abnormality

The seven participants recruited from the breast clinic were asked about their experiences of clinical and support services. Their comments reflected an 'appreciation of the whole process', but some found the waiting period for definitive diagnosis too long. Privacy regarding diagnosis and disease was a particularly important consideration for these women. In this respect, they described themselves as being different to New Zealand women.

Maybe we don't share with... maybe we Chinese people are more private. ...I think we are more private than the European. (#7; breast clinic interviewee)

For some, this wish for privacy extended to their own family, not wanting to bother others with their problems. This made communication a particular challenge for some.

I don't like to... my only family but me here, is my husband... And I don't like him to worry about me. So I don't tell him until the last stage, until

I really go to the medical check. (# 8; breast clinic interviewee)

Communicating and translating medical information to family could then be difficult around the time of diagnosis.

...because when the doctor tells you it's 90% breast cancer, at that time I think oh... and me and my husband just stay in the car like for 45 minutes...It's silent, and no talking because we don't know how to do it. ...my parents [were] here. I don't know how to talk to them at that time ...but you still need to talk... Because they know you're feeling pain and you see the doctor. They want to know the results. (#9 breast clinic interviewee)

Follow-up services at the breast clinic were also difficult. Clinic nurses were described as respectful and helpful, but junior doctors in New Zealand were sometimes considered inexperienced, with unhelpful attitudes.

I saw an intern doctor instead. I don't want an intern to check me. I really hate that. ...the intern should have read my clinical notes, but he only cares about how the wound from the operation recovers. If I complain to him that it still hurts or other problems, he simply told me to talk to my GP. So, I think the follow-up service after the operation is really not that good here. (#3; breast clinic interviewee)

Communication barriers

Communication was repeatedly raised as the key issue when seeing a doctor in New Zealand. A Chinese-speaking GP was preferred by most participants if available, not just for the language, but also for a 'shared philosophy' in relation to health.

Women with limited English reported communication difficulties during interactions with the breast screening programme, but either had a family member with them to interpret, or relied on body language and non-verbal communication techniques to assist through the process. Despite the inconvenience of relying on a husband or children to interpret for them, with family members often needing to take time off work, and/

or appointment delays, this option was generally preferred to professional interpreting services.

They do provide an interpreter, but it's still difficult and makes us feel awkward at times with a stranger around. Interpreters can't be 100% accurate, and sometimes I don't like to discuss some issues with the third person. That is a problem. (#3; breast clinic interviewee)

One woman described preferring to attend the breast clinic unaccompanied and use a dictionary.

You know how I communicate with my doctor now? I have to take a dictionary with me each time I went to see doctor. When he wants to tell me something, he also looks up the word and pointed the word to me. But sometimes I didn't know how to spell those English words. See, how difficult it is for both of us! (#6; breast clinic interviewee)

Written and audio-visual resources were regarded as potentially valuable communication tools, preferably in Chinese, but pictorial materials could also be useful.

[The Cancer Society] sent me booklets with some useful information on it every month. But it's in English, so I don't understand. I tried to read as much as I can, mainly the pictures. (#6; breast clinic interviewee)

There was also a need voiced for more information about breast health to be made available through existing Chinese language media.

I hope there are more materials in Chinese. There are not only written materials on newspaper, but also [on the] Chinese TV station in Wellington. TV, radio broadcast and newspaper as mass campaign.... Plus lectures on breast health, disease prevention and self-examination would also be welcome. (#2; community interviewee)

Discussion

The migrant Chinese women in this study perceived their risk of breast cancer to be somewhat lower than that of their New Zealand counterparts, and placed variable importance on screening mammography. They described important

differences between their experiences of health care in New Zealand and their countries of origin, finding New Zealand health professionals respectful and helpful but sometimes lacking in direction and experience. Participants considered New Zealand doctors' understanding about use of traditional Chinese medicine to be limited, while their own understanding about the nature of primary care in New Zealand was evidently inadequate. Although a good proportion of interviewees were enrolled with a GP and would seek acute, episodic medical assistance, they were relatively unfamiliar with the notion of preventive primary health care. This is a relatively new concept for health services in China, where the majority of participants were from.

Communication difficulties were mentioned repeatedly by the study participants with limited English, and were the biggest barrier to seeking and receiving good medical care. Both language and attitudinal barriers were described. Language barriers were most often overcome by asking family members to attend appointments as interpreters. The use of family members in such situations can be difficult,¹⁶ and when combined with the desire for privacy expressed by some participants, present the potential for significant misunderstanding.

There is currently no nationwide breast screening programme in China, a factor likely to contribute to a relative lack of awareness about breast cancer screening.¹⁷ A desire for more good-quality information in Chinese languages about breast cancer screening and treatment was expressed by participants but had been hard to find.

The low rate of participation in breast screening among women in this study (around half of those who were eligible for the national screening programme) was consistent with national data on screening rates among Asian women.⁴ In contrast to previous studies, where non-participation has been mainly related to lack of knowledge about cancer symptoms, lack of transportation and facilities, issues relating to cultural modesty and fear of cancer, or belief that cancer is contagious,^{8,18} poor awareness of New Zealand's free national breast screening programme was described here as the main reason for non-par-

ticipation. Lack of a primary health provider has been shown elsewhere to reduce the likelihood of seeking breast screening,¹³ and also to reduce participation in cervical screening by women born in China, now living in New Zealand.¹⁹ This finding is consistent with the current study, with most of those women who had not received breast screening not being registered with a GP and reporting they had not heard about the breast screening programme.

Participants expressed some preference for Chinese-speaking health providers, particularly GPs, but recognised that this was not always possible. Like other Asian migrants in New Zealand,⁴ participants saw a role for traditional Chinese medicine in prevention and treatment of illness, and called for better appreciation by Western-trained doctors. They identified Chinese-language information and resources as especially important when oral language was a barrier, including the use of Chinese-language media, a finding similar to that of a United States study about breast health for Chinese immigrants.²⁰ While multi-language information about breast screening and breast cancer is available from New Zealand's National Screening Unit website,²¹ strategies are needed to improve awareness of, and access to this information by primary care providers and women in the community. In 2007, the Waitemata District Health Board adopted a more culturally appropriate approach to reaching non-English speaking Korean and Chinese women,²² which successfully resulted in increased uptake of mammography screening by this group.²³

This study is one of the first attempts to identify a range of factors affecting participation in breast screening by migrant Chinese women in the Wellington region. The study was limited by the 'opt in' nature of participation, so may not have included those women who are most distanced from engagement in screening. However, women recruited from the local breast clinic represented just under half (7/17) of those eligible in the study period, so the study is likely to have drawn in women with a range of opinions about their experiences. Results regarding these Chinese women's experience of procedures and services relating to diagnosis and treatment of breast cancer

need to be treated with caution until explored in a larger national study.

In conclusion, Chinese make up a significant proportion of New Zealand's growing Asian population, so a greater understanding of issues affecting their access to health care and health outcomes is needed. While primary care providers are obvious sources of information about breast screening, not all migrant women are registered with a GP, and the preventive role of primary care providers is not well recognised.

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Greater efforts are needed to ensure migrant Chinese women are engaged with, and understand the role of, a primary care provider. Ready use of Chinese-language resources and a better understanding about Chinese perceptions of ill health (including complementary use of traditional Chinese medicine) by New Zealand health professionals in both primary and secondary care services is needed.

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COMPETING INTERESTS

None declared.