

Grenadian Women’s Perspectives on Screening for Breast and Cervical Cancers: A Participatory Approach to Understanding Prevention

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Abstract

Breast and cervical cancers present a heavy disease burden on countries with a limited resource base. This study explored the behavioral determinants that facilitate breast and cervical cancer screening among women within the cultural context of Grenada. One focus group discussion was held within each of the seven parishes of Grenada with women between the ages of 21 and 64 years with no history of abnormal cells of the breast or cervix. Four major themes emerged from the data, including (1) social interpretation of breast and cervical cancers, (2) price of participating in screening, (3) facilitators to screening, and (4) preferred methods of communication. In addition to basic information on cancer prevention, educational campaigns must address health literacy and the social interpretations of breast and cervical cancers in this population, particularly the persistent stigma. The results of this study highlight potential issues faced in limited-resource settings that should be acknowledged.

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Keywords

cervical cancer; breast cancer; screening; Caribbean; Grenada; focus groups; prevention

Background

Among women, breast cancer is the most commonly diagnosed cancer, and cervical cancer is the third most common worldwide (American Cancer Society, 2015). Globally, incidence rates for these cancers continue to increase despite the availability of effective screening tests. In 2012, approximately 1.67 million and 528,000 new cases of breast and cervical cancers, respectively, were diagnosed in the world (Ferlay et al., 2012). This compares to 1.3 million and 529,000 cases in 2008 (International Agency for Research on Cancer, 2010). Alarming, over 50% of breast cancer cases and more than 80% of cervical cancer cases occur in developing countries, of which the Caribbean region is a subset (Ferlay et al., 2012). These cancers continue to create a pressing disease burden on resource-poor countries such as Grenada.

The state of Grenada includes the islands of Grenada, Carriacou, and Petite Martinique and covers a land area of 344 km². Grenada is located at the southern end of the Windward Islands, about 100 miles north of Venezuela in the Southeastern Caribbean Sea. The estimated population of Grenada was 111,764 in 2010. More current numbers are available from the World Health Organization (WHO) website (<http://www.who.int/gho/countries/grd.pdf?ua=1>). Malignant neoplasm was reported to be the leading cause of death in Grenada in 2006 and in 2010, accounting for approximately 20% of all deaths (Pan American Health Organization, 2012). Breast and cervical cancers account for 16% and 9%, respectively, of all cancer deaths for women in Grenada (Pan American Health Organization, 2013).

According to Luciani, Cabanes, Prieto-Lara, and Gawryszewski (2013), age-standardized mortality rate for breast cancer, based on the most recent data, is relatively high in the “English” Caribbean, of which Grenada is a member. Records from the Grenada oncology unit indicate that the number of newly diagnosed breast cancer cases increased from 13 cases in 2009 to 38 cases in 2014. Additionally, the age-standardized mortality rate increased from 7.3 in 2000 to 16.9 in 2009 (Luciani et al., 2013). This rate is higher than the WHO Americas region, lesser developed regions (LDR), and global age-standardized rates of 14, 11.5, and 12.9, respectively (Ferlay et al., 2012).

Cervical cancer continues to contribute to the burden of disease in Grenada. Although cervical cancer is one of the most successfully controlled cancers as a result of the Papanicolaou test (Pap smear), which detects cervical cancer and precancerous lesions, developing countries have not benefited from these

advances. There is a limited capacity to prevent as well as treat cervical cancer as prevention programs are either unavailable or underfunded because they compete with other priorities (Jones, 1999; Ngoma, 2006; Sherris, Herdman, & Elias, 2001). Between 1996 and 2000, the age-standardized incidence rate was estimated to be 60.7 and the age-standardized mortality rate 9.7 (Asulin et al., 2004). The mortality rate for 2000–2010 was an estimated 16.7/100,000 (Bahadoor-Yetman et al., 2013), an almost twofold increase to the previously calculated rate and higher than the rates at the global, lesser developed countries (LDC), and WHO Americas regions at 6.8, 8.3, and 5.9, respectively. The prevalence rate for this period was 52.4/100,000 women 15 years and older (Bahadoor-Yetman et al., 2013). This is of concern, because low cost screening using the Pap test is available country-wide and because mortality rates from cervical cancer have been decreasing for countries in the Americas (Luciani et al., 2013).

Although the causes and natural histories of these two cancers are different, the public health approaches to these diseases are similar. Breast and cervical cancer mortality can be reduced if the cancer is detected early. Increasing access to and improving quality of screening programs have been identified as key components of effective programs for the early detection of breast and cervical cancers in low-resource settings. Mammography, breast self-exam, and clinical breast exams can be used to detect asymptomatic breast cancer. However, screening mammography has proven to be the most effective method (Nyström et al., 2002) and can help to reduce the number of deaths from breast cancer among women aged 50 to 74.

Grenada does not offer free mammography-based screening (Luciani et al., 2013), nor is the service offered at government clinics. Nevertheless, the service is available through private practitioners at a relatively high cost. For this reason, there are no available data on rates of mammography. Breast self-exam and clinical breast exams are encouraged in the absence of affordable mammography (C. Baptiste, personal communication, October 22, 2015).

Population-based screening, using the Pap smear test, has significantly reduced rates of cervical cancer in developed and developing countries. Although the Pap test is available in Grenada at government clinics at a low cost, coverage rates are relatively low. Cervical cancer screening in Grenada is performed within each of the seven health districts, which consists of seven health centers, 30 medical stations, and the Grenada Planned Parenthood Association. The data by parish show that Pap screening rates appear to be steady between 2011 and 2013. For example, from 2011–2013 in St. George, the numbers of Pap tests completed were 272, 304, and 216, and in Carriacou the numbers were 38, 25, and 34 (Grenada Ministry of Health, 2014). The data clearly indicate that coverage levels are insufficient, as demonstrated by the relatively high rates

of breast and cervical cancers and low Pap test rates. These survival statistics can be improved with the use of effective screening and treatment strategies (Ngoma, 2006); however, cancer diagnosis in these populations is commonly made in advanced stages (Sener & Grey, 2005). Therefore, efforts to increase screening coverage levels among women in Grenada are imperative.

A thorough review of literature revealed little research on the perceptions and attitudes of women in the Caribbean toward breast and cervical cancers. A survey by Ncube, Bey, Knight, Bessler, and Jolly (2015) found that in Portland, Jamaica, women who did not know where to go for a Pap smear were 85% less likely to have been screened. A focus group study in Barbados found that the most frequent misconception of the Pap smear was that it was for the detection of sexually transmitted infections (Christian & Guell, 2015). In terms of breast cancer, a focus group study on breast cancer screening barriers among Barbadian women found that many women expressed fear about mammography and its potential consequences including social stigma and losing romantic relationships (Granado, Guell, Hambleton, Hennis, & Rose, 2015). A major cultural barrier to breast screening in Tobago was the cultural belief that no matter what they did, there was no way to prevent breast cancer (Modeste, Caleb-Drayton, & Montgomery, 1999). These studies are important contributions to the literature on breast and cervical cancer screening; however, they are in the context relevant to larger islands with more resources or those classified as high income countries by The World Bank (2015).

The purpose of this research study was to explore the behavioral determinants that facilitate breast and cervical cancer screening among women within the cultural context of Grenada. Further, we will examine how attitudes toward screening are influenced by the availability of screening within the existing health system.

Method

A community-based participatory research approach was used to optimize involvement and increase the research project's chance of success. Key stakeholders were invited to a planning meeting to discuss the potential benefits of the research project. These members formed an interprofessional advisory board composed of nurses, physicians, public health practitioners, and community members representing the Grenada Medical Association, Grenada Nurses Association, Grenada Heart Foundation, Grenada Cancer Society, Pink Ribbon Society, and Grenada Public Health Association. Stakeholders at this initial meeting provided input on the focus group guide, recruitment flyer design, and strategies for disseminating information regarding the study and recruitment. As a result of these consultations, the focus group guide and recruitment flyer were tailored for cultural appropriateness. The resulting focus group guide was piloted among a sample of nursing students and revised based on the feedback received.

The research team used a qualitative design of focus group discussions for data collection. Ethical approval was obtained from the institutional review boards (IRB) at St. George's University and Nova Southeastern University. To ensure that opinions were obtained from across Grenada, one focus group discussion was held in each of the seven parishes. To achieve this, women were purposefully recruited by age and parish from August to November 2014. The goal was to recruit a minimum of seven women in each focus group because previous literature indicated that an optimal focus group would consist of five to seven respondents (Debus, 1988). Eligible participants were women between the ages of 21 and 64, a Grenadian citizen living on the island, without a previous diagnosis of breast or cervical cancer.

Recruitment

Members of the project team promoted the study on a local television station and posted flyers at government ministries, health clinics, supermarkets, bus stops, beauty salons, pharmacies, banks, and other business places. Supporting organizations also posted flyers on their Facebook pages. The recruitment flyer provided information on eligibility criteria for participation and the contact information for the project manager. Because of insufficient recruitment numbers during Phase 1, a second phase of recruitment was implemented. Phase 2 involved direct, face-to-face recruitment of eligible people. The project team visited each parish, handed out flyers, provided information about the study, and collected contact information. The project manager contacted interested people to confirm their eligibility and to share the time, date, and venue for the focus group discussions.

Focus Group Discussion

Once the required number of people was recruited within a parish, the focus group discussion was scheduled at a convenient location. Refreshments were served before the start of each session to establish rapport. Participants read the informed consent, were given an opportunity to ask questions, and then completed a demographic questionnaire. Next the focus group moderator, a local, female clinical nursing instructor, introduced herself and the note taker. She explained the procedures and used the semistructured interview guide to initiate the discussion. The semistructured interview guide comprised 19 questions on participants' knowledge, screening barriers and facilitators, information sources, and potential channels of information related to breast and cervical cancers. Each session lasted approximately 90 minutes and was tape-recorded along with handwritten notes being taken. A token of \$10 XCD (\$4 USD) was given to each participant at the end of each session.

Analysis

Each focus group was audiotaped, which was transcribed verbatim by a professional transcriptionist and reviewed for accuracy. A codebook with operational definitions was created using the themes that were extrapolated from the data using thematic analysis (Thomas & Harden, 2008). Two team members individually coded a small sample of focus group transcripts, and they reconciled through discussions any differences in coding. Once thematic saturation was achieved, a revised codebook was developed. The remaining transcripts were coded by a single coder using NVivo 10 (QSR International Pty Ltd).

Results

Forty-seven Grenadian women participated in the study. Their demographic characteristics are presented in Table 1. All of the women indicated that they were never previously diagnosed with any form of cancer. The results are organized by the following emerging themes: (1) social interpretation of breast and cervical cancers, (2) price of participating in breast and cervical cancer screening, (3) facilitators to screening, and (4) preferred methods of communication.

Table 1

Focus Group Participants' Demographics

Demographics	<i>N</i>	%
Age		
20–30 years	18	38.3
31–40 years	16	34.0
41–50 years	7	14.9
51–60 years	4	8.5
61–70 years	2	4.3
Employment Status		
Employed	31	66
Unemployed	16	34
Education		
Primary School	7	14.9
Secondary School	18	38.3
Community College	12	25.5
University	8	17.0
Trade or Technical School	2	4.3

Table 1 (cont.)

Demographics	N	%
Monthly Income (East Caribbean Dollar [XCD])		
< \$500	5	10.6
\$500–\$1,500	16	34.0
\$1,501–\$3,000	5	10.6
\$3,001–\$4,000	3	6.4
No Response	18	38.3

Note. \$1 USD = \$2.70 XCD.

Social Interpretation of Breast and Cervical Cancers

The initial focus group interview guide questions were asked to gain an understanding of women's knowledge of breast and cervical cancers and related screening. It was clear from the responses that the women's interpretations of breast and cervical cancers are related to the belief that something that occurs physically is a cause for cancer. It was clear that these beliefs were heavily influenced by their social contexts.

Abuse. Several participants spoke of different forms of abuse as being a cause of either breast or cervical cancer. According to participants, women who experience abuse in their lifetime may have an increased risk of later developing breast or cervical cancer: "... I heard people talk about because, oh she was abused, they beat her up so much that she get breast cancer, she get knock up in her breast..." (FG1, R3). The participants also believed that women who have been abused sexually are at higher risk of breast and cervical cancers: "Sexual abuse can cause breast and also cervical cancer [but] I don't think with the breast it's true" (FG2, R3).

Sexual activity. Promiscuity or sexual activity was also cited by focus group participants as a cause of breast and cervical cancers. For example, one participant noted, "... Because she have too much sexual partners, it is believed that because of that you tend to get cancer, also cervical cancer..." (FG1, R3). Conversely, a lack of sexual activity was also mentioned as a cause for cervical cancer: "Sometimes they say like when you not sexually active, like people will say stay there and let all the thing pile up inside you there and you get this, some people believe for the cervical cancer" (FG4, R6).

Breastfeeding. Another theme mentioned during focus group discussions as a cause for breast and cervical cancers was the act of breastfeeding children. One participant shared a belief that children would be at an increased risk of breast cancer if their mother had breast cancer while breastfeeding them. Another participant cited difficulty with breastfeeding as a potential cause of cancer tumors:

I use to hear my grandmother talking about it back then growing up, my first sister had her first son and she had some problems with the flow of the breast milk and she was like you have to knead it with the corn stick otherwise it go stay there and form cancer. If the milk don't flow up it will stay there and form a lump. (FG4, R7)

Barriers and Price Associated With Screening

Women expressed many barriers related to the price of screening. Price in this case refers to what women must do to obtain breast and cervical cancer screening. This may be monetary or something intangible that women consider valuable.

Cost of care. In each parish, focus group participants frequently cited the cost of health care as a barrier to receiving care: “. . . If it's costly sometime you may not have the money to go and get it done” (FG5, R1). In addition, the cost of care was also mentioned as a reason that Grenadians may postpone seeking preventive care if they are asymptomatic. One participant stated, “The cost attached to it so sometime they might find that they don't have no signs or symptoms but just to get up and go and pay money to do that and they could use the money to do something else” (FG5, R4). Another participant said,

. . . Now when we go to the clinic, usually it is because, [the free clinic – the government clinic] it's usually when we just had a child or so then we could get it for free but we would have to pay after. If it could be easily assessable in terms of cost, it is cheaper then, that would for me make women more willing to do it. (FG2, R11)

Time. In addition to monetary affordability, women were clear that another factor to consider is time. Many of the working women mentioned that it may not be possible to take time off from work to get screened, even when they are willing. One participant shared her personal dilemma: “. . . Based on what you doing and where you working you just can't afford to waste time . . . yes you want to go, but the job is more important because you need the money and you just don't have the time” (FG2, R3).

Discomfort. Feelings of discomfort with the testing procedure also surfaced as a deterrent for participants to undergo a screening procedure. One participant stated, “I'm talking from my experience, I always hear people talking about Pap smear and I always scared to go and do it because the experience friends tell me . . . that they push it in and it hurt so much and so uncomfortable so I'm so scared . . .” (FG3, R7).

Discomfort was expressed about not only the procedure, but also the feeling of being exposed in front of health care providers. Several participants re-

ported being uncomfortable as a result of either being subconscious about their bodies or being exposed to several health care providers. This concern, which may not present itself until in the health care setting, may prevent women from being screened, even when they have an initial interest in their health care.

. . . Reading up about it that made me a little bit more willing to do it . . . when I went to the clinic it was really uncomfortable for me going to do the Pap smear because actually I had reach and I had taken off my clothes, was just to actually get up onto the bed, but then when I saw the amount of persons in the room it made it really uncomfortable for me, so I just changed my mind and went back home. (FG2, R10)

Confidentiality. Even when access to health care was free, barriers still existed that prevented women from participation in screening. A major barrier was health professionals' confidentiality measures. One respondent mentioned, "I would go to a place where I could get the services done one time, and secondly they have to be confidential in that place. Whether public or private, they have to be confidential" (FG4, R6). Several participants reported having concerns as to whether their care and personal information would be shared with those outside of the health facility by nurses: "Some people may want to go to do it . . . that nurse is not trustworthy, she might talk so I not going there . . . must be somebody confidential that you could go and expose you self to do those things" (FG6, R2).

Despite many confidentiality concerns, a few women felt that concerns about confidentiality should not supersede taking preventive health measures. Instead, women should put additional effort in finding a practice with which they are more comfortable: "I would like to admonish people that even if they find a nurse or nurses in a particular area not confidential, because of their own health they look for somewhere else . . ." (FG4, R1).

Facilitators to Screening

Financial incentives. Providing financial incentives to cover the costs of services (four parishes) and access to care (two parishes) was identified as a major facilitator to this population being screened. One woman stated, ". . . According to the cost of the test if you're not working it may be difficult for you to do the test and sometimes if it's not something offered by government you may have to forego the test" (FG1, R1). Other participants also mentioned provision of incentives during nationally recognized cancer awareness months: "Since we celebrating cancer month, October is cancer month, at least we should have some incentive, give us a special, like maybe a discount for the mammogram, this is one incentive" (FG7, R1).

Participants also brought attention to some of the free or low-cost services available, but most of these are provided through health clinics or health

centers. These facilities are an additional barriers, as they are typically associated with concerns regarding confidentiality among participants, which was another barrier raised by four of the parishes. For example, one participant mentioned, “. . . If you don’t have the money to go by a private doctor, you have to go by a public doctor, health center” (FG5, R4). Another noted, “There’s an issue with confidentiality for the health centers” (FG5, R6).

Knowledge. Knowledge was also identified as a facilitator to screening participation. According to participants, increasing education and knowledge may increase cancer screening: “I think what would make people want to do Pap smear is education; I think lack of knowledge is preventing people . . .” (FG2, R3). In addition to an increased general knowledge about cancer, participants also felt that they needed to learn the process for when to initiate screening for cancer and that they needed clarification on conducting breast self-exams. This points to a need for increased health literacy in the population. For example, one participant stated,

. . . The next one could be educating, educating us on where we should have it, and this is cancer month, we need to be educated on where, what’s the different changes you notice in your body to have it done, giving us the discount, things to encourage people to grow, so we have this thing going on now so we’d want to be a part of it. (FG7, R1)

Preferred Methods of Communication

Face-to-face. Participants provided information on their preferred methods of communication to receive information about breast and cervical cancers. A common subtheme shared across all parishes was the use of communication methods that include personal interaction. Participants felt that communication was better when it was more personal and “face-to-face.” One of the benefits women noted about this type of encounter was that the health educators conducting the sessions “. . . would be a good source of information, people could ask questions and get answers . . .” (FG2, R3). The participants tended to be receptive to various face-to-face encounters. Some preferred small groups for “. . . open discussion with the facilitator and the people there” (FG7, R1), whereas others were open to more-professional settings.

Some participants thought residents of Grenada would be receptive to settings such as workshops and conferences: “My preferred method will be a forum like a workshop with recent researches and stuff like that” (FG4, R1). Women also recommended having these workshops in locations where women work or congregate often.

Another participant also thought a workshop hosted by or conducted in their place of employment would be ideal for those with schedules that are less flexible: “. . . Some people based on the time they work maybe it would be nice

that the work place arrange some kind of workshop if it's a two day workshop so you could get all the information ...for women to get more educated on that breast cancer or cervical cancer" (FG6, R9).

Media. Although mentioned less frequently, different forms of media such as "television programs and radio programs" (FG7, R3) were also mentioned as ways to reach the target population to educate them about breast and cervical cancers. However, participants also noted that these formats may not be ideal for a couple of reasons. One reason participants thought that technology might not be suitable for the population was a lack of access to technology: "Not everyone have a television so that why they could come and have a small meeting in the different parishes" (FG5, R1). Another mentioned limitation was that media formats do not allow for personal interaction with individuals:

Its case where you have that kind of one-on-one interaction, to me the radio and the television, the mass media you could use them, but in terms of that interactive one-on-one connection, we don't get it. They will just give the information and the information will be more generalized, but one you have persons who is sitting here and you could see that persons you could actually feel the passion . . . with those kind of sessions we could actually learn how to do a breast examination. (FG3, R3)

Discussion

This qualitative study explored the attitudes and perceptions among a sample of Grenadian women without a previous breast or cervical cancer diagnosis toward breast and cervical cancer screening. The results of this study contribute to the knowledge base of breast and cervical cancer screening in the Caribbean, with a special focus on a smaller Windward island with a limited resource base. By conducting focus groups with women without a previous diagnosis of breast or cervical cancer, researchers were able to capture the attitudes and perceptions of women without a firsthand experience with cancer treatment in Grenada, thus limiting the influence of a survivor's knowledge and experience on the undiagnosed women's responses.

This study aimed to reach women from all seven parishes in an effort to compare similarities and differences between women based on the parish in which they live. The researchers hypothesized that women living in the capital of St. George, where the general hospital is located, would have different perceptions of breast and cervical cancer than women living in the more rural parishes. However, no major differences were found among the women, as each theme was present in a minimum of six of the seven parishes. All the women agreed that there is a lack of information on the importance of breast and cervical cancer screening in Grenada.

The first theme of social interpretation of breast cancer was heavily influenced by the women's social contexts and cultural beliefs related to sex and sexuality. Women saw their cancers as taboo and as likely caused by sexual activity, both voluntary and involuntary sexual abuse. As a result, women saw cancer as a social stigma and something that they should not share with others, including family. A few women mentioned physical trauma to the breast and breastfeeding as causes for breast cancer. Some of these beliefs were learned from their grandmothers. Likewise, Swinney and Dobal (2011) conducted a study with older African American women who stated that they were taught by their mothers that breast cancer could result from hitting or squeezing the breast and from clogging of the breast due to not breastfeeding. Therefore, it is important that women, a significant source of information for children, be educated so that they can impart accurate information to their children. The women in this study also mentioned indiscriminate sexual practices as a cause of cervical cancer. This finding is supported by Brown, Wilson, Boothe, and Harris (2011), who conducted focus group discussions with Caribbean women, among others, and found that they believed that multiple sexual partners and unprotected sex cause cervical cancer. These are risk factors, but it is important that practitioners highlight the importance of screening as a prevention tool. The women in this study also believed that physical or sexual abuse could result in the development of breast or cervical cancer. A similar finding of the belief that cancer is caused by a bruise or a sore is the results of a study conducted among Caribbean women by Consedine, Magai, Spiller, Neugut, and Conway (2004). These misconceptions may increase women's vulnerability to breast and cervical cancers, diminish the relevance of screening, and thus contribute to increased rates of breast and cervical cancers.

Women discussed whether the local beliefs regarding the potential causes mentioned were accurate, indicating a need for more education on cancers that affect women in an effort to dispel local myths related to susceptibility. An opportunity exists for local organizations dedicated to reducing cancer incidence to play a larger role in addressing the deeply ingrained stigma associated with cancers that affect women.

The second theme is related to the price of screening. Price in this case refers to what women must do to obtain breast and cervical cancer screening. This may be monetary or intangibles. In Grenada, the minimum wage is \$800 XCD/month or about \$296 USD/month. Women described the monetary cost of screening locally along with the potential expense of seeking treatment abroad if cancer is detected. It is important to find ways to encourage screening for prevention, as it has been found that the demands of chronic care for a disease such as cancer can be crippling and contribute to poverty, because most patients pay for care directly out of pocket (Chan, 2010). Taking time off from work to attend an appointment during work hours was cited as an example

of an intangible price. The women suggested having educational sessions supported by employers so that the sessions can occur during work hours. This may be a potential channel for outreach. The perceived lack of confidentiality in health care facilities was a major concern for the women. They were not confident that nurses and hospital staff would keep their diagnosis confidential if cancer was detected. It has been found that women in small communities may be inhibited from seeking health care services because of confidentiality concerns (Committee on Health Care for Underserved Women, 2015). This was linked to the stigmatized status of cancers that affect females in Grenada, as women feared the news of a potential diagnosis becoming public.

The third theme of facilitators to screening was closely related to price in that access to convenient screening appointments was an issue in addition to the availability of local cancer treatment. Some women felt that Grenada did not have access to a mammography machine or the resources to read the results. Many others suggested subsidized mammography screening as an incentive to screening. The need for increased knowledge was mentioned as a major facilitator to increasing breast and cervical cancer screening in Grenada and relates to the fourth theme of preferred methods of communication. Many focus group participants suggested the organization of community educational sessions in which the women could interact with other Grenadian women. This is important given that Hodge, Stubbs, Gurgin, and Fredericks (1998) stated that for educational cancer prevention programs to be an effective tool, they must be designed in culturally acceptable styles of communication. Therefore, the preferred method of receiving information must be considered when developing any educational program.

Lack of knowledge may be related to low health literacy. Health literacy has been defined as a person's ability to obtain and use health information to make decisions (Nielsen-Bohlman, Panzer, & Kindig, 2004). Limited health literacy is associated with poor management of chronic diseases, poor ability to understand and adhere to medication regimens, increased hospitalizations, and poor health outcomes (Agency for Healthcare Research and Quality, 2015). In low-resource settings, the concept of screening to prevent disease is often not well understood (Committee on Health Care for Underserved Women, 2015). Therefore, it is important to not disregard the need for health literacy efforts that highlight the importance of adherence to breast and cervical cancer screening. Despite improvements in technologies to predict and detect cervical neoplasia, these technologies will not detect disease in women who have not participated in the prevention process, even with a perfect screening method (Leyden et al., 2005).

The next steps are planned to conduct this study in the other English-speaking Windward Islands to better understand this issue related to screening in settings similar to Grenada. Future research will also examine the quality

and availability of breast and cervical cancer treatment options in the English-speaking Windward Islands. A lack of treatment options inherently hinders clinicians' ability to treat their cancer patients in a holistic manner using best practices. It also creates an ethical dilemma for public health and clinical practitioners to recommend screening for women who will not have access to the proper treatment in the event that cancer is detected. Providing education without screening and treatment will raise hopes among women living in a medical system that does not have the resources to support their care (International Federation of Gynecology and Obstetrics, 2009)

Conclusion

This research study explored Grenadian women's perceptions of breast and cervical cancer screening. It is clear from the results that in addition to basic information on cancer prevention, educational campaigns must address the social interpretations of breast and cervical cancers in this population, particularly the persistent stigma related to cancers that affect females. Future health education efforts must also recognize the possibility of low health literacy rates among the population. The women who participated in this study identified many barriers to accessing breast and cervical cancer screening in the health care system and to understanding the importance of screening. The results have the potential to contribute to formative research for future social marketing campaigns. The aim of this study was to represent a range of perceptions to better understand the topic, rather than to collect a demographically representative sample. Therefore, these results are specific to Grenada and may not be generalized to all islands in the Eastern Caribbean. However, the results of this study highlight potential issues that may be applicable to similar limited resource settings that should be acknowledged and addressed.

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