

Access to cancer services – do culture and ethnicity make a difference?

Introduction

This module should take approximately 4 hours to complete, made up of about 2 hours of activities and 1-2 hours of thinking and reflection.

Learning Objectives

The activities and content of this module are built around the following learning objectives;

- Understanding the issues involved in collecting data on ethnic diversity
- Understanding awareness of and detection of cancer in Black and Minority Ethnic (BME) communities
- Identifying of the diverse cultural needs of people affected by cancer
- Understanding how those needs can be assessed and met.

This module is designed to provide you with knowledge and understanding of the diverse cultural needs of people affected by cancer, and assessing and meeting those needs. Using the UK experience we will explore the issues of awareness of, and detection of cancer in BME communities.

Background

Equity of access to cancer services should be available to everyone, regardless of who you are and where you come from. However, in the UK, there are inequalities in the delivery and take up of cancer services by BME community members. These inequalities are more likely to lead to deaths, resulting from late cancer diagnoses.

Society is becoming ever more multicultural and this must be reflected in the commissioning of health services. The 2001 census showed that the size of the minority ethnic population was 7.9 per cent of the total population of the United Kingdom. Of the non-white population of England, 9% describe themselves as being from a Black or Minority Ethnic (BME) community. Indians were the largest minority group, followed by Pakistanis, those of mixed ethnic backgrounds, Black Caribbeans, Black Africans and Bangladeshis (UK Census, 2001). Almost half (45%) of the BME population lives in London, forming 29% of all residents (Raleigh & Polato, 2004).

The links between ethnicity and cancer are multifaceted and in order to understand how ethnicity impacts on health, we need to know the ethnicity of people diagnosed with cancer. Most countries (82.4%), have a national cancer registry responsible for collecting population-based cancer data (MOSES, 2006). The nine regional registries in England monitor trends in cancer incidence, prevalence and survival over time, and between different areas and social groups. They also monitor ethnicity. The data also help with the evaluation of the effectiveness of cancer prevention and screening programmes. In the European Union, the European Network of Cancer Registries monitors cancer incidence and mortality. Until we improve our data collection, we will be limited in developing a sound evidence base to understand why BME

populations have a lower up take of screening and other health services. Agreeing ethnic classification in the UK involved a wide consultation with minority ethnic groups. Yet individuals may still classify themselves in a different way to researchers (Geerish, 2000). There is a younger ethnic minority population than the white population in the UK and the aging pattern will be determined by future fertility levels, mortality rates and migration. Given that cancer is predominately a disease of older people, the current incidence of cancer within BME groups is likely to change as their population ages. The incidence and mortality from cancer may also increase as individuals from BME groups adopt the lifestyles of the indigenous population (Watts et al, 2004).

Ethnicity and socio-economic status are often linked together and it may be difficult to separate out the different strands (Lodge, 2001; Elkan et al, 2006).

A number of strategies are needed to develop the evidence base on ethnicity and cancer. One such strategy is the UK Centre for Evidence in Ethnicity, Health and Diversity (CEEHD), established in 2001 to feed research evidence into the development of health policies and practice. The Cancer Reform Strategy (2007) also has as one of its aims, to reduce inequalities in cancer incidence and increase access to high quality cancer care and cancer outcomes, particularly in BME groups.

Much of the research around ethnicity and cancer has focussed on screening for cancers, in particular, attempting to identify the uptake of screening services. Many of the issues identified in this context can also be applied to BME groups who have been given a cancer diagnosis. Studies have mainly focussed on a South Asian population – people from India, Pakistan and Bangladesh.

It is also relevant that clinical trials have been conducted predominantly with white populations. There is now evidence that ethnicity affects response and toxicity to some breast cancer treatments (Palmieri et al, 2008). Therefore it may not be possible to generalise trial results to BME groups. Future research needs to acknowledge and report on ethnicity within clinical trials. Trials should perhaps, seek to recruit more participants from BME groups, although this is likely to impact on resources, as there will be an increased need for trial information in other languages and interpreting services.

Thinking Point:

- What is the ethnic mix of the geographical population your organisation serves?
- What is the ethnic mix of your patient population?
- What is the practice for recording ethnicity in your organisation?

Activity 1 (allow 45 minutes)

Task 1: Ethnic communities

Allow 30 minutes

- What are the main ethnic communities served by your local health services?

- Identify documents that outline the demographic details of your local geographical population. Starting points could be your local cancer registry and local government offices.
- Does your local patient population reflect these data/statistics?
- What percentage of your patient population is from a BME community?

Task 2: Barriers

Allow 15 minutes

- Can you identify any barriers to minority ethnic groups accessing the cancer services in your organisation?

Resources required to complete this activity

Useful websites

UK National Government Statistics – Census

http://www.statistics.gov.uk/census2001/access_results.asp

BME Cancer Communities

<http://www.bmecancer.com>

Ethnicity and Health Specialist Library

<http://www.library.nhs.uk/ethnicity/>

The European Network of Cancer Registries (ENCR)

<http://www.encr.com.fr/>

The National Cancer Registration System

http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Cancer/DH_4068586

Ethnicity, Health and Diversity in Cancer

<http://www.networks.nhs.uk/news.php?nid=1556>

Background reading

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Incidence of cancer in BME groups

Ethnicity information has generally not been well recorded in the UK (Jack et al, 2006), which means that routine data on ethnic differences in cancer incidence is not very reliable. In England it has been mandatory to collect information on ethnic group classification in NHS inpatient services (e.g. hospital wards) since 1995. This has provided cancer registries with some statistical information but the majority of cancer patients are treated as outpatients. General practitioners and outpatient services in the UK are only just beginning to monitor ethnic data after years of patchy, or no monitoring.

The incidence of different cancers varies between different BME communities and the general population. This is thought to be linked to a combination of factors, including lifestyle, and in some cases, cancer genetics (Raleigh & Polato, 2004). Prostate cancer incidence is higher in African Caribbean men compared to the general population and lower in Asian men. There is a higher incidence of mouth cancer amongst some South Asians and liver cancer among Bangladeshis and Chinese communities (Cancer Reform Strategy, 2007; CRUK, 2008).

Alcohol consumption tends to be undertaken at lower rates within BME groups compared to the general UK population. Irish men and women were more likely than any other ethnic group in the UK to exceed the recommended guidelines for alcohol. This is then followed by Black Caribbean men and women. Less than 5 per cent of men or women from the Pakistani, Bangladeshi and Chinese groups exceeded the recommended amounts. Very few Indian women exceeded the guidelines (2%) but 14% of Indian men drank above this level (Department of Health <http://www.statistics.gov.uk/cci/nugget.asp?id=266>)

Prostate cancer

The few studies looking at variations in prostate cancer between ethnic groups are mainly from other countries. The evidence is that it is substantially higher in black groups (Aspinall & Jacobson, 2004). Black American men have higher rates than white American men and black African Caribbean men in the UK have about two to three times the risk of being diagnosed from prostate cancer than white men in the UK. A prostate cancer study in East London (Chinegwundoh et al, 2006) paved the way for a larger UK study (PROCESS) looking at prostate cancer in ethnic subgroups. PROCESS showed that black men are three times more likely to develop prostate cancer compared to white men (Ben-Shlomo et al, 2008). However, the same study showed a lower incidence of prostate cancer amongst South Asian men living in England, in comparison with white men (Metcalf et al, 2008). This group of South Asian men also presented with clinical features of earlier disease. That lifestyle factors may play a part is suggested from studies showing that people from a country with a lower cancer risk develop an increased risk when migrating to a country with a higher risk (Winter et al, 1999).

Breast cancer

The incidence rates for breast cancer are varied, and the highest rates are in the developed world and the lowest rates are in East Asian countries (IARC). A retrospective study of women with breast cancer in a London hospital showed that the predominantly younger population of black women were more likely to present with aggressive triple negative tumours, not fuelled by hormones. Black women in the study presented on average, 21 years younger than white women (Bowen et al, 2008). Further research is needed to find out if the comparative youth of black women was due to the fact that the UK BME population is generally younger (2001 population Census), or linked to the less common type of triple negative breast cancer found in this group. The UK study echoed research in the United States.

A study in South East England found that South Asian women appear to have a lower risk of breast cancer compared to non-South Asian women. South Asian women who develop breast cancer may also have a higher survival compared to non-South Asian women (dos Santos Silva et al, 2003). Yet other research indicates that the incidence of breast cancer is rising faster in South Asians than in other ethnic groups in the UK (McCormack et al, 2004).

The Thames Cancer Registry looked at breast cancer in ethnic groups in South East England and found Black African women had a significantly worse overall survival rate than other ethnic groups (Jack et al, 2009). This echoes the findings of other US studies, where white American women have the highest incidence rate but black African American women are more likely to die from the disease (Chlebowski et al, 2005; Pesquera et al, 2006). African American women with a family history of breast cancer were found to be less likely to undergo genetic counselling compared to white women with a family history of breast or ovarian cancer (Armstrong et al, 2005).

It is unclear what factors influence the incidence of breast cancer and subsequent survival rates and this is clearly an area where more research is needed to enable better strategies to be developed for the detection and treatment of the disease in black women.

Oral cancer

Oral cancer is a problem within some South Asian communities and although it is generally more common in people aged over 50 years, it is more common in some younger Asian people in developing areas. This is a reflection on the widespread habit of betel quid/pan or areca nut chewing in some parts of South Asia. The tobacco leaf is often used to wrap pan.

Betal use is widespread among Bangladeshi adults in the UK but there is less prevalence among mixed Asian groups (IARC, 2004). Studies suggest that Asian adolescents living in Britain develop betel-quid chewing habits at a young age. It also appears that betel-quid chewing habits and use of tobacco are continued beyond first generation Asian men.

A study in Tower hamlets commissioned by Cancer Research UK found that the predominantly Bangladeshi community (33%) lacked awareness about the signs and symptoms of mouth cancer (Croucher & Gamboa, 2006).

Oral cancer is the most common cancer in men in Sri Lanka, India, Pakistan and Bangladesh. It may account for up to 30% of all new cases of mouth cancer compared to 3% in the UK and 6% in France (CRUK <http://info.cancerresearchuk.org/cancerstats/types/oral/incidence/>).

Other cancers

The links between ethnicity and other cancers are less clear. American statistics show that the incidence of bladder cancer in white men is twice that of black men, and black women also have a lower incidence than white women. An increased risk of bladder cancer may be due to genes.

Again, the incidence of squamous cell oesophageal cancer in the USA is almost six times higher in black men than in white men, while the incidence of adenocarcinoma is almost four times higher in white men than in black men (CRUK <http://info.cancerresearchuk.org/cancerstats/types/oesophagus/incidence/>).

People with dark skin are not immune to developing skin cancer, although African Caribbeans are less likely than people from other ethnic groups to develop it. In particular, they can be at risk on the soles of the feet and palms of the hands.

In a UK study (where 22% of the population studied were south Asian) there were lower rates of lung cancer for south Asian men than non-south Asian men (Smith et al, 2003). However, there are higher rates of smoking in some BME communities, particularly among Bangladeshi, Caribbean and Chinese men. This may be related more their socio-economic status rather than their ethnicity (Gordon-Dseagu, 2006). While women from BME groups are less likely to smoke than men, tobacco chewing is relatively common in Bangladeshi women (Raleigh & Polato, 2004). In the UK, the mortality in BME groups from lung cancer is lower than other ethnic groups (Aspinall & Jacobson, 2004). Conversely, the incidence of lung cancer is greater for Black Americans than other ethnic groups in the USA and they were more likely to die of lung cancer (<http://www.cdc.gov/cancer/lung/statistics/race.htm>)

Cancer screening

Screening can play an important role in the early detection of some cancers and in the UK, there are screening programmes for breast, cervical and bowel cancers.

The European Union set out recommendations for screening for breast, cervical and bowel cancer in 2003. A commission report in 2009 concluded that Europe needs to intensify and double cancer screening (<http://europa.eu/rapid/pressReleasesAction.do?reference=IP/09/113&format=HTML&aged=0&language=EN>).

The UK NHS Cancer Screening Programmes commissioned a review to assess the inequalities of access to cancer screening (Chiu, 2003). Chiu reviewed a number of studies on inequalities and cancer screening, most of which were from the USA. While some factors may be relevant to the UK and perhaps other European countries, some of the themes identified are not transferable. A key factor affecting access to health care, particularly outside the UK, is whether or not an individual is eligible for free health services. Screening programmes are available to the UK population free of charge. However, the rising number of homeless people, asylum seekers, travellers and refugees leads to a more mobile population that may be difficult to map.

The uptake of screening is affected by factors such as knowledge of screening, literacy, age, attitude, beliefs, and social and economic status.

Szczepura et al (2008) carried out a study of the uptake of bowel screening and breast screening by a South Asian population compared to a non-South Asian population. Breast screening uptake is also low.

Breast screening

There is a low uptake for breast screening among South Asians compared to non-Asians (Szczeputra et al, 2008). Breast screening uptake failed to improve for only one subgroup Muslim Asian women. They concluded that low breast cancer screening uptake rates observed in the South Asian population could not be attributed to socio-economic or age/gender population differences.

Chiu (2003) found there was a low uptake of breast screening among BME groups both in the USA and the UK. However, it is difficult to make a direct comparison because cancer screening in the UK is free at the point of access whereas in the USA, people have to pay for screening through their insurance cover. In the UK, the pattern of uptake for screening reflects the incidence and mortality statistics (Chiu, 2003). There is a large variation in uptake rates among regions, which reflects the distribution of ethnic populations. Uptake is lower in areas where there are considerable BME groups.

Watts et al (2004) reviewed the literature on the breast health information needs of women BME groups in the UK. A recurring theme from British studies was the suggestion that a lack of information and awareness about the availability and importance of screening services contributes to low uptake.

A survey of over 1,000 BME women, commissioned by the UK charity, Breast Cancer Care, confirmed verbal reports from BME community workers. A report published in 2005 showed that women from Britain's BME communities were dramatically less likely to check their breasts for unusual changes than white British women. 56% of BME women said they did not check their breasts because they did not know what to look for, and 43% said they never looked at or felt their breasts (Breast Cancer Care, 2005).

Bowel screening

BME groups are less likely to participate in cancer screening programmes than the white population in the UK. Rob et al (2008) explored the attitudes of BME groups and found that their knowledge about the causes of bowel cancer was poor. However, a bigger barrier to screening is more likely to be embarrassment.

A study looking at the knowledge and attitudes to bowel cancer and its early detection in the UK found that knowledge levels were generally low. The authors suggested that increased knowledge might reduce negative perceptions of cancer, which in turn could increase screening uptake (McCaffery et al, 2003).

The UK Colorectal Cancer Screening Pilot (2003) looked at the feasibility of bowel screening using faecal occult blood testing. People offered bowel screening in the UK are sent a faecal occult blood testing (FOBT) testing to their home. They found that there was a significantly lower uptake for the South Asian community. It was up to half as low as for non-Asians and the uptake was particularly low in the Muslim community. Written information about bowel screening is available in 20 languages.

Focus groups held with South Asians and African-Caribbeans highlighted a number of shared concerns such as low levels of knowledge and awareness of bowel cancer and screening, and varying literacy levels. Given that there is a need to understand written instructions in order to complete the test, the degree of literacy is very relevant. Szczepura's study (2008) also found that South Asian women were less likely to comply, again, because of lower literacy levels.

If Asian Muslims experience low completion rates with FOB kits, this may be an issue that other Muslims experience, regardless of their ethnicity.

Positive FOB tests are followed by an invitation to attend a local hospital for a colonoscopy. Uptake rates for colonoscopy were also found to be significantly lower among Asians.

Cervical screening

Bangladeshi women are less likely to take up cervical screening (Aspinall & Jacobson, 2004). They suggest reasons for low uptake include lack of accessible information, lack of awareness about smear tests, communication barriers and a higher level of population movement.

Box (1999) surveyed BME women on their knowledge, attitudes and experiences of cervical screening. Many of the women surveyed were unaware of the screening service. Again, lack of knowledge about the smear test, and fear, embarrassment and previous negative experiences all contributed to lower screening uptake.

Chiu (2004) explored issues experienced by BME women regarding cervical screening. Having identified barriers to taking up smear tests, she devised a health promotion programme to address them and then evaluated the impact of the programme. Visits to women by community health educators for pre-screening education proved to be effective and was likely to have contributed to raised uptake. The lack of ethnic monitoring was an additional barrier to language and culture, as it hampered accurate measurement of improved uptake.

Activity 2 (allow 30 minutes)

Task 1: Cancer screening programmes

Allow 15 minutes

- What national cancer screening programmes are in place for your population?
- Are these programmes accessible to the eligible population?

Task 2: Cancer awareness and screening.

Allow 15 minutes

- What information resources are you aware of for BME groups concerning cancer awareness and screening?
- What support services are available for BME groups?

Resources required to complete this activity

Useful websites

UK National Government Statistics

http://www.statistics.gov.uk/census2001/access_results.asp

BME Cancer Communities

<http://www.bmecancer.com>

Ethnicity and Health Specialist Library

<http://www.library.nhs.uk/ethnicity/>

Ethnicity, Health and Diversity in Cancer

<http://www.networks.nhs.uk/news.php?nid=1556>

The International Agency for Research on Cancer (IARC)

<http://www.iarc.fr/>

CRUK – Health and Cancer Inequalities

http://info.cancerresearchuk.org/publicpolicy/Ourpolicypositions/healthcancerinequalities_policy/

National Cancer Institute

<http://nci.nih.gov/>

American Cancer Society – Statistics for 2008

http://www.cancer.org/docroot/STT/STT_0.asp

Background reading

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Ethnicity and culture

Race is a term that has been used to describe groups on the basis of their common inherited physical characteristics. The terms 'cultural' or 'ethnic' diversity tend to be preferred to 'race' within Europe.

Ethnic groups share a common ancestry, history, culture, including religious traditions, language and diet. People may identify themselves through their ethnicity or through their culture. Culture is a broader term, encompassing the shared practices, beliefs, attitudes and rituals that characterise a group. Ethnicity can also include cultural variations and individuals may feel they identify with more than one culture. The similarities and differences ethnic and cultural identities are not fixed. Geerish (2000) in addressing some of the concerns relating to researching ethnic diversity, suggested that to get round problems with ethnic classification, a range of variables could be used such as language, religion and length of residency in a country.

There are a number of issues highlighted in the literature to explain some of the inequalities experienced by BME groups relating to access to health care, late diagnosis and a poorer uptake of screening services. These are:

- Cultural beliefs and values
- Cancer knowledge and awareness
- Communication – literacy and language

Cultural beliefs and values

Everyone has their own cultural belief system. Problems arise when beliefs of minority groups differ from the beliefs of the majority. Cultural beliefs and values will impact on the development of relevant and suitable information resources (Watts et al, 2004). People have many beliefs including views on the cause of cancer, how it presents and the outcomes of cancer treatment. Examples of beliefs are that cancer is contagious (Box, 1998) or that that breast cancer is mainly a white women's disease or asymptomatic (Watts et al, 2004). In a literature review on the inequalities of access to cancer screening, Chiu (2003) noted different beliefs held by people within the minority ethnic groups studied. For example, 'the belief among Samoan

women that cancer means death and the belief among Thai immigrant women that poor personal hygiene and benign breast tumours or cysts can cause cervical and breast cancers'. Other barriers to the uptake of cancer screening within the Asian community are social and religious taboos (Deepak, 2004). Lodge (2001) also lists a number of beliefs, needs or difficulties identified with ethnic minority groups and cancer support. The stigma and fear of cancer may be stronger in some ethnic groups, which may prevent them from taking up screening services.

Cancer experience, knowledge and awareness

Knowledge of cancer within BME groups differs and they have unmet needs relating to the provision of cancer information. The result is that BME groups have a lower awareness of cancer risk factors, signs and symptoms and cancer services (CRUK, 2008). Inequalities exist from information provision through to palliative care. Negative experiences and outcomes of cancer will increase fear and stop people accessing services (Deepak, 2004).

People from BME groups have the right to adequate information, which includes information in their preferred language. The 'one size fits all' model of producing and disseminating information is unlikely to meet the needs of all ethnic groups.

Health professionals need to take the cultural beliefs and values, and language of the intended audience into account, in order to produce culturally sensitive and relevant information resources. Racial stereotyping and misconceptions about cancer in minority ethnic groups will add to the challenge of disseminating information (Watts et al, 2004). There may be a lack of awareness about the benefits of screening or a belief that they are not likely to develop cancer.

Translated materials should have the information in both languages – the language in which the information was originally written as well as the language for the intended audience. A native speaker of that language should check the information once it has been translated. The two languages will enable different generations in a family to read the information in their preferred language. However, literacy can still be a problem. Not all spoken languages are written and not everyone can read a language they speak. Translating information is not a simple process, as it needs to be culturally sensitive as well as technically correct (Gerrish, 2001). Some words and concepts may not always translate easily into some minority ethnic languages.

Other mediums for producing information should be considered. One alternative to written information is audiotapes as these overcome the barriers of literacy and a lack of written forms of languages (Watts et al, 2004). DVDs and pictorial information are further options.

For many BME groups, spoken communication is preferred over written information. This is particularly relevant to people of South Asian and Somali origin (Watts et al, 2004). Studies evaluating the use of lay health workers or educators working with specific BME groups and providing language support suggest that they enhance the uptake of breast and cervical screening programmes but the methodologies are not necessarily comparable (Chiu, 2003).

CancerBACUP found that as a result of lack of information and support, cancer patients from BME groups were less likely to understand their diagnosis and treatment options (Deepak, 2004).

Access to services

The attitudes of BME groups to using cancer screening and preventative services may act as a barrier to uptake of such services (CRUK, 2008). Equally, the attitudes of health professionals to BME individuals may also have an effect. Lack of understanding about health services may inhibit BME groups from accessing health information and services. Frequently, it is a lack of

understanding of the concept of screening and awareness of services, rather than lack of need that accounts for low use of some services (Elkan et al, 2006). Fear and embarrassment are other factors that impact on the attendance for screening services (Box, 1998; Robb et al, 2008).

The cultural sensitivity of health services needs to be improved and acknowledge the health beliefs from different cultures (Chiu, 2003).

Communication

Language difficulties and cultural differences remain a significant barrier to good communication between patients and health professionals (Papadopoulos & Lees, 2004). That language barriers are an issue has also been highlighted in many other studies (Chevannes, 2002; Gerrish, 2001; Owens & Randhawa, 2004; Cortis 2004). Communication problems are compounded by a lack of appropriate translation and interpreting services (Elkan et al, 2006).

To overcome language barriers may involve the services of suitably skilled health interpreters. Effective communication with people whose first language is not English (or the language of their host country) often requires additional time, support and sensitivity as well as simply translation. People should also have a choice of gender of interpreter. Interpreters should be fluent in both the language of the host country and the first (or fluent) language of the service user. Health professionals should be provided with training in working with professional interpreters.

The UK London Health Commission established the Language Support Services Project to reduce inequalities in health by improving access to quality language support services across public sectors in London. Their recommendations included providing better guidance on working with interpreters to public sector services and providing additional training in specialist areas (such as cancer) for qualified interpreters (Silkap, 2006).

When interpreters are not available, individuals may need to rely on family members. This can be inappropriate if the information being communicated is sensitive and also, family members may censor information. A good grasp of a language does not necessarily mean that the person understands and can translate medical terminology (Gerrish, 2001).

When an interpreter is not equally fluent in both languages, they may fail to translate, mistranslate or edit the questions and replies. Speaking a language is no guarantee that a person is able to translate it accurately.

Health professionals and cultural competence

Throughout the literature, studies suggest there is a poor understanding of the concept of culture and how it is applied in a practice setting (Cortis 2004; Chevannes, 2002; Owens & Rhandhawna, 2004) and of how people's cultural values and beliefs of cancer may influence the uptake of screening services and early diagnosis (Lees & Papadopoulos, 2000). Yet many studies addressing the cultural needs of BME groups fail to define what they mean by concepts such as culture.

Individuals, regardless of their ethnicity, expect health professionals to listen to them. Lack of knowledge and uncertainty about cultural issues and racial stereotyping may lead to health professionals avoiding communicating with their patients for fear of 'getting it wrong'. When this happens, communication invariably breaks down. Health professionals need to be aware of how their patients understand their illness as this will impact on how they live with cancer (Papadopoulos & Lees, 2004). Cultural awareness and the provision of culturally competent

care is also important for health professionals involved in cancer screening and prevention services (Pesquera et al, 2006).

Kai et al (2007) used focus groups to explore the experience and attitudes of health professionals working with ethnic populations in the Midlands of the UK. They found that health professionals frequently struggle with communicating with BME communities either because of language barriers or through lack of knowledge of cultural practices.

'Cultural competence' is about health professionals and organisations developing the awareness, knowledge and skills of cultural differences such as health beliefs and practices, religion, and communication styles, to enable them to work effectively with people from different cultures. Fear of getting it wrong or saying something inappropriate seems to inhibit many health professionals in their communication and interactions with BME groups.

Chevannes (2002) undertook a training needs analysis among health professionals to enable them to meet the diverse needs of people from ethnic minority groups. Following the delivery of a training programme, Chevannes established that for learning to be sustained, it needs to be undertaken in the environment in which the health professionals interact with BME groups.

While training programmes on cultural diversity clearly have a place for people working with BME groups, ethnic and cultural identities are not fixed. Health professionals may not benefit from education programmes outlining specific cultural attributes as this may only serve to entrench stereotypical views.

The uptake of screening programmes may improve if attitudes and beliefs about screening and the positive benefits of the effectiveness of screening are addressed with BME groups. Neither should the significance of support from family, friends and the community be underestimated.

Activity 3 (allow 60 minutes)

Task 1: While on a holiday of a lifetime, you have the misfortune to end up as a patient in the local hospital. You only have a few words of the local language, and certainly the idea of trying to express how you're feeling is outside your comfort zone. The local health care system is clearly different to what you are used to at home.

Allow 30 minutes

- What are the key characteristics of the culture you identify with?
- How would you communicate?
- What would you worry about most, trying to communicate it to the health care team providing your care?

Task 2: Describe your role or the service you provide from a variety of perspectives. How might the following people view or describe it?

Allow 30 minutes

- Service users from the majority ethnic population
- Services users from the minority ethnic population
- Families and friends of service users

- Clinicians
- Staff

Express things in the language of that person; how would *they* say it?

Summary

Individuals from BME groups will adopt to different degrees, the lifestyles and beliefs of the indigenous population. Within family groups, different generations may share some cultural beliefs and not others, depending on the culture and experiences they are exposed to. Second generation migrants often have information and support needs more similar to the indigenous population, rather than those of their parents (CRUK, 2008). As BME groups adapt to the health system and language of the country they live in, this will have an impact on the screening uptake, incidence and mortality from cancer.

However, emotional and practical support for health professionals is particularly important, if the difficulty in providing information and support to people from BME groups 'lies not in ethnic diversity but in poverty, social exclusion and low literacy' (Lanceley & Cox, 2006).

Resources required to complete this activity

Useful websites

BME Cancer Communities

www.bmecancer.com

Ethnicity and Health Specialist Library

<http://www.library.nhs.uk/ethnicity/>

Ethnicity, Health and Diversity in Cancer

<http://www.networks.nhs.uk/news.php?nid=1556>

Background reading

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- Silkap (2006) Language Support Services (LSS) Project Summary.
<http://www.silkapconsultants.co.uk/home.htm>
- Watts T, Merrell J, Murphy F & Williams A. (2004) Breast health information needs of women from minority ethnic groups. *Journal of Advanced Nursing*. 47(5): 526-535.

Discussion Board

The discussion board is a forum in which you can exchange ideas with other participants. This activity relates to the work you will have completed in earlier tasks and provides an opportunity for you to explore the difference in perspectives between the participants.

Discussion Board

When will it take place

For a 3 month period from date of publication of this article.

Which discussion thread

Access to cancer services – do culture and ethnicity make a difference?

What is expected of you as a participant

This module has only touched on some of the issues affecting minority ethnic groups and the inequalities in the delivery and take up of cancer services by BME groups. By sharing your experiences of the cultural diversity and how it impacts on your practice, we can build on the current body of knowledge.

Summary of this module

By completing this module you should have a better knowledge of ethnic diversity and how it impacts on the health of BME groups, particularly regarding cancer awareness and early diagnosis. You should have had the opportunity to reflect on the assessment of the diverse cultural needs of people affected by cancer and how those needs can be met.

On completion of this module you will have had the opportunity to:

- Consider the incidence of cancer in BME groups
- Reflect on the issues involved in collecting data on ethnic diversity
- Consider the access and uptake of BME groups to cancer screening programmes
- Identify of the diverse cultural needs of people affected by cancer affecting uptake of cancer services
- Understand how those needs can be assessed and met.

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