

BREAKING TABOO IN MEDIA CONCERNING BREAST AND CERVICAL CANCER

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ABSTRACT

Communication about health in general and cancer in particular is much like any other sort of goal-directed communication. In many ways, communication about cancer and cancer control is a restricted subset of health communication. Communications about cancer deal with a topic that is scary, negative, and may impact, in some way, virtually everyone. Some cancers were seen to be more taboo than others including breast and cervical cancer. Despite screening exams that can detect these cancers early and increase survival, screening rates are lower than expected rate. This study examined the sources of information and their impacts on cancer screening compliance among female staff. A cross sectional study was conducted at Faculty of Modern Language and Communication, university Putra Malaysia. A total of 82 female staff including academic and non-academic personnel was selected randomly to participate in the study. A self administered pre-tested structured questionnaire completed for the purpose of the study. A relatively small proportion of the respondents were compliant with recommended breast and cervical cancer screenings, and their screening rates were below compare to their knowledge level and perception. Knowledge of cancer risk factors and screening were not associated with higher rates of compliance with cancer-screening procedures. Since the mass media were the main sources of getting cancer screening information, it seems that there are some taboos in disseminating knowledge through media which could not able to change screening practice. Fortunately, the emergence of new media and information and communication technologies (ICT) has provided new ways to help bypass social taboos and provide effective education. Taboo that stifles discussion of cancer in the media had to be broken and women must know the importance of regular screenings for breast and cervical cancer.

Keywords: Breast Cancer, Cervical Cancer, Media, Taboo

INTRODUCTION

Prevention and early diagnosis of cancers are the vital factors in control of disease and increase life expectancy. Performing cancer screening tests can decrease cancer related mortality and morbidity (McDonald *et al.*, 2004). Breast cancer is one of the most detectable cancers and it is a common cause of death among women across the world (WHO, 2008). Cervical cancer is the most common malignancy among women in developing countries (Ghotbi and Anai, 2012). In Malaysia, it is ranked second after breast cancer (Lim *et al.*, 2008). Cancers of the breast and cervix made up 30.4% and 12.9% of all cancer cases in Malaysia. Based on the National Cancer Registry data, one in four Malaysians will develop cancer during his or her lifetime. The cancer burden was estimated to be of about 40,000 new cases per year per entire population (Looi *et al.*, 2004). Furthermore, peculiar to Malaysia, the overall female incidence of 148.4 per 100,000 was higher than the male incidence of 118.9 per 100,000 persons (Adeeb *et al.*, 2008). In earlier research, several types of barriers to screening, either perceived or objective, have been identified. Women fail to be screened due to

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insufficient resources, lack of knowledge, inability to access the health care delivery system, individual psycho-social and cultural contexts, fear, or limited family support and community participation (Othman and Rebolj, 2009).

Solving the problem of how to provide effective health education on diseases subject to social taboos is an immediate need (Sorcar & Nass, 2010). Cancer is a taboo or forbidden condition in almost of the countries, and patients would rather consult the gods, oracles, prayer centers, or other spiritual media to know 'why and who is behind' the condition. Some cancers were seen to be more taboo than others including breast and cervical cancer (Thomas *et al.*, 2005). Despite screening exams that can detect these cancers early and increase survival, screening rates are lower than expected rate. This study examined the sources of information and their impacts on cancer screening compliance among female staff.

METHODS AND MATERIALS

Study Design and Population

A cross sectional survey was conducted from 5th January to 15th March 2010 at Faculty of Modern Languages and Communication, University Putra Malaysia. Out of 164 ladies who worked in the faculty, a total of 82 female staffs including academic and non-academic personnel were selected randomly to participate in the study. Verbal informed consent was obtained from all the study participants.

Data Collection and Study Instrument Development

A self administered pre-tested structured questionnaire completed for the purpose of the study. The questionnaire was designed to obtain information on socio-demographic characteristics, knowledge, and perceptions of breast and cervical cancer and their screening. It was developed based on information drawn from the literature on risk factors, signs and symptoms, and common methods for early detection of these cancers.

A five point Likert type scale (from strongly agree to strongly disagree) was used to elicit the perception of the women towards management and treatment outcomes of breast and cervical cancer. Developed in English language, the questionnaire was then translated into Bahasa Malay, which is the national language of Malaysia. The translation was validated using the standard forward and backward method. Face and content validation was done by five senior faculty members from different departments including Community Health, Family Medicine, Imaging, Cancer Laboratory and Gynaecology. The questionnaire was pre-tested on a convenient sample of 30 women (not included in final sample) drawn from the target population. Participants were awarded one point for each correct response and zero points for each wrong or "do not know" response on items related to knowledge.

Data Analysis

All data were analyzed using the Statistical Package for the Social Sciences (SPSS Inc., Chicago, IL) version 18.0. One-way ANOVA with Post Hoc Tukey HSD (Honestly Significant Difference: a Post Hoc analysis used for multiple comparisons in order to detect where differences exist between pair-wise groups) was used. The level of statistical significance was set at $p < 0.05$.

RESULTS

The mean age of the participants was 31.6 ± 7.9 years (Table 1). Support Staff group constituted the majority of the participants (58.3%) followed by the Non-academic Staff (25.6%). More than fifty-seven percent of the respondents were married.

Table 1. Socio-demographic profile of the respondents

Characteristics	N	%
Total Subjects	=82	
Mean Age	=31.6±7.9	
Age Group		
20-30	48	58.5
31-40	25	30.5
41-50	5	6.1
51-60	4	4.9
>60	0	0
Marital Status		
Single	32	39
Married	47	57.3
Divorce	1	1.2
Widow	2	2.4
Educational Level		
High School	20	24.4
Community College	7	8.5
B.Sc	34	41.5
M.Sc	12	14.6
Ph.D	9	11
Designation Group		
Academic Staff	13	15.9
Non-academic Staff	21	25.6
Support Staff	48	58.3

The finding revealed that the majority of information regarding breast and cervical cancer screening recommendations was belong to total media including magazines/ newspaper followed by television, brochure, poster and books/scientific journals in both cervical and breast cancers (Figure 1).

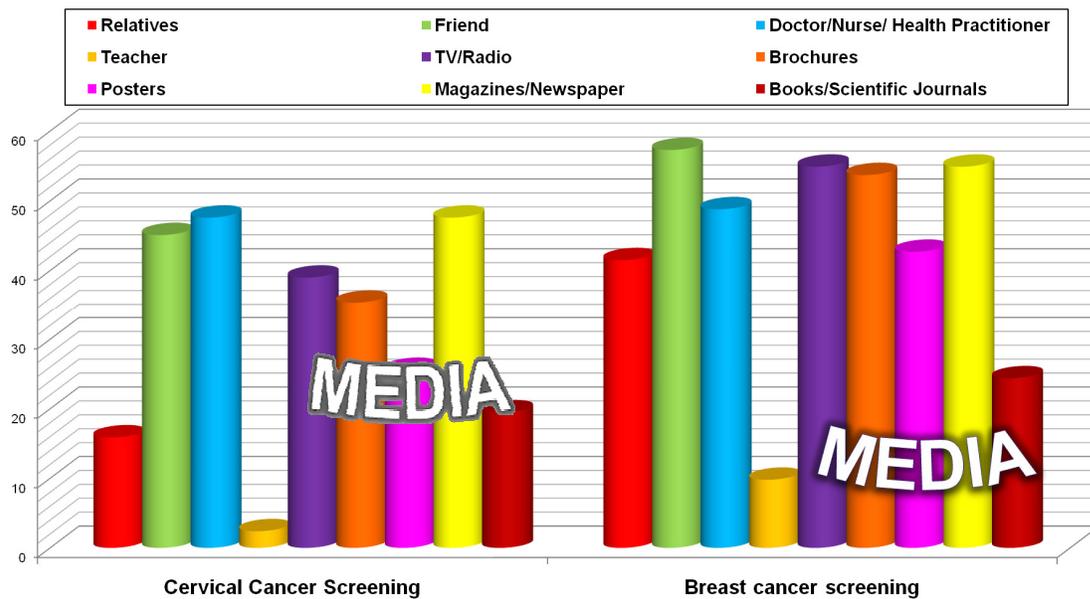


Figure 1. Sources of information regarding Breast and Cervical Cancer Screening

The questionnaire was assessed the participants' knowledge and practice regarding standard recommendation for screening of breast and cervical cancer. The results indicated that their knowledge about breast self examination (BSE), Clinical breast examination (CBE) and mammography (76.3%, 64.5% and 41.6% respectively) were higher than their practice (26.8 %, 17.1% and 8.3% respectively). In case of cervical cancer screening also the staff's practice (14.3%) was more than 3 times less than their information level (46.4%) (Figure 2).

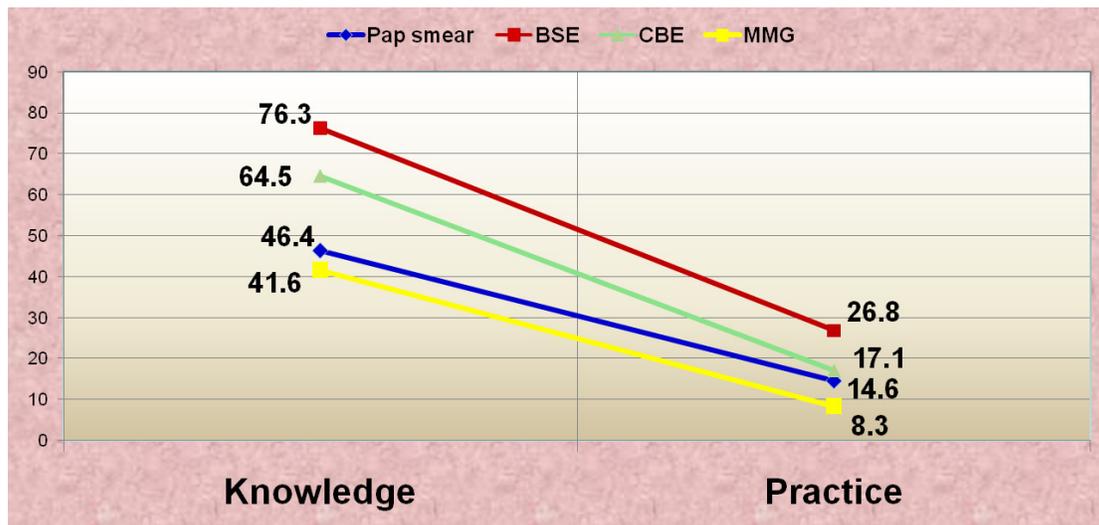


Figure 2. Knowledge and Practice score regarding Breast and Cervical Cancer Screening

DISCUSSION

The finding indicated that the subjects' practice regarding both cancer screening was likely less than their knowledge level which have been showed in other studies not only in Malaysia (Chee *et al.*,

2003; Rahman, 2003; Hadi, 2010; Othman *et al.*, 2009; Wong *et al.*, 2009) but also globally (Yeoh *et al.*, 2006; Twinn *et al.*, 2002; Rutledge *et al.*, 2001; Ni-Riain *et al.*, 2001; Ibrahim & Odusanya, 2009). Improving screening coverage will remain an important strategy for combating breast and cervical cancer in Malaysia. The focus should be on the policy-making context, improving awareness and the screening infrastructure, and making the service better accessible to women (Othman & Rebolj, 2009). Since the mass media were the main sources of getting cancer screening information, it seems that there are some taboos in disseminating knowledge through media which could not able to change screening practice. Fortunately, the emergence of new media and information and communication technologies (ICT) has provided new ways to help bypass social taboos and provide effective education. Taboo that stifles discussion of cancer in the media had to be broken and women must know the importance of regular screenings for breast and cervical cancer.

Incidents of breast and cervical cancer are higher in the West but the cure rates are also much higher (Jemal *et al.*, 2010) and the main reason is the culture and knowledge of not only the patients (women), but also of the doctors, health system, community and the media.

However, besides sensitization, there is also the need of breaking the taboo. It is very disheartening that in the 21st Century, there are women who still consider their anatomy to be a taboo. If you'd ask them to look at themselves, naked, in the mirror, they would be ashamed to do so (Messelis & Callewaert, 2008). In many ways, communication about cancer and cancer control is a restricted subset of health communication. Communications about cancer deal with a topic that is scary, negative, and may impact, in some way, virtually everyone. Communicating about cancer includes all of the goals extant in other forms of health communication: awareness (e.g., of new treatments and findings), reinforcement of behaviors that decrease cancer risk (e.g., NOT smoking), knowledge gain (e.g., creating messages that give people information about cancer, medication, treatment, etc.), persuasion (e.g., changing people's minds about the health risks of common and uncommon behaviors such as getting a tan, drinking a glass of wine, or having yearly mammograms), and behavior change (e.g., getting screened, stopping smoking, eating more vegetables). Communication about cancer may be highly targeted (e.g., teens, women over 55, sufferers of a specific condition) or it may be aimed at the entire population (e.g., messages about healthy eating and lifestyles or the danger of too much sun). In other words, communication about health in general and cancer in particular is much like any other sort of goal-directed communication. Policy makers must determine the audience for their message, the goal of their message, what medium can be used to reach that audience, and then they must build an effective message (Pickle *et al.*, 2006). A broad range of strategies based on social psychological theories and models of behaviour could introduced as ways to promote more effective communication approaches to women cancer prevention and care. It seems that the most related theory is the limited capacity model of motivated mediated message processing which purposed by Lang (2005). It is a theory about how individuals' process mediated messages. The theory is meant to be applicable to all contents, all media, and all goals. The medium, the content of the message, and the goal of the message are variables within the theory. Different media, contents, and goals will lead to different patterns of motivational and cognitive responses in viewers that, interacting with the structure and content of the messages and the individual differences of the media user, determine a great deal about how a message is processed, including which parts of the message are attended to, encoded, and stored and how the message is evaluated and liked. Future research in this perspective should be done to learn how to optimize cancer messages for specific target audiences using specific media to convey that information.

CONCLUSION

Taboo that stifles discussion of cancer in the media had to be broken and women must know the importance of regular screenings for breast and cervical cancer and other forms of the disease. For people living in areas that cannot easily access explicit gynecological cancers materials due to social, cultural or other constraints, these results suggest that it is possible to design curricula that are socially acceptable and accurate which transfer through suitable media, that promote significant gains in learning, retention, and changes in attitudes and consequently screening practice. Furthermore, these materials can encourage learners to proactively seek more information regarding the taboo topic and share prevention information with others. Educators who are reticent to teach about such subjects due to embarrassment or lack of health expertise can utilize similar applications to educate students who are able to deliver information to target groups using acceptable media. Such efforts can also close the existing gap between female knowledge and practice.

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