Grenadian women’s perspectives on screening for breast and cervical cancer:

 A participatory approach to understanding prevention

**Background**

Among women, breast cancer is the most commonly diagnosed cancer, while cervical cancer is the fourth most common worldwide(American Cancer Society [ACS], 2015). Globally incidence rates for both of these cancers continue to increase despite the availability of effective screening tests. The most recent global estimates from 2012 report that approximately 1.67 million and 528,000 new cases of breast and cervical cancer cases respectively were diagnosed worldwide (ACS, 2015) This compares to 1.3 million and 529,000 cases in 2008 (ACS, 2008; International Agency for Research on Cancer, 2010). Alarmingly, 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 344km squared. 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 110,694 in 2015 (Central Intelligence Agency, 2016). 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 cancer 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, & Gawryszewski, 2013)~~,~~ age standardized mortality rates (ASMR) 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, ASMR increased from 7.3 in 2000 to 16.9 in 2009 (Luciani et al., 2013). This rate is higher than the World Health Organization (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 benefitted from these advances. There is a limited capacity to prevent, as well as treat cervical cancer due to prevention programs being either unavailable or underfunded because they compete with other priorities (Jones, 1999; Ngoma, 2006; Sherris, Herdman, & Elias, 2001). Between 1996 – 2000 the age standardized incidence rate was estimated to be 60.7 while the age standardized mortality rate was estimated to be 9.7 (Asulin et al., 2004). The mortality rate for the period 2000- 2010 was an estimated 16.7/100,000 (Bahadoor-Yetman et al., 2013) an almost 2 fold 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, 5.9 respectively. The prevalence rate for this period was also a reported 52.4/100,000 women 15 years and older (Bahadoor-Yetman et al., 2013). This is of concern as 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).

Developing countries such as Grenada contribute more than 85% of the global burden of women’s cancer (Colombo et al., 2012). The age standardized mortality rate in these countries is 10/1000, which is three times higher than in developed countries (Colombo et al., 2012). Screening programs in developed countries have proved to be successful, accounting for approximately 5 per every 10,000 of the mortality rate in these countries (Wright, Aiyedehin, Akinyinka, & Ilozumba, 2014). Despite the successful reduction of mortality rates in breast and cervical cancers in developed countries, effectiveness of screening strategies in developing countries varies based on the resources available and the needs of the population involved (Luciani et al., 2013). Therefore, technologies that have the potential to reduce the mortality rates due to breast and cervical cancers in the Caribbean and Latin America continue to face challenges to implementation due to constrained resources.

 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 has been identified as a key component of effective programs for the early detection of breast and cervical cancer in low-resource settings. Mammography, breast self-exam and clinical breast exams can detect asymptomatic breast cancer. However, screening mammography has proven to be the most effective method (Nyström L. et al., 2002) and can help to reduce the number of deaths from breast cancer among women ages 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 (Nurse Carla Baptiste, Personal Communication).

Population based screening, using the Pap smear test, has significantly reduced rates of cervical cancer in both 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, thirty medical stations, and the Grenada Planned Parenthood Association. Multiple efforts to find the most recent data related to breast and cervical cancer screening were employed. However, in the absence of a national cancer registry it proved difficult to find a breadth of current literature that would provide a more revealing picture of cancer incidence and mortality in Grenada. When examining available data by parish, Pap screening rates appear to be steady between 2011 and 2013. For example, during the 2011-2013 time period in St George, the number of pap tests completed were 272, 304 and 216 while 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 both breast and cervical cancers and low Pap test rates. 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 breast and cervical cancer in the Caribbean 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 was recently conducted and found that many women expressed fear about mammography and its potential consequences including social stigma and losing romantic relationships. 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 an important contribution 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 (The World Bank, 2015).

The purpose of the 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.

**Methods**

A community-based participatory research (CBPR) approach was utilized 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 comprised of nurses, physicians, public health practitioners and community members representing the Grenada Medical Association, Grenada Nurses Association, Grenada Heart Foundation, the Grenada Cancer Society, the Pink Ribbon Society and the Grenada Public health Association. Stakeholders at this initial meeting provided input on the focus group guide, recruitment flyer design and strategies for dissemination of 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 Georges 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 since 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 21-64, 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 flyers were posted 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. Due to insufficient recruitment numbers during phase one, a second phase of recruitment was implemented. Phase two involved direct, face-to-face recruitment of eligible persons. The project team visited each parish, handed out flyers, provided information about the study, and collected contact information. The project manager contacted interested persons to confirm their eligibility and share the time, date and venue for the focus group discussions.

**Focus group discussion**

Once the required numbers of persons were recruited within a parish, the focus group discussion was scheduled at a convenient location. Refreshments were served before the start of each session to allow for the establishment of 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 semi- structured interview guide to initiate the discussion. The semi- structured interview guide comprised 19 questions on participants’ knowledge, screening barriers and facilitators, information sources and potential types, sources and channels of information as it relates to breast and cervical cancer. Each session lasted approximately 90 minutes and was tape-recorded along with hand written notes. A token of $10EC ($4US) dollars was given to each participant at the end of each session.

**Analysis**

Each focus group was audiotaped, transcribed verbatim by a professional transcriptionist and reviewed for accuracy. A codebook with operational definitions was created using 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 reconciled any differences in coding through discussions. Once thematic saturation was achieved, a revised codebook was developed. The remaining transcripts were coded by a single coder using NVivo 10 software (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 cancer, 2) Price of participating in breast and cervical cancer screening, 3) Facilitators to screening, and 4) Preferred methods of communication.

**[Insert Table 1]**

**Social Interpretation of Breast and Cervical Cancer**

The initial focus group interview guide questions were asked to gain an understanding of women’s knowledge of breast and cervical cancer and related screening. It was clear from the responses that women’s interpretation of breast and cervical cancer 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). In addition to physical abuse, women who were abused sexually are also believed to be at higher risk of both breast and cervical cancer. “Sexual abuse can cause breast and also cervical cancer (unclear) I don’t think with the breast it’s true” (FG2, R3).

**Sexual Activity.** Promiscuity or sexual activity has also been cited as a cause of breast and cervical cancer among focus group participants. 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 that was mentioned during focus group discussions as a cause for breast and cervical cancer 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 in order to obtain breast and cervical cancer screening. This may be monetary or something intangible that women consider valuable.

**Cost of Care.** In each parish the cost of healthcare was frequently cited as a barrier to receiving care among focus group participants. “…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)

“ …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 in order to get screened even when they are willing. One participant shared, their person 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 when it comes to undergoing a screening procedure as one participant states, “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 when it comes to not only the procedure, but also when it comes to feeling exposed in front of health care providers. Several participants reported being uncomfortable either as a result of being sub-conscious when it comes to 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 participation in screening among women. 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 there were a few women felt that concerns over confidentiality should not supersede taking preventative health measures. Instead, women should put additional effort in finding a practice that they are more comfortable with.

“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 (4 parishes) and access to care (2 parishes) was identified as major facilitators to this population being screened. “…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 providing incentives either 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).

While participants also brought attention to some of the free or low-cost services available, most of these provisions are through the use of health clinics or health centers. These facilities raise additional barriers, as they are typically associated with concerns regarding confidentiality among participants, which was another barrier raised by 4 of the parishes. For example, while one participant mentioned, “…if you don’t have the money to go by a private doctor, you have to go by a public doctor, heath center” (FG5, R4); it was also noted “There’s an issue with confidentially 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 s preventing people…” (FG2, R3). In addition, to increasing general knowledge about cancer, participants also felt that they needed to learn the process for when to initiate screening for cancer and clarification on conducting breast self exams. This points to a need for increased health literacy in the population. For example, one participant states, “…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 when it comes to information about breast and cervical cancer. A common sub-theme 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 noted by this type of encounter were that they, “…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. While some preferred small groups for “…open discussion with the facilitator and the people there” (FG7, R1), 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). These workshops were also recommended 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 who may have 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 (unclear) so if they would arrange a workshop for women to get more educated on that breast cancer or cervical cancer” (FG6, R9).

**Media.** While 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 cancer. However, participants also noted that these formats may not be ideal for a couple of reasons. One reason participants thought technology might not be suitable for the population due to 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). A mentioned limitation of using media formats was that they 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 of breast and cervical cancer screening among a sample of Grenadian women without a previous breast or cervical cancer diagnosis. 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 first-hand 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 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, there were no major differences found among the women as each theme was present in a minimum of six of the seven parishes. All women were in agreement 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 their social contexts and cultural beliefs related to sex and sexuality. Women’s cancers were seen as taboo and likely caused by sexual activity both voluntary and involuntary sexual abuse. As a result cancer was seen as social stigma and something that women did not share with others including family. A few women mentioned physical trauma to the breast and breastfeeding as a cause 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 clogging of the breast due to not breastfeeding. It is therefore important that women, a significant source of information for children, be educated so that accurate information can be imparted 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, using focus group discussions with Caribbean women among others, found that they believed that multiple sexual partners and unprotected sex caused cervical cancer. While these are risk factors, 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 sore was 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 cancer, diminish the relevance of screening and thus contribute to increased rates of breast and cervical cancer.

 Women discussed back and forth on whether the local beliefs regarding the potential causes mentioned were accurate indicating that there is a need for more education on women’s cancers as 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 engrained stigma associated with cancers that affect women.

The second theme is related to price of screening. Price in this case refers to what women must do in order to obtain breast and cervical cancer screening. This may be monetary or intangibles. In Grenada, the minimum wage is $800 Eastern Caribbean Dollars (XCD) per month or about $296 USD per 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 since it has been found that the demands of chronic care for a disease like cancer can be crippling and contributes to poverty since 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. It was suggested to have educational sessions supported by employers so that the sessions can take place 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 female cancers 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 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. There were many suggestions by focus group participants to organize 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, it 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 regimes, increased hospitalizations, and poor health outcomes (Agency for Healthcare Research and Quality, 2015). In low resource settings it has been found that the concept of screening to prevent disease is often not well understood (Committee on Health Care for Underserved Women, 2015). Therefore it is important 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 it will not detect disease in women who has not participated in the prevention process even with a prefect screening method (Leyden et al., 2005).

Next steps are planned to conduct this study in the other English-speaking Windward Islands to better understand this issues 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 utilizing 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 Gynecological 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 cancer in this population; particularly the persistent stigma related to female cancers. 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 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 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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