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Research paper

How black West African migrants perceive cancer

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What is known on this subject

- Cancer is generally perceived as a taboo subject among people of African origin.
- No previous research on cancer health beliefs among Ghanaian and Nigerian people living in the UK has been identified. Anecdotal information on this subject comes from studies undertaken among black people in the USA.
- There is a substantial literature on health beliefs among South Asian migrants living in the UK.
- There has been only limited research on cancer awareness among black and minority ethnic (BME) groups in the UK.

What this paper adds

- West African migrants' perceptions of cancer are similar to those of other ethnic groups, cultures and countries across the world.
- Ghanaian and Nigerian people have an understanding of cancer and its likely risk factors.
- Community and religious leaders of black people should be involved in cancer screening programmes to increase utilisation of cancer services among their communities.
- There is a need to critically review the generalisation of the perceptions used to describe people of black African origin from studies undertaken in both the USA and the UK.

ABSTRACT

This paper examines health beliefs, knowledge and perceptions of cancer among two Anglophone black African migrant communities in Luton, UK. Using a focus group approach, 53 participants from the Ghanaian and Nigerian migrant communities were recruited for separate and mixed male and female groups as well as separate and mixed groups of different nationalities and religious backgrounds.

The study showed that the participants have both biomedical and faith-based understandings of cancer. They will seek medical help as quickly as possible, as well as expressing their health concerns to God in prayer. Silence, concealment and stigma were identified as barriers that prevent some individuals from accessing cancer services. It is hoped that the findings of this study may contribute to cancer awareness campaigns as well as forming the basis for future research among this and other under-researched black minority migrant communities in the UK. Professionals working with these communities need to have an awareness of these perceptions in order to ensure that these populations receive culturally sensitive care.

Keywords: culture, health beliefs, perceptions of cancer, West Africa

Background and literature review

Around 309 500 people were diagnosed with cancer in the UK in 2008. Cancer is the second leading cause of death in the UK, and was responsible for 40% of all deaths in adults aged 25 to 74 years between 2007 and 2009. Epidemiological studies and cancer awareness surveys indicate that there are considerable differences in the incidence of cancer and mortality across different ethnic groups in the UK (Marlow *et al*, 2012). A survey among black and minority ethnic (BME) groups to launch an ethnic minorities cancer awareness campaign in 2009 revealed that many ethnic minority groups had a low awareness of the signs and symptoms of various forms of cancer, even though some groups have a higher risk of certain types of cancer than others (Cancer Research UK, 2009; Banning, 2011). It revealed that 46% of ethnic minorities were unsure of the signs and symptoms of the various forms of cancer, or of how to reduce their cancer risk, although 61% of respondents had a family member with cancer. Two different studies among BME groups indicated that African-Caribbean women were more likely to have had cervical smears on their own initiative than other women in the group (Waller *et al*, 2009; Thomas *et al*, 2005). They showed a clearer understanding and were more knowledgeable about breast self-examination and cervical smears. Similar findings have been reported among black people of West African origin. In a study that assessed the barriers to effective uptake of cancer screening facilities, black Africans were able to correctly identify liver, breast, cervical and prostate cancers as commonly occurring within their community (Thomas *et al*, 2005).

In view of this kind of disparity in the levels of cancer knowledge and perceptions of cancer in black people, among other members of BME groups, there is a need to assess the opinions of the different communities that constitute the diverse black African immigrant populations in the UK. This is because of the increased migration of black Africans who have settled in the UK. Census and other government data group them together as one entity, rather than as separate entities originating from a huge continent with a great diversity of societies and traditions. The research presented in this paper examined cancer health beliefs and perceptions among two such Anglophone West African migrant communities (Ghanaian and Nigerian) in Luton in the UK.

Methods

A qualitative study was undertaken to investigate the views of Nigerian and Ghanaian people about cancer. This paper focuses on the first phase of the study, in which the aim was to gather baseline data. Five focus groups were held between January and July 2012. These included three single-gender groups, consisting of Ghanaian women ($n = 10$), Nigerian women ($n = 10$) and Nigerian men ($n = 9$), and two separate specific religious groups of mixed gender and nationality, namely Christians ($n = 10$) and Muslims ($n = 14$). Separation of the participants by gender, nationality and religion permitted an open discussion of more personal and religious topics and allowed tailored questions to be discussed. It helped the participants to talk openly and express themselves freely. The mixed groups gave an opportunity to individuals who had religious inclinations but did not consider the open discussion of gender-sensitive issues an obstacle for them to freely express their opinions. Each focus group lasted for between 45 and 90 minutes and was audio taped. The recordings of all the sessions were transcribed and analysed using iterative inductive analysis (Halfpenny, 2005). This process required that patterns, themes and categories of analysis emerged from the data, and it resulted in the development of a coding scheme (Krueger and Casey, 2000). Once the coding scheme had been developed, the transcripts of the focus groups were read again and coded. The act of coding allowed a re-examination of the salient issues generated from the focus groups, and provided an opportunity to peruse the narrative for particular subtopics.

Participants were recruited from a range of local churches, mosques and West African organisations. This strategy required considerable time and effort to build relationships with key individuals in these settings so that they could vouch for the researcher to their members, many of whom were initially reluctant to engage in a project on a subject that they regarded as taboo. The participants were black West African migrants who had been residing in the UK for 3–5 years, were aged 20–55 years and could speak English. Their educational and vocational levels ranged from students to teachers, accountants, carers, administrators, healthcare professionals, security workers and unemployed migrant workers. Ethical approval for the study was obtained from the Ethics Committee of Birmingham City University.

Findings

The key themes generated during the study are discussed below.

Knowledge of the nature, types and causes of cancer

Despite being a relatively heterogeneous group, all of the participants were unanimous in describing cancer as a deadly disease. Wording such as 'cancer is a killer' and 'a drastic disease which can affect any part of the body' was used to describe the disease. The majority of the participants indicated that although cancer is not a major killer disease like malaria, typhoid or poliomyelitis in their home countries of Ghana and Nigeria, they were aware of the different types of cancer, such as breast cancer, prostate cancer, bowel cancer, skin cancer and leukaemia. One of the Nigerian men indicated that 'there are different types of cancer ... and my uncle died of one ... like leukaemia six years ago.' Responses such as 'cancer is a disease that affects the skin ... and your ... your brain' (Nigerian men's group) provided indications of what the participants knew about different types of cancer. Another example was 'My dad had prostate cancer ... he was unable to pee for a long time' (Ghanaian women's group). Comments such as 'I know cancer to be like some abnormal growth in certain parts of the body' (Nigerian women's group) and 'the fear and knowledge of cancer is enough to kill people' (Ghanaian women's group) were used to describe individual perceptions of the disease. Other comments from the Ghanaian women, such as 'our people needs to realise that it is just like any other disease', were also used to describe how cancer is perceived compared with other diseases. One of the Nigerian women participants stated that 'we are the product of our environment, and here everybody knows about cancer in the UK.'

Religion and cancer

Although both Islam and Christianity encourage the use of orthodox medicine, some of the participants also regarded divine healing as a way of seeking a cure for cancer. There were divided opinions on this issue. Whereas some of the participants believed that God had a role in the origin of cancer, others did not share this view. However, accounts documented in the literature about how some black people perceive cancer as a spiritual attack by the devil, or as retribution for evil deeds or not 'living right with God', did not resonate with any of our participants (Schumaker *et al*, 2007). Rather, there was a general consensus that it was only the uneducated who believed that cancer was a punishment from God. A woman from the Nigerian women's group stated that 'you can't compare what they believe with our own Christianity now ... things are different now.' Although it was suggested that God created everything, both good and bad, and that by assumption this included cancer, the participants were unanimous in their belief that God was the person to turn to when one had cancer, and they also believed in the existence and efficacy of gifted men of God who could pray for healing from cancer. However, prayer was not enough. Members of the Nigerian and Ghanaian women's groups indicated that although most Africans are religious and believe that God will take care of them, people should not hold on to beliefs at the expense of seeking medical advice. One participant stated that 'because of our beliefs in God, we assume it is not there when it is there' (Nigerian man from mixed-gender Muslim group). This was because there had been instances when some individuals had trusted God for divine healing and delayed seeking medical help early on when their cancer could have been easily diagnosed and treated. When asked what they would do if they suspected that they had cancer, one response was 'If I see cancer, the first thing I will do is to pray about it' and then 'I will immediately go to my GP because he has to check me' (Ghanaian man from mixed-gender Christian group).

Adoption of western lifestyle and its effects

The majority of the participants in the Nigerian men's group believed that living in the UK increased the likelihood of developing cancer. For example, one participant stated that 'here they have things like nuclear plants, nuclear energy and stuff like that to power their electricity ... and all these produce radiation which have [been] proven medically to cause cancer' (Nigerian men's group). Similar arguments were made about the use of food preservatives and some of the constituents of fizzy drinks. Further comments were made by the Ghanaian women's group, such as 'The chickens here are genetically modified' and 'The things we drink ... erm fizzy drinks and people smoking around you everywhere' (Ghanaian women's group). The association between consumption of western sugary foods and fizzy drinks containing aspartame and the likelihood of developing cancer was not new to most of the Ghanaian and Nigerian participants. They argued that such foods and lifestyles are now commonplace in most Ghanaian and Nigerian cities and states. The hardness of the water in many parts of the UK (demonstrated by the constant need for descaling of kettles and washing machines), and the exposure of young girls to the contraceptive

pill at an early age, compared with the traditional moral and religious values back home, were also identified as likely risk factors that could cause most African migrants to develop cancer as they settled here in the UK over time and became integrated into the larger society.

However, contrasting opinions were expressed by the Nigerian women's group and by the mixed-gender, mixed-nationalities Muslim group when participants were asked to discuss the significance of the adoption of western lifestyles and consumption of *oyinbo* (white man's) foods, which some research has identified as causes of cancer (Parkin *et al*, 2011). The term *oyinbo food was* regularly used to describe all of the foods consumed in the UK, but there was no consensus about the effects of living in the UK or the possibility of an increased risk of developing cancer (Parkin *et al*, 2011). Whereas some participants indicated that they only heard of and became aware about cancer when they migrated to the UK, others indicated that they had known about or had experience of the disease back home in Africa. This was demonstrated by comments made by participants in both the Ghanaian and Nigerian women's groups, such as 'I don't think cancer is a UK or western democracy thing ... back home a lot of people were dying of it and are still dying of it.'

African herbal medicine

Opinions about the use of traditional African herbal medicine in the treatment of cancer were varied and divided. Different uses of local herbs, such as soaking them in gin and then boiling and blending them with fruits or vegetables such as carrots, were identified as local practices back in Africa. The use of local African herbs such as '*agbo*' (unidentifiable) and '*Egun inu igo'*, a palm wine West African homebrew sometimes called *masquerade* or *folly in a bottle,* was identified in the treatment of cancer and other diseases. Comments such as 'Some people prefer it instead of going to the doctor, they *agbo*' and 'That one used was fruit, ... carrots. She started drinking those blended carrots ... it worked for the other family member' (from the Nigerian men's group) showed that some of the participants had seen or experienced the use of local herbs to manage cancer patients in the past. However, diverse and conflicting opinions about their efficacy and use in treating cancer and other diseases were also expressed in comments such as 'I use it very ... very well! I believe it does work, but how it does work in relation to cancer, I don't know' and 'I think it boils down to ignorance for people using herbs as a precaution for not having cancer' (mixed-gender Muslim group). Examples of how people perceived the use of local African herbs in treating cancer and other diseases could be seen in responses to inquiries about whether they would use them here in the UK. For example, participants stated that 'I knew about them ... I was never exposed to using herbs and I will never take them' and 'I've been using herbs since when I was young, and I have been using it even until now' (Nigerian men's group).

Stigmatisation in cancer care

One other key finding from our study was the importance of overcoming the stigma and secrecy associated with cancer. All of the participants agreed that cancer is a common disease in the UK. The Ghanaian women's group was quick to identify stigmatisation as a likely barrier to accessing cancer services and facilities. This could be seen in the following response: 'Our people are ashamed to even talk to someone about a simple gout in their finger, talk less of a lump in their breast.' As in most cultures across the globe, the giving and receiving of bad news is not always a palatable experience, especially when it concerns one's health. As one of the participants in the mixed-gender Christian group stated, 'We are Africans and even though we have left home our cultures are still with us.' Such secrecy and stigmatisation are well documented as barriers that have prevented people from seeking medical help which could have ensured a better outcome of cancer treatment (LIVESTRONG, 2010).

Steps to increase utilisation of cancer services

One of the primary aims of this study was to explore avenues for informing black West African communities about cancer. In response to being questioned about how the utilisation of cancer services could be increased, the participants were unanimous in suggesting that information about cancer and cancer services should be tailored to incorporate their religious and community activities. Churches and mosques served both as places of worship and as venues for socialisation. This can be seen in comments from the mixed-gender Christian and Muslim groups, such as 'There are so many churches and mosques in the UK where Africans go for prayers' and 'Government should work with the leadership of all the churches and the mosques if they want black people to use cancer services more.' This finding is important in the context of the comments of a Nigerian woman, who stated 'I am a Christian and everything I think emanates from and ends with God.' Similar enthusiasm for cancer enlightenment campaigns was expressed in comments such as 'To be honest that is why I really wanted you to come and talk about cancer in this

place.' Furthermore, the participants made it clear that 'having doctors and question time' in churches and mosques and not just 'spiritual food alone' were some of the ways they would like to see information about cancer being made available. Holding focus groups such as those undertaken in this study, and having people who could sponsor them, were also identified as strategies for increasing the participation of black Africans in cancer awareness programmes, as well as the utilisation of cancer services in their communities.

Discussion

The focus group discussions were productive and provided both new and confirmatory information on factors identified in the literature. The themes showed participants' level of knowledge and perceptions of cancer, as well as what they described as the dangers of adopting '*oyinbo*' lifestyles and eating '*oyinbo* foods.' Sedentary lifestyles, whether within or outside the UK, were seen as increasing the risk of developing cancer. These risks were considered to be increased in the UK. Recently published research, such as that of Parkin *et al* (2011), has identified elements of these '*oyinbo*' lifestyles and foods as predisposing factors in the development of heart disease, stroke, obesity and cancer. The findings of our study also appear to contradict previous accounts which suggest that BME groups have little knowledge of cancer or awareness of its likely causes (Marlow *et al*, 2012; Scanlon and Wood, 2005). Although this may be true for some sections of the BME population, it does not appear to be so for Ghanaian and Nigerian migrants. This is consistent with the findings of Thomas *et al* (2005), whose study participants from the West African sub-Saharan region were reported to be more aware of cancers such as liver and ovarian cancer. They were also found to have a clearer understanding of and be more knowledgeable about breast self-examination and cervical smears than other members of the BME groups.

Our study participants used combatant and militaristic descriptions such as 'Cancer is a killer; it can attack any part of the human body' to describe cancer as a deadly and drastic disease. However, they were able to name and identify different types of cancer. They reported personal experiences of ovarian and prostate cancer survivors, and of relatives of people who had died from breast cancer, prostate cancer and leukaemia. Members of all five groups were able to provide examples that showed their understanding of the nature of cancer, the orthodox treatment pathways available, and the fact that cancer could be cured if it was detected early enough. Lumpectomies for simple lumps in the breast and prostate screening measures for men in their early forties were identified as ways of identifying and curing these types of cancer. These findings are consistent with those of Robb *et al* (2008) and Thomas *et al* (2005) in their article on barriers to effective uptake of cancer screening among black and minority ethnic groups. They indicated that black Africans in their study were able to identify liver, ovarian, lung and breast cancer as common occurrences among their communities. Consequently, there appears to be a need to debate the significance and the relationship of previous studies undertaken among black people of African origin in the USA and the UK which have then been generalised to all black populations. Such reports have indicated that black people have little knowledge of and are least likely to be aware of the risk factors for cancer.

It is also interesting to note the emergence of a Yoruba term for cancer. *Arun jejere* was identified by two of the five groups as a name that was used to refer to cancer back home in Africa. Members of the Nigerian men's group were unanimous in pointing out that, because cancer is white man's language for a disease which is not indigenous to Africa and most Africans, there is a misconception about what to do and how to respond to it even when it is suspected or diagnosed among local people. Such confusion has led to misunderstandings about how to describe it to others or be specific about its signs and symptoms. They argued that the absence of a generic and popular local African name could have prevented some from identifying how to treat or manage the disease. It was argued that, unlike most health conditions that are normally treated with traditional African herbal medicines, cancer required a different approach, and that treatment with herbs constituted ignorance. The lack of terminology for cancer was evident in different groups, such as the Nigerian women's group and the mixed-gender, mixed-nationality Muslim group. *Arun jejere* was a local Yoruba name for cancer, but participants from other ethnic groups, such as Ibos, Ijaws, Urobos or Hausa from Nigeria and the Akans, Ewes, people from Mole-Dagbane, Guan, and Ga-Adangbe, Krobbo in Ghana, did not identify a local name for the disease in their native dialects. No other ethnic group or tribe represented in the study population reported a local African name for the disease.

In the same vein, some of the participants reported that, among the uneducated, cancer could be viewed as the result of an attack by the devil. During the interactions in the group discussions, the participants agreed and accepted that such opinions existed only among uneducated Africans. This is similar to other views about the nature and causes of the disease across the world (LIVESTRONG, 2010). This point leads one to question and critically review some of the perceptions and reports about black people's health beliefs

from studies undertaken previously in the USA (Talosig-Garcia and Davis, 2005) and in the UK. For example, a UK study by Brown *et al* (2007) on the health beliefs of African-Caribbean people with type 2 diabetes reported that they had poorer outcomes than other individuals with diabetes, and noted that they preferred natural treatments and regarded dietary or tablet-controlled treatment as a mild form because they feared insulin treatment. Although this type of perception has been reported across different ethnic groups, cultures and nations, with particular reference to western and South American countries (LIVESTRONG, 2010), it seems to be specifically used to describe black people of African origin.

This point leads to the question of the relevance of the participants' discussion on the role of God and cancer. The Nigerian women's group and the mixed-gender, mixed-nationality Muslim group argued that God plays a significant role in cancer diagnosis and treatment, and in overall management of or healing from the disease. The role of churches and mosques in providing spiritual and emotional guidance in times of physical and health challenges is well documented in the literature (Swartz, 2002). Perhaps this is what the participants were referring to when they indicated that God had a role to play in cancer treatment. In these groups there was a willingness to utilise cancer services in the UK, and most were happy to have their community and religious leaders involved in cancer awareness and screening programmes. The findings of this study are similar to those of Wittink *et al* (2009), who indicated that addressing spirituality during the clinical encounter of African Americans may lead to improved detection of depression and treatments that are congruent with the patient's beliefs and values. Although the findings of this study appear to be in contrast with the trend towards cancer awareness and cancer incidence reports associated with black people in the UK, it is important to consider the impact of such reports on cancer policies and programmes that are developed for members of black and other minority ethnic groups in the UK. This is highlighted by our review paper, which examined whether black African migrants' perceptions of cancer differ from those of other ethnicities, cultures and races (Ehiwe *et al*, 2012).

Limitations of the study

We are aware of the limitations of the small sample size. Our participants were drawn from a particular social group, namely educated people, from only two West African countries. We are also aware that we did not include migrants from Francophone West African countries. Consequently, we cannot generalise our findings.

The time frame of 3 to 5 years was included as one of the selection criteria because it was assumed that many of the traditional health beliefs and perceptions of the migrants would persist throughout this time period. It allowed enough time for individuals to familiarise themselves with healthcare in the UK, but also to ensure that their beliefs were not unduly influenced by the impact of the UK society and environment. Finally, it is known that some of the participants were from the healthcare professions, but it is unclear whether their opinions were influenced by their training and profession.

Conclusion

This exploratory study provided a baseline report on how Nigerian and Ghanaian migrants in Luton perceive cancer. It has provided an insight into the different levels and types of knowledge they have about cancer, even though the disease may not be commonly recognised in their native countries. The impact of their religious and spiritual beliefs on the occurrence of cancer, and their ability to live with the disease, have also been briefly discussed in this paper. The diversity of opinions about the effects of adopting a western lifestyle or living in societies where cancer appears to occur more frequently, and their experiences of the use of local traditional African herbs in the treatment and management of cancer, have also been discussed. The participants indicated that they believed that migrants from the West African sub-Saharan region can be helped to utilise cancer facilities and resources more effectively if their community leaders and religious places of worship are incorporated in such programmes by relevant policy makers and programme designers.

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