Promoting Breast Cancer Screening Among African American Women in Prince George’s County, Maryland
A Qualitative Exploration

June 2015

Prepared by University of Maryland School of Public Health
Center for Health Equity
Commissioned by the Primary Care Coalition
and Doctors Community Hospital
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Prepared for:
Doctors Community Hospital
Primary Care Coalition
Summary

**Results:** Focus group research among African American women aged 40+ in Prince George’s County reveals barriers to breast cancer screening including: (1) knowledge (confusion about screening guidelines and risk perception for African American women); (2) social norms or expectations (secrecy and caregiving roles); (3) beliefs (fear of mammography and fear of diagnosis); and (4) structural limitations (inconvenience, confusion navigating health care and insurance systems). Motivations include: (1) knowing people experienced with breast cancer; (2) wanting to live (belief in the efficacy of early detection); (3) reminders from health professionals; and (4) convenience.

**Conclusions:** Several barriers and motivators are interrelated. While participants are moved to screening by having a personal connection with someone with a breast cancer diagnosis, African American women in the county tend to withhold such information. In fact, participants see breast cancer to be “more of a white women’s problem.” Similarly, while women are motivated by a belief in the power of early detection to enhance survivorship, they also are not exposed to personal stories of positive outcomes due to the hesitancy to share such stories among other women. This evidence points to the potential power of shared stories from survivors and targeted media to increase both accurate risk perception and belief in early detection. In addition, findings point to the influence providers have in the provision of cues to action for breast cancer screening; the potential for messaging to ally fears of the pain of mammography and a need for navigation assistance for some women.
Introduction

In the United States, African American women are more likely to get breast cancer (BC) at a young age; to be diagnosed at a late disease stage and to die from BC than women of other ethnic and racial groups. The state of Maryland ranks fifth in the nation for overall breast cancer mortality (Karcher, Fitzpatrick, Leonard, & Weber, 2014) and the distribution of incidence and mortality follow the national trend. During 2006-2010, the average annual breast cancer incidence rate for African American women in Maryland was 125.7 cases per 100,000 compared to an incidence rate of 131.3 for white women yet the death rate was 31.7 compared to a 22.8 death rate (ACS Breast Cancer Facts & Figures 2013-2014).

Because early detection is tied so closely with mortality, there have been many studies of barriers to screening among African-American women. Most recently, Jones et al (2015) have reviewed this substantial literature to arrive at the following factors influencing screening behaviors. These are: 1) insurance coverage; 2) access to regular medical care; 3) lack of knowledge of breast cancer and risk; 4) family environment; 5) physician recommendation; 6) and perceived risk of breast cancer.

While these large scale explorations are valuable, local conditions frequently require a tailoring of promotion efforts. To this end, the current study sought to explore factors that impact BC screening behaviors among African American women specifically in Prince George’s County. The goal of this study was to delineate specific methods to effectively promote screening in the county. As a whole, women in Prince George's County tend to be better educated, have medical insurance and have higher incomes than their counterparts elsewhere in the country. Thus, this study was structured to focus on issues (perceptions of risk, knowledge of BC, family environment) most relevant to our priority population. Another goal was to focus specifically on avenues to screening rather than barriers which suited our desire to develop actionable results.

Methods

For this project we implemented a qualitative design to explore BC screening beliefs and behaviors in the county among three types of groups: 1) four focus groups with African American women living in Prince George’s County, 2) one focus group with community health navigators working in the county, and 3) one focus group with community leaders and stakeholders in the county. Preliminary findings from the initial four focus groups with the African American women were presented at the two subsequent groups.

Women’s groups included 26 participants with an age range of 42-64 and a median age of 52.5. Despite the large number of African and Caribbean immigrants in the Washington DC area, this project was limited to non-immigrant women who identified as African American and reside in Prince George’s County. Women were recruited from Doctor’s Community Hospital records. We specifically sought women with some experience with screenings to explore pathways to screening. Table 1 below presents some basic information on the participants who were, on the whole, well-educated, healthy and had health insurance. These are characteristics representative of the county (Quinn et al 2012). Participants all had received at least one mammogram in the previous 5 years but only 15% reported that they have a mammogram every year.

The navigators’ group consisted of six participants employed as health care navigators in Prince George’s County area hospitals. The community leaders’ group was attended by approximately 20 participants who were stakeholders in the community. They included representatives from several community based organizations serving African American women, healthcare providers, local government, Prince George’s County Health Department, and the faith community.
Table 1: Demographic Characteristics

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-reported health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td>5</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>8</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>11</td>
<td>42%</td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>2</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade school (1 to 8 grade)</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Some high school (9 to 11 grade)</td>
<td>2</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>High school graduate or GED</td>
<td>4</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Some college</td>
<td>4</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Associate’s degree (2 years of college)</td>
<td>6</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s Degree (4 years of college)</td>
<td>4</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Postgraduate degree/study</td>
<td>6</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>7</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Living together with partner</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>1</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>10</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>7</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td><strong>How often have you gotten a mammogram in the past 5 years?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every year</td>
<td>4</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Most years but not all</td>
<td>10</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Once or twice</td>
<td>12</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Do expect to have a mammogram in 2015?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Undecided</td>
<td>2</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td><strong>What was your annual income for 2014?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 20,000</td>
<td>4</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>20,000-40,000</td>
<td>3</td>
<td>11.5%</td>
<td></td>
</tr>
<tr>
<td>40,000-60,000</td>
<td>6</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>60,000-80,000</td>
<td>3</td>
<td>11.5%</td>
<td></td>
</tr>
<tr>
<td>80,000-100,000</td>
<td>9</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td><strong>Do you currently have any kind of health care insurance?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

As noted, preliminary findings from the women’s groups were presented to navigator and leader groups. Overall, prevalent themes are presented below. In general, the same themes were found in all discussions (women, navigators and leaders). Where differences were found, they are identified in the discussion. Please note that the following is not a complete listing of all views, thoughts, and perspectives that emerged during data collection but is intended to point out those most prevalent and those with the highest level of coherent relevance across discussions. Quotations presented in tables were selected for clarity and do not represent the total number of participant statements related to each theme or concept.
Results

Motivations for Screenings

Motivations for being screened are especially valuable as these are potential avenues to focus on to promote screenings for this population. Women reported several motivators for screening. These included: knowing someone with experience with breast cancer; “wanting to live;” being reminded by a doctor or other health professional; and convenience and (See Table 2).

Knowing someone who had been through an experience with breast cancer was a powerful motivator yet as we see below in the discussion of obstacles to screening, a tendency towards secrecy in this population may add to the perception that few African American women actually have experiences with breast cancer.

Wanting to live implies both a belief in the connection between screening and treatment as well as a belief in the power of early detection. This is interesting particularly in light of evidence from other studies of “fatalism” regarding breast cancer in the African American community (Gullatte et al 2010, Phillips, Cohen & Moses 1999). It is worthwhile to also note that evidence of personally held views of fatalism was not found in any group. While several women expressed fear of a cancer diagnosis as a barrier to screening, none failed to recognize that the chances of survival were greater in cases of early detection.

Finally, both convenience of being screened and encouragement from health providers were valuable parts of the decision to be screened.

Table 2: Motivations for Screenings

<table>
<thead>
<tr>
<th>Women</th>
<th>Navigators</th>
<th>Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowing people who went through it</strong></td>
<td>I saw my aunt. Actually, I had two aunts, one died of skin cancer, and the other one died from liver cancer. And just seeing how it affected them, even as they were going through their treatments and up to their final days I saw in them almost a fear of I can't believe I didn't do something earlier. You see somebody waste away like that and you just want to do better for yourself and for your kids.</td>
<td>In the first group we had one woman who had everything, had the insurance, educated, knew she needed to do it, complained about the pain, but she felt that, “I just can’t relate to it. I don’t know anyone close to me who has had it, so it’s just not a relatable issue. And I don’t really see.”</td>
</tr>
<tr>
<td><strong>Wanting to live</strong></td>
<td>I want to live as long as I can. If I can erase a lot of things that has happened-- like she said, it's going downhill. I want to pull it up and tuck it up and keep going as long as I can.</td>
<td>____</td>
</tr>
</tbody>
</table>

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~ 4 ~
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Obstacles to Screening

Although the women in our sample were successfully screened for breast cancer in the previous 5 years they reported that they experienced several difficulties accessing screening or being motivated to be screened either for themselves or others around them. Tables 3-6 present these obstacles which are broken up into four categories including: 1) Knowledge; 2) Social Norms; 3) Beliefs and 4) Structural limitations.

Knowledge: Despite a great amount of attention on BC in the media, the focus groups did reveal lack of knowledge to be a significant obstacle and pointed to the media itself as playing a role in the creation of confusion and misconceptions.

Lack of knowledge was an issue reported in all focus groups including women’s, navigators’ and leaders’. Women reported being unsure of guidelines but generally estimated that one should be screening every 1 to 3 years. A majority noted that screening was recommended beginning at age 40 in all groups. However, all groups also wondered about why screening begins at age 40 as they see evidence around them of breast cancer occurrences and mortality at much younger ages. Some also wondered why mammography is not recommended for older women. All groups asked about guidelines in question and answer sessions held immediately after data collection. Among the women, there was little or no evidence of understanding that the risks and benefits of mammography vary by age. Making this point to the community may go a long way to having guidelines make more “sense” to women.
In navigator and leader groups, participants agreed that guidelines are confusing. They noted that the media has been reporting differing opinions on screening recommendations. They also noted that structural factors add to the confusion. For example, leaders noted that some public health programs recommend different screening guidelines and that some insurance companies may only pay for screenings every other year. Our findings indicate the negative impact of the confusing and differing guidelines from trusted organizations such as the American Cancer Society, National Comprehensive Cancer Network and U.S. Preventive Services Task Force.

In addition to the confusion regarding guidelines for BC screening women in our groups reported serious misunderstandings of the relationship between race and BC. In all four of our women’s groups, there were participants who see BC as a “white women’s disease.” For example:

“This is just my opinion - I think for the most part, breast cancer is seen as a white woman's disease. So, it's not something that we feel that is running rampant in our communities at least. A lot of people don’t know that it is. I mean, just from what I understand, African American women are not diagnosed as early as white women, so that leads to a higher incidence of death and diagnosis at later stages. And I think our community doesn’t really know about that, maybe because it’s not discussed.

In all groups, this belief was directly tied to images in the media and frequently accompanied by direct references to the Komen Foundation (see quotes in Table 3).

Table 3: Obstacles to Screening - Knowledge

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Women</th>
<th>Navigators</th>
<th>Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m familiar. But I was going to say most of the time we are, whatever the disease is, black women suffer more from it than any other ethnic race. Whatever it is, it seems like black women have the highest numbers in terms of statistics. —</td>
<td>…a couple years ago the American, the U.S. Task Force or whatever was like, “Oh yeah, you only have to get screened starting at age 50 and once every three years.” But like it blew up in everybody’s face, because everybody who believes that you need to get one every year was kind of like, “No, no, no, no, don’t listen to what they’re saying.” But when you have the American Cancer Society who hasn’t changed their view on it, which is getting it once every year, —</td>
<td>The second thing is we as healthcare professionals; we can’t get the message straight. You’ve got one group saying every other year. You’ve got another group that says no, every year. You’ve got a group that says you’ve got to have an abnormal so that you can get a diagnostic…</td>
<td></td>
</tr>
<tr>
<td>Well, I know they keep changing the data, before 40, at 40, 10 years, every year, every other year, every third year. So, the information needs to be consistent and accessible and at least to be everywhere.</td>
<td>For one thing, at least in the African community, breast cancer …it presents at a much younger age, and so what is happening is that is not the norm when you go out there and encourage women to go to screening, because you are telling them if you are 40 and above, but there you have women 32, 27, 29, 40, 39, and they’re saying, “What about us?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social Norms: There are many behaviors and social norms that might interfere with women’s’ screening practices. In much of the literature on African American health disparities there is reported a cultural avoidance of the topic of cancer and a related belief that a diagnosis of cancer is a death “sentence” (Phillips, Cohen & Moses 1999). This has been especially noted among older members of the community. Indeed, the women in our groups also noted the hesitation among older members of the family to share health information. For example,

> I had an aunt, she didn’t have breast cancer, but she died from esophageal cancer, and her family - these two other people died from it - and they never told it. It was like taboo to mention the word cancer. And it just started in the ’70s or ’80s where some people started talking about it - really in the ’90s when people felt comfortable. Before that, and depending on how you were raised and in what environment, you did not hear the word cancer; if you did, you did not talk about it.

In addition, groups also revealed other reasons for secrecy that continue to have salience with younger generations of women. These had to do with expected roles as caregivers and fears of being “labelled” or treated differently (See Table 4). For example, participants told personal stories of how they or others dealt with BC diagnosis without telling family members. In one group, when the story of a woman who didn’t disclose her diagnosis to others emerged, a participant said, “I did that.” She went on to tell her own story of secrecy around her cancer diagnosis. When asked why she didn’t disclose her diagnosis, she said, “they’re all worriers, and I knew if I told them they would worry.” When this story was, in turn, was related to community leaders, a participant in that group added the following:

> And so I have one daughter and a granddaughter and I have two, a sister. I didn’t want anybody-- I am the one that never has problems in the family. So just to keep everybody knowing that about me I just didn’t say anything…

This perception was related to expectations that African American women are able to be “superwomen” by some participants. For example, one participant explained that black women are “usually the pillar that keeps the family, the African American family together—and if something is wrong with that pillar the family starts to fall apart.” It was clear in all groups, that roles of caregiving and support of the family were significant barriers to screening.
Table 4: Obstacles to Screening – Social Norms

<table>
<thead>
<tr>
<th>Women</th>
<th>Navigators</th>
<th>Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>I've been talking to my mother, not knowing that my niece and my baby</td>
<td>So, I do know people that would probably be in high places that have breast</td>
<td>A relative 81 years of age called to say she wanted to walk in Race</td>
</tr>
<tr>
<td>sister at 19 and 20 had biopsies early on. They had like cysts under</td>
<td>cancer or have had breast cancer, but never uttered a word…. Maybe some</td>
<td>for the Cure with Us. And she said, &quot;I need to tell you why I want to talk.</td>
</tr>
<tr>
<td>both arms two years in a row, but nobody said anything about it. It</td>
<td>people don’t want to be labeled as breast cancer.</td>
<td>It’s just not because of the breast cancer. I was diagnosed with</td>
</tr>
<tr>
<td>was a hush-hush thing…So, right now, I don’t even know if breast</td>
<td></td>
<td>leukemia 20 years ago, but I didn’t want to share that, because I</td>
</tr>
<tr>
<td>cancer runs in my family.</td>
<td></td>
<td>didn’t want you guys to worry.&quot; That was just last night. We had no</td>
</tr>
<tr>
<td></td>
<td></td>
<td>idea…We were not able to really help her, because she chose, she made</td>
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<tr>
<td></td>
<td></td>
<td>the decision for us that she did not want us to worry about her. And</td>
</tr>
<tr>
<td></td>
<td></td>
<td>that is going on a lot in our communities.</td>
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<td></td>
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<td></td>
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<tr>
<td>I was saying, sometimes you just can’t take that day off. When you’re</td>
<td>Especially as women, we save our sick days for our kids, because when</td>
<td>I know I would not have gotten my screening last year if it wasn’t for</td>
</tr>
<tr>
<td>the only one providing for them kids, you got to make everything</td>
<td>they are sick we don’t have a choice, we have to stay off of work.</td>
<td>this lovely lady here for that very reason - juggling between career,</td>
</tr>
<tr>
<td>count. You got to take care of them kids, and you don’t be thinking</td>
<td>Oftentimes you don’t take off for yourself.</td>
<td>spouse, children, volunteer work at my church. I have an elderly parent</td>
</tr>
<tr>
<td>about yourself.</td>
<td></td>
<td>that needs care from me. I have barely enough time to sleep, much less,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and when I do have a little bit of free time I do sleep. So this is</td>
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<tr>
<td></td>
<td></td>
<td>one of the last things that I’m thinking about unless there is something</td>
</tr>
<tr>
<td></td>
<td></td>
<td>snacking me in the face that I need to get this done today.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Like my sister, I told her, go and get a mammogram after I learned</td>
<td>…my response to those women is if you don’t come in and take care of</td>
<td></td>
</tr>
<tr>
<td>my lesson. She waited and she waited. She got to have a biopsy did.</td>
<td>yourself you’re not going to be there to pay the bills and take care of</td>
<td></td>
</tr>
<tr>
<td>And she almost lost a breast, because she was a teacher substitute</td>
<td>these kids, and so I understand how you have this need to do this, but</td>
<td></td>
</tr>
<tr>
<td>and she couldn’t take off. At that time they were laying off people</td>
<td>if something happens to you they’re not going to have anybody to do this</td>
<td></td>
</tr>
<tr>
<td>left and right, so she couldn’t afford to take off.</td>
<td>anyway. So, and that usually kind of catches them and eventually I do see some…</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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</tbody>
</table>
Beliefs: There were a few beliefs that participants reported that gave them pause about getting screened for BC. These included: (1) fear of pain or discomfort of mammograms themselves; (2) Fear of being diagnosed with cancer. Additionally, a third belief, mistrust of the medical profession, did arise in one women’s group and in the leader’s group. However, it was not as powerful a theme as the others in our groups.

Table 5: Obstacles to Screening - Beliefs

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Navigators</th>
<th>Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of pain</td>
<td>The pain. When they called me for this study I told them, I said, that was my second one. She said, you haven’t had one since 2012? I said, no, and I vowed after 2012 that was my last one because it was just so painful. So, it wasn’t really until my 40’s that I started having the yearly mammograms, which sometimes I still forget to— purposely forget to do it -- because they hurt.</td>
<td>I had a woman who came in to the clinic just a couple weeks ago, and she said that she has never had her mammogram, but all of her friends told her that it was pain shooting the encounter for the 30 minutes she was in the machine. I said, “First of all, you’re not there for 30 minutes. Let’s explain that. And there is not this whole stretch of pain.”</td>
<td>—</td>
</tr>
<tr>
<td>Fear of diagnosis</td>
<td>MOD: So why do you put it off, do you think? __: Because of fear. MOD: Fear of? __: Fear of I don’t want to know that I have it or that I don’t have it, I mean honestly…</td>
<td>…we have had women that we have to call back for additional views and they’re like, “No, I’m not going to come back because I don’t want to know.” And it’s just kind of, again, the sooner you know about something the better. And you don’t have to live with the stress of not knowing. But that’s a tough one.</td>
<td>—</td>
</tr>
<tr>
<td>Trust</td>
<td>And people don’t know about it. They think it’s radiation and all that kind of stuff; and then it makes you think about what was the Tuskegee [study]</td>
<td>—</td>
<td>So it wasn’t necessarily a thing where she wasn’t insured. It was free also, so it wasn’t a money thing also. And it was just funny to me, because everyone in there, it was the African American women who did come to me and say that, everyone else just came and just signed up and then kept it moving and whatnot. So, it goes deeper than just insurance or whatnot. There really is, I want to say like a distrust of just the medical system in general, and that just goes back from history, like as the Tuskegee syphilis study was just referred to earlier, so it goes beyond just insurance barriers.</td>
</tr>
</tbody>
</table>
**Access.** Most women in our groups and in Prince George’s County are insured so access was less of a strong theme than knowledge, beliefs or social norms. However, they noted the difficulty of navigating confusing health care and insurance organizations to schedule BC screening (See Table 6). They also recognize that lack of insurance may be a barrier for some.

### Table 6: Obstacles to Screening - Access

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Women</th>
<th>Navigators</th>
<th>Leaders</th>
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<td>I noticed that when I did go, it was when most of us worked. So, I don’t see any Saturday hours and I don’t see any evening hours where a person can come and do that. I think that would make it a lot easier for people to come and do. Because like I just started working maybe a year and a half ago or two, and to take off to do that doesn’t look good when you’re just starting a job; and then you also have other doctor’s appointments and stuff like that to do.</td>
<td>Fitting it in on their lunch break or providing Saturdays [would help motivate]</td>
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<td>The times that I couldn’t go it was because of insurance. With my job like where I'm at now, I'm a government contractor; we don't have insurance unless we pay for it. It’s expensive. So, every time I’ve had insurance that’s the first thing I do is make a full physical exam to get everything done. — —...a lot of women don’t have healthcare and they’re not aware that there are free screenings for people who don’t have healthcare. So, I think to make them more aware that that resource is available will encourage people to get it done.</td>
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**Participant Suggestions and Recommendations**

In the course of discussions participants (women, navigators and leaders) were asked for specific suggestions to promote breast cancer screening among African American women in the county. These suggestions follow with those most frequently suggested across groups listed first.

1) **Education/Promotion Content:** Use of AA women and images in promotion & health education materials. All groups strongly suggest the use of images that promote identification with African-American women.
Messaging regarding how BC screening supports caregiving in the long run. As one participant noted, “you have to take care of yourself to be here for them.” This was noted in all groups.

Messaging regarding pain. Navigators suggested a comparison that they use to help women manage their fear of the pain of BC screening. For example:

I try and ask them, like especially if they have had babies, like some women are like, "I have five babies," I'm like, "Then this should be a piece of cake. Five babies? Yeah, you're going to be just fine."

Our lead mammographer … has some lively conversations about this, and she kind of puts it in a humorous perspective. She says, "How many fillings do you have? You didn’t make a big deal about going to the dentist and get that kind of treatment."

Or like tattoos. We have women that come in with tattoos. I’m like, "You can do a tattoo, you can do this." So yeah I think that all of us try to compare it to something else, like have you ever had whatever it is.

Promotion at younger ages. Participants were concerned about women with BC at younger ages reflecting incidence rates. This may be something to address in promotion efforts. Participants also suggested that women should not have to wait until age 40 to hear about BC screening.

2) Sharing of BC experiences. The power of sharing stories was noted in all groups. It was noted to be valuable to illustrate: a) the risks specifically for African American women and b) the value of early detection. Sharing could be interpersonal sharing or accomplished more formally through media.

3) Promoting BC screening year around. This was brought up by women, navigators and leaders. One navigator suggested, “We only hear about breast cancer when it’s October, but how about February, which is Black History Month, if this is the group that you’re trying to reach?”

4) Promotion of BC screening from health providers, especially primary care physicians. This was noted in all groups.

5) Promoting BC screening at community events, neighborhoods, local businesses, churches and health fairs. This suggestion was made in all women’s groups. In one group, participants further suggested the use of Mobile Units for screening at community events

6) More convenient scheduling. This was noted in all women’s groups. However, structural limitations make this a specifically difficult task.

7) Navigation Assistance. Navigating the health care system was an issue brought up in all groups. Community leaders strongly suggested providing African American women access to information regarding both BC in general and BC screening. This group suggested creating a central “clearinghouse” for information in the county.

8) Promotion of self-advocacy and advocacy for other women. This was strongly promoted in the leader discussion. One participant noted:

I have 13 sisters and I check on them all the time. I am responsible for them… I’m responsible for each and every one of them, because I am the advocate in my family. I am responsible for my 32 nieces. I am the advocate in my family. When I go home I do a check off. Who has not had their mammogram yet? I’ll schedule the appointment to drive down there. I am an advocate.
Conclusions

Many of our participants had excellent ideas about how to promote breast cancer screening among African American women in Prince George’s County. However, the promotion of any one program to increase screening rates in the county is beyond the scope of this study. We can say that it is advisable that any such attempt, first consider the findings presented here.

Initially, it is important to recognize that several barriers and motivators are interrelated. While participants are moved to screening by having a personal connection with someone with a breast cancer diagnosis, African American women in the county tend to withhold such information. In fact, participants see breast cancer to be “more of a white women’s problem.” Similarly, while women are motivated by a belief in the power of early detection to enhance survivorship, they also are not exposed to personal stories of positive outcomes due to the hesitancy to share such stories among other women.

It is suggested that any program or other effort to reach African American women in the county take into consideration the following conceptualizations of the “Decision not to be Screen” (Figure 1) and the Decision to Screen (Figure 2) below which are based on these findings.

Figure 1: Decision not to screen
Overall, results indicate no great barriers to screening other than perceptions about the relative benefits and difficulties of breast cancer screening. Tipping this scale into a direction favorable for screening will involve some sort of messaging directly tailored to this population. African American women are generally aware that breast cancer is a threat, but consider it to be a minor one, in part due to messaging perceived to be directed at women of other ethnic and racial groups. In addition, we see the power of the stories of friends, family and other figures which indicate the use of targeted media or interpersonal campaigns that stress relatable and recognizable survivor stories. This is supported by McQueen et al (2011), who similarly point to the effectiveness of survivor narratives as a motivator for screening and treatment. The effectiveness of media and word of mouth approaches has been demonstrated in other contexts as well. Coughlin (2014) find success with a combination of text messaging, church interventions and radio promotion while Hall et al (2012) report the effectiveness of radio promotion as well.

It should be noted that promotion with the authority of health providers – as indicated by this research - has been shown to be effective as well (Sabatino et. al. 2008). Such approaches may prove to be a powerful supplemental to reaching women through other means. However, issues of mistrust of the medical profession among this priority population should be considered. Finally, navigation assistance for screening and messaging to help women accurately assess the pain involved in mammography are also suggested.
References


McQueen, Amy; Kreuter, Matthew W.; Kalesan, Bindu; Alcaraz, Kassandra I. Understanding narrative effects: The impact of breast cancer survivor stories on message processing, attitudes, and beliefs among African American women (2011) *Health Psychology*, 30(6), Nov 2011, 674-682.

