RESEARCH ARTICLE

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Early Detection of Breast Cancer and Barrier to Screening Programmes amongst Thai Migrant Women in Australia: A Qualitative Study

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Abstract

Background: Breast cancer screening programme is seen as the best practice to detect breast cancer early. However, there are circumstances that can prevent immigrant women from attending screening programmes. Little is known about Thai migrants and the barriers to their seeking breast cancer screening when living in a new homeland. This paper aimed to discuss the barriers to attending screening services among Thai migrant women living in Australia. **Methods:** This study adopted qualitative approach. Semi-structured in-depth interviewing and drawing methods were employed as data collection technique with 25 Thai migrant women who had not experienced breast cancer and were living in Metropolitan Melbourne, Australia. Thematic analysis method was employed to analyse the data. **Results:** Basing on the Health Belief Model, most Thai migrant women did not perceive that they were at risk of breast cancer. Despite seeing a breast cancer screening programme as important, the women rarely paid attention to breast cancer screening and used the mammography services provided by the Australian health care system. The barriers included the location of the services, unfamiliar patterns of health care provision, and language difficulties. **Conclusions:** There are many barriers that that they encountered in Australia that prevent Thai migrant women living in Melbourne Australia to pay attention to mammographic screening service provided by Australia health system. Our findings suggest that health services and interventions need to be designed more sensitive to the needs and socio-cultural context of migrant women in general and Thai migrant women in particular.

Keywords: Breast cancer- early detection- mammography service- barriers-Thai migrant women

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Introduction

Breast cancer is a major risk to women's health and one of the leading causes of death in Australia (Australian Bureau of Statistics, 2018). According to the Australian Bureau of Statistics (Australian Bureau of Statistics, 2018), the number of breast cancer cases has gradually increased from 2,722 cases in 2003 to 2,709 cases in 2007 and to 2,819 cases in 2012. It was ranked 12th of all the leading causes of women's deaths in Australia.

The age group which is vulnerable to breast cancer varies (Ham, 2005; Jordan et al., 2009; Kim et al., 2011). In recent decades, the incidence of breast cancer has increased among women aged between 35-50 years old (Jordan et al., 2009; Kim et al., 2011). Parsa et al., (2006) revealed that more than half of the newly diagnosed breast cancer cases in recent decades have been found among younger women who were below the age of 50. Youlden et al., (2014) indicated that breast cancer has emerged as a major public health problem in Asian nations. They pointed out that the majority of breast cancer among females occurred in Asian countries by the year 2012. In Thailand, Sripan et al., (2017) disclosed that although the trend of breast cancer has varied from region to region, it becomes a common incidence and continually increases in the last decades or so. According to Laoitthi and Parinyanitikul (2016), the prevalence of breast cancer is mostly found in women aged 45 - 50. The prevalence of breast cancer among Thai women that was reported in 2011 indicated that breast cancer stage I to II was up to about 64 per, stage III was about 24 per cent and stage IV was approximately 9 percent. The severity of the disease is also worse among older women and many have been discovered to be in the late stage, stage III and IV. This trend could be associated with the lack of concern by individuals about the necessity for early screening practices to detect breast cancer (Veena et al., 2015). According to Kim and associates (2011), there has been an increase in the number of breast cancer cases among younger Asian women who are less than 35 years of age. This group of women has a lower chance of survival because the severity of their disease is greater compared

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to those of a more advanced age.

One way of decreasing the rates of breast cancer is through prevention and, in Australia, screening for breast cancer is a common practice (Australian Bureau of Statistics, 2018). Breast cancer screening programmes have played a key role in reducing the mortality rate of breast cancer patients (Jordan et al., 2009; Kwok et al., 2012; Veena et al., 2015). There are several options available and the individuals can choose the one appropriates to their age and living situations: mammography, self-breast cancer examination, ultrasonography, magnetic resonance imaging breast, MRI breast and clinical breast examination (Laoitthi and Parinyanitikul, 2016). Such services are aimed at early detection when the lump is smaller and has yet to spread out to other cells (Jirojwong and MacLennan, 2003; Gele et al., 2017).

However, the general trend in terms of numbers for screening for breast cancer among Asian women (i.e Malaysia, Iran, Jordan and China) is relatively low. It has been shown that less than 20 per cent of women use the facilities provided by programmes for early detection. The main reason for the low participation is the cultural attitudes towards screening practices, especially feeling shameful to expose their breasts to others (Parsa et al., 2006). Parsa et al., (2006) and Marmot et al., (2013) suggest that if individuals are not concerned about being involving in programmes to screen for early breast cancer, their chances of survival may be lower as their cancers cannot be diagnosed early.

There are a number of Thai migrant women in different age groups living in Melbourne, Australia. However, we know little about their perceptions, attitudes and experiences of breast cancer prevention. There may be some barriers that prevent Thai migrant women in Australia from accessing screening programmes. To date, little is known about the actual barriers to Thai migrant women utilising breast cancer screening facilities, particularly the mammography programme. In this paper, through a qualitative approach, we explored the barriers to cancer screening, particularly the mammography programme, among Thai migrant women in Melbourne, Australia. Our paper extends the literature in this field and thus is of value for health service programmes for breast health among migrant women in Australia and elsewhere.

Theoretical framework

We adopted the Health Belief Model (Rosenstock et al., 1988) to enhance our understanding of the barriers faced by Thai migrant women in their decisions about participation in programmes for the early detection of breast cancer. The Health Belief Model suggests that there are reasons why individuals will or will not engage in health prevention activities. These are influenced by how they value health, their understanding of the disease, their perceived threat to their health and their expectations of positive health outcomes (Yarbrough and Braden, 2001; Wu et al., 2006). Based on the Health Belief Model principles, there are six key dimensions that indicate the probabilities that influence people to take steps to improve their health behaviour. These are: 1) their perceived susceptibility; 2) their perceived severity of their condition; 3) the perceived benefits; 4) the perceived barriers; 5) the cues to action; and 6) self-efficacy (Rosenstock et al., 1988).

This paper focuses primarily on the perceived susceptibility to breast cancer and barriers to early breast cancer screening. Perceived low susceptibility and barriers are generally accepted as major factors that cause people to refrain from or stop health prevention practices (Mobley et al., 2009; Kristiansen et al., 2012; Kwok et al., 2012). Although individuals may have a high perceived susceptibility about the severity of disease, their perceptions and perceived barriers could prevent them from taking action. Jirojwong and MacLennan (2003) suggest that it is necessary to investigate the perceived barriers about screening for breast cancer among Thai migrant women living in Australia. The results obtained could offer guidelines for intervention concerning health behaviour among this group of women. A good understanding about health beliefs and behaviour of Thai migrant women could help to increase attendance on breast cancer prevention programmes in the future. This could also reduce the mortality rates caused by breast cancer in Australia.

Materials and Methods

Methods

This study adopted a qualitative approach as it allowed us to learn about lives of the individuals and their meanings and behaviours (Bryman, 2012; Suwankhong and Liamputtong, 2016). This methodology is essential when the researchers do not have much understanding about the participants' world (Liamputtong, 2007, 2010, 2013). Our research is situated within a feminist framework (Liamputtong, 2007); a methodology that has its focus on the exploration of women and their lives. Feminist research intends to benefit women. It captures women's lived experiences in a respectful manner and legitimates women's voices as sources of knowledge (Liamputtong, 2007, 2010, 2013). Feminist research is flexible and it allows researchers to look deeply into the experiences of people through giving them a voice and allowing them to express themselves in great depth.

Participants and Recruitment

In this study, we included 25 Thai women who had not experienced breast cancer and were living in Metropolitan Melbourne, Australia. Purposive sampling technique was used to include the participants who met the criteria of this study and could provide richer data relevant to the study purpose (Liamputtong, 2013). The inclusion criteria were: 1) Thai women who have been living in Melbourne; 2) aged 30 years and over; and 3) are willing to participate in the study. We initially recruited the participants through the Thai Buddhist temple in Melbourne as many Thai women would often go to the temple as part of their daily lives. Some go on special Buddhist ceremonial days. Later, snowball sampling was used to expand the number of participants who could provide us with detailed information about our investigation. The final number of participants was determined by a theoretical sampling

technique; we stopped recruiting participants when little new data emerged (Morse, 2006; Padgett, 2012).

After we explained about the study, the duration of interviewing time involved and the scope of the questions, the participants were asked to sign a consent form. The interviews were arranged according to their convenience.

Data Collection

The semi-structured interview was employed as it supported us to be flexible when using words or asking questions, and offered the participants a wider scope for sharing their knowledge and experiences, for example, "What are the perceptions of breast cancer and breast cancer screening?" and "What are the barriers to attend breast cancer screening?", Each interview took about one or two hours. Later, the participants were asked to do some drawings about their perceptions of breast cancer, how they would feel when undertaking breast cancer screening. We also asked their thought about how they cope if they were diagnosed with breast cancer. They were given a packet of 48 coloured pens and blank papers for the drawing task. When finishing drawing, individual woman was asked to describe the image they had drawn. The drawings were used as a means to support participants to discuss their experiences and concerns. Their descriptions were tape-recorded for data analysis.

Data Analysis

Thematic analysis technique was adopted for data analysis (Braun and Clarke, 2006). This method aims to identify, analyse and report patterns or themes within the data. Open coding was initially performed, whereby codes were first developed and gave name. Then axial coding was applied to develop the themes from the data. This was done by taking the codes that we had developed from the data during open coding stage and re-organising them in such new ways by making connections between categories and subcategories. This resulted in themes, which were used to explain the experiences of the participants. The emerging themes are presented in the results section. In presenting the women's verbatim responses we used fictitious names to preserve the confidentiality of the women.

Results

Women's Socio-Demographic Characteristics

Table presents the socio-demographic characteristics of the women who participated in the study. More than half of the women were within the risk group; 35-45 years old. Most had high levels of educational attainment. More than a third was married. Most women worked part-time, and just over half had been living in Australia less than five years. About two thirds had an income of less than AUD 3,000 a month. Most women had no family history of breast cancer; about half had children.

There are several themes emerged from the qualitative data: perceive susceptibility: breast self-examination and self-awareness; attitude towards mammography screening; barriers to the mammography programme; and breast cancer prevention: what could be done better?

Table 1. The Socio-Demographic Characteristics of the Women Participated in This Study

Socio-demographic characteristics	Number	Percentage
Age		
<35	10	40
35-45	13	52
>45	2	8
Education level		
Primary school	1	4
Certificate	2	8
Bachelor	15	60
Master degree	6	24
PhD	1	4
Marital status		
Single	7	28
Married	14	56
Widowed	1	4
Divorce	3	12
Occupation		
Employee	21	84
Student	2	8
Business owner	2	8
Family history		
Yes	2	8
No	23	92
Period of living in Melbourne (years)		
<5	14	56
5-10	6	24
>10	5	20
Number of children		
0	13	52
1	9	36
2	3	12

These are presented below.

Perceive susceptibility: Breast Self-Examination and Self-Awareness

This theme refers to how the participants in our study perceive their susceptibility to breast cancer and what they do to prevent breast cancer. For most Thai women in the study, breast self-examination was perceived as a basic practice that can detect breast cancer from developing to an advanced stage. Many women remarked that this technique was more convenient and a way to alert them to any changes or unusual signs developing or developed in their breasts. If there were any changes in their breasts, it would encourage them to see their healthcare professional sooner. This would reduce the chance of developing advanced breast cancer. Amara, for example, put an emphasis on the early detection of breast cancer and stated that:

> I just touch it regularly. If I feel any lump I cannot ignore them because I don't know if these are bad

> tissues or not. I don't wait. We are told that cancer can be cured if we are able to detect it earlier.

Although many women perceived breast self-examination to be a basic practice for early detection of breast cancer, not all of them would do so in practice. Many women paid little attention to it. This was mainly because they had no family members or relatives who had been diagnosed breast cancer, and hence did not believe that they were at risk. This experience made them to be not too concerned about the possibility of their having breast cancer. Because of this perception, most women rarely sought any information about breast cancer and screening facilities. Joy told us: "If I have no family history, I am not scared of breast cancer that much. I believe that I am not in the risk group. So, I am not too keen to read about it".

Many women had no time to examine their breasts. This was largely due to the nature of their work and life in Australia. Nearly all Thai migrant women in our study worked for wages and often they worked long hours in different kinds of jobs. Nearly all the women participating in our study did not want to take time off from work. They had to work hard in order to preserve a good standard of life in a modern society. Thus, they tended not to reserve any extra time for breast cancer screening. Ta remarked:

> I knew that screening is good for women but I have to work every day. I have no time. I mostly finish work late at night and arrive home at about 12 am or 1 am and I would be very tiring. I often did not even take a proper shower; only wash my face and go to bed, you see!

For women who wished to practise breast self-examination, some did not know how to do it correctly. They had difficulties in finding a person who could provide them with clear information about and a proper training for the breast self-examination practice. Mai contended that: "I never do breast self-examination myself. I don't know how to do it correctly. I am not quite sure. The doctor demonstrated it and I tried but I need to be confirmed that I did correctly".

Most women in our study agreed that breast cancer knowledge played an important part in determining whether individual women would decide to attend a screening programme or not. In reality, they had difficulty in accessing breast cancer education. In fact, they received insufficient information about breast cancer and its prevention strategies. Some had little knowledge about breast cancer and had no experience with the prevention of breast cancer. Interestingly, many women did not know what a normal breast should be and what a defective one looked like. Emmy told us: "I am not clear really... thinking and thinking...I want to know what the normal breasts cancer like? How should the abnormal signs feel?" Kaesorn also said:

> I have heard about breast self-examination but I have not tried it yet. They told me that we have to raise [our] arm up and feel around the breasts to see if there are any lumps. I am not sure how it feels when I touch it. I only feel that that is my breast, that's it (laughing).

Attitude Towards Mammography Screening

As mammography screening programme was a common practice in Australia, we specifically asked the women in our study about their perceptions and experiences of a mammography programme. Most women did not see mammography programmes as relevant to them. For those who have used the programme, they had some negative experiences with it. Many women did not see mammography screening as something that they needed to be concerned about. As most of the women in our study were younger than 45 years old, it was not too surprising to see that the utilisation of mammography programme was relatively low.

Many women had no knowledge about the mammography service. They could not see how this facility could help with the early detection of breast cancer. They perceived that they would not have any benefit from attending this programme. Joy expressed her ideas of the mammography screening:

> "What is mammography? How does it work? I have not heard about it. I have not seen it before. I don't know anything about the mammography programme". Another woman, Amara, remarked: "I am not sure if I know anything about this programme. I don't think it really helps to find breast cancer. I am not sure".

For the women who had undergone mammography screening, they believed that the programme had some negative impacts on women's breasts and health in general. They thus considered it a questionable technology. Thus, they had little wish to make use of this modern medical service. Some were embarrassed as they would have to take off their top and their body was revealed to a stranger when screening. Sunan expressed:

> "For me, being naked to others even to health care staff is very embarrassing. I don't like to show my breasts to other people".

Many women also found mammography a painful process. Sunta shared her negative experience when she attended the mammography screening service:

> It was so painful. I don't want to do it anymore. It would be good if there are other ways to do this that do not hurt. I think it is better than having a compressing machine on our breasts. It hurt a lot. I still remember that it was not good.

Figure 1. Negative Experience of Mammography

She expressed her experience when experiencing mammography through drawing.

About one third of the women we interviewed saw that the mammogram service was important for breast cancer detection. Although they understood that this screening programme provided benefits to women in screening for breast cancer, many did not place this service as their first priority. Other women felt that early detection through attending a mammography programme was not that important. These women would pursue a healthy diet as the key factor in preventing breast cancer. For example, they would consume lots of fruits and vegetables especially fresh and organic products. Such products were believed to be able to reduce the level of toxic substances in the bloodstream. It was not only eating natural products that were beneficial. The women also suggested that living in a good environment could reduce the risk of developing breast cancer.

Barriers to Breast Cancer Screening Programmes

A number of barriers to breast cancer screening programme were raised by the Thai women in this study including location issue, different and unfamiliar health care, and language issue. Their prior experiences in seeking general health care in Australia also had some effects on the way they sought breast cancer screening services.

Location Issue

The locations of the breast cancer screening sites were not convenient to access for many Thai women. Most mammography screening centres, for example, were located far from their areas of residence and public transport was not accessible to them. Due to their low incomes, most women in our study did not own a car, so they had to rely on public transport. Joy shared her experience: "If the access is easy, I would like to go for it. But I have no car. Public transport is just not convenient for me."

Different and Unfamiliar Health Service Structures

To most women in our study, the health service system and its structure in Australia were very different from what they were familiar with in Thailand. To seek a physician or visit a health care professional at a public hospital in Australia, they would have to book through a general practitioner. Often, too, it was a long wait before they could receive care. In their experience of seeking health care in Thailand, they could walk into a health centre or hospital and receive services in one location. Thus, most women found the Australian system very inconvenient to them. They also suggested that it should have a mammography service at most hospitals as this would help them to have easy access to it. Mai expressed her experience:

> I don't like going to the hospital here. It's difficult for me to make an appointment and it takes so long to wait in a queue. The hospital here is not like in Thailand. In Thailand, you go and can receive a quick service. We can receive nearly all health services at one hospital. But here, it is different, so I mostly like to go to a clinic, and even for that I have to book as well. But there is no mammography screening provided at the clinic where I go.

The women remarked that the general practitioners they visited for general health issues provided minimal information about breast cancer and its prevention. They stated that if the general practitioners could give advice on breast cancer prevention it would help them to become more aware of whether they were at risk of breast cancer or not. Ta observed:

> The doctors should recognise women's health issues when we visit them. The doctors should know what information will be relevant to our age group. This will help us to pay closer attention on how to prevent it. They should not wait for us to ask them.

Language Barrier

Many women in our study faced significant language difficulties when they accessed healthcare, including seeing general practitioners and attending a mammography screening programme. This barrier kept the women away from learning about programmes for the early detection of breast cancer. Nearly all women considered themselves as not having sufficient English and with limited skills to deal with their health care providers, despite the fact that some of them had been living in Australia for a number of years. They found that it was still very difficult to explain their health concerns to their health care providers in deep detail. Many also lacked confidence about seeking help from health professionals as they were confused by medical terminologies. Most required an interpreter to explain their concerns to the providers and to understand what the providers offered. Tip shared her experiences:

> I am reluctant to see any health care providers here because I cannot explain to them well. I am scared to seek care here. Sometimes, we understand what they say but not all and not in sufficient detail. Even when we try to explain to them, they cannot understand what we are trying to say. It is difficult to make them understand our health concerns!

She expressed her negative experience through drawing

Ta too shared her experiences about seeking health care in Melbourne:

Figure 2. Feeling Worried when Seeking Mammography Service

> When I wanted to ask the health carers questions, I didn't know how to ask. I could not think of any words and I was stuck. When they explained my health issues, I didn't understand well. When they asked if I had any questions, I had no idea what to ask as I could not understand their explanations fully. It would be good if we could have Thai interpreters to help.

Some health centres had an interpreting service available to the customers who needed them. However, many Thai women were dissatisfied with this service. The interpreters always provided with them unclear explanations. They only delivered what was said which provided very superficial health information. The women had no confidence that the interpreters explained what the doctor had actually told them. Often, the interpreters were not Thai. A Lao interpreter might be used with Thai women, and they did not possess a good understanding of the Thai language and culture. The women believed that this could create poor understanding of the issues and this might also give them wrong recommendations for health practices. The women in our study sought to remedy this by consulting friends, co-workers and family members. Due to this, many of these women did not want to visit the medical health services if it was not essential. Down told us that:

> I could only understand some words. The interpreters did not really understand our Thai language. They could not help me much. I went back home with an unclear understanding of my health issues. I was more worried. I sometimes tried to confirm my ideas with Thai friends who used to visit the doctor with similar health issues.

Language barriers created a distant relationship between health care providers and the women. All participants in this study perceived that they were individuals from a minority group in Australia. Thus, they had less confidence in seeking help from the mainstream Australian health care systems. Many women thought that they would have a better relationship with their carers if they could have health professionals from their own ethnic group who shared the same cultural background. This would increase the women's confidence and offer them a more comfortable atmosphere when discussing any health issues with carers from the same cultural background. Tean told us about her lack of confidence with health providers in Melbourne city, particularly the general practitioners she had seen.

> To be honest, I have more confidence with the Thai doctors [in Thailand]. They tell us about the treatment procedures and this can reassure us. We also receive warmer support from them. So I would feel more relaxed when seeing a doctor there. Here, we do not know who is a good doctor or who is not. We also do not know if the doctors provide effective treatment or not. We spend only five minutes consultation time with a doctor. This is not enough and there is no time to explain anything as we have to leave quickly.

Breast Cancer Prevention: What Could Be Done Better?

The participants provided a number of suggestions regarding what can be done better in order to help to prevent breast cancer among migrant women. The women expected health care professionals to be the best person to provide them with clear guidelines for following breast cancer prevention programmes. They hoped that health care organisations and the providers would play more proactive roles in the provision of sufficient breast cancer health education, including screening for breast cancer, to women of migrant backgrounds.

Many women remarked that existing breast cancer campaigns did not include information that met their need. For example, although these organisations mainly set up the campaigns for breast cancer screening, the women needed to know more about the causes of breast cancer. If they did not know about the causes, they would not know how to prevent it and why they had to do and follow procedures. Thus, the current activities organised by the breast cancer organisations and relevant sectors to prevent breast cancer did not really help them. Joy stated:

> I have never seen a breast cancer organisation that could tell women what causes breast cancer or how to prevent it. No one can tell us about this. We want to know, and not only just tell us to go for breast cancer screening.

The women also suggested that promoting sufficient breast health education could encourage women to participate in breast screening programmes more. Many participants proposed some ways to provide education to target groups. An accessible media that could make Thai women more concerned about breast cancer prevention was through television, as they tended to watch television programmes in their everyday life. Breast cancer screening services need to be displayed and education undertaken consistently to increase each individuals' self-awareness of breast cancer and the importance of attending breast cancer screening programmes.

> I think it is a good way to add health education about breast cancer on television programmes at any time of the day to increase our awareness and to remind women about this health issue. We can access this source easier. I am sure that the advertising on this media source can promote more public awareness of breast cancer screening (Kaewta).

More than one third of women participating in our study suggested that Thai consulate offices could be sources that could provide this information to Thai people living in another country, such as Australia. Thai consulate offices should also develop useful projects to promote the health and well-being of Thai women, especially for breast cancer. Thai consulate offices should provide news and information packages for Thai women about breast cancer and its prevention. On remarked: "Thai consulate offices

can help us with breast cancer information. We have a Thai consulate here to help us with many things that we need".

The women also suggested that the Internet could be another source of information for breast cancer and its prevention. However, as most women in our study were not knowledgeable about how to search for this and other information from the Internet, they were somewhat reluctant to use it, despite the fact that many had access to a computer. They commented that if they knew where to look for health information via the Internet, they would have more knowledge about it. Breast cancer campaigns should also incorporate this in their programmes for migrant women. Jintana said:

> I like to search for information from the Internet as it is convenient for me. But there is lots of information on that. It would be better if someone can create a specific block for breast cancer knowledge and care. This will help us a lot.

Discussion

Many of the causes of breast cancer are relatively unknown and there is no single means to prevent it (Hulka and Stark, 1995; Ham, 2005). Early breast cancer detection is recognised as a common way whereby breast cancer can detected earlier. This can reduce the development towards advanced breast cancer and death from the disease (Hulka and Stark, 2005). Early detection programmes can be performed through using various options such as breast self-examination, clinical breast examination and mammography screening (Canbulat and Uzun, 2008; Diktapanidou and Ziogou, 2011; Kim et al., 2011). However, our study has shown there were many barriers that prevent Thai migrant women from attending early breast cancer detection programmes relating to mammography screening, although the programme was recognised as important. Using the Health Belief Model (Wu et al., 2006) as a basis, we found that most Thai migrant women in our study had a low perceived susceptibility of breast cancer. This is mainly because they had no family members who had been diagnosed with breast cancer. Therefore, they did not believe that they would be susceptible to breast cancer (Yarbrough and Braden, 2001; Rosenstock et al., 1988). This perception held back these women from attending breast cancer prevention programmes (Kristiansen et al., 2012; Kwok et al., 2012).

According to the Health Belief Model, individuals will not take action to prevent illness if they perceive too many barriers (Wu et al., 2006). In this study many barriers were found that affected attempts to prevent breast cancer among Thai women. Previous studies have shown that transportation and the inconvenient location of screening facilities have resulted in low uptakes for breast cancer screening (Schueler et al., 2008; Kristiansen et al., 2012; Kwok et al., 2012). The location of the services can impact on women's decision-making regarding early detection activities (Schueler et al., 2008). Modeste et al., (1999) state that if a mammographic service is not conveniently available for women and is difficult to access, only a proportion of potential sufferers can access such a service. This barrier is in line with Kristansen et al., (2012); Kwok et al., (2012) and Gele et al., (2017), who claim that if individuals perceive barriers to services, this can prevent the individuals from not taking health prevention seriously. Thus, being unaware of public health prevention services becomes a common health issue.

The Thai migrant women in our study had little familiarity with the health service systems in Australia. They expected to receive medical services at one health centre when seeking for help as they had been used to when using the Thai health service system. Because of these difficulties, the women lacked interest in or were unwilling to find out further about the screening facilities available. Lamyian et al., (2007) have reported that the inconveniences involved and the lack of transport decreased the accessibility of breast cancer programmes; thus there was limited uptake.

Many of the women in our study had a strong sense of modesty. Attending mammography screening programme made them feel embarrassed or shamed as they had to expose the top part of their body. Garbers et al., (2003), Kwok et al., (2012) and Lee and Vang (2010) and have also reported that embarrassment or shame is seen as a negative experience when going through the process of screening for breast cancer. Our findings are also consistent with Kristiansen et al.,'s study (2012). They found that intense embarrassment is a deterrent to and barrier to mammography screening services. This factor is also noted by Gany et al., (2006) who suggest that mammography screening programmes are underutilised among non-Western women. Such facilities do not seem to be appropriate for these women. This also suggests that cultural barriers regarding access to and attendance at breast cancer screening activities are significant within ethnic communities.

According to Gany et al., (2006), migrants tend to have insufficient knowledge and information about cancer and its prevention. All the women interviewed in this study did not have sufficient knowledge about breast cancer and relevant issues. This led to the lack of interest in undertaking screening for breast cancer. Garbers et al., (2003), Ham (2005) and Schueler et al., (2008) have suggested that lack of information is a significant barrier to participation in breast cancer screening. These authors suggest that to encourage target groups to be more concerned about activities for preventing breast cancer, it is necessary to have regular breast cancer awareness campaigns. This will allow migrant women to have more exposure to information which may also change their attitudes toward breast cancer screening and prevention programmes.

In our study, we found that language problems prevented many women from attending breast cancer screening programmes. Most women in this study had limited proficiency in English and were unable to communicate effectively with health care professionals. They were unable to understand medical terms that would help them understand symptoms and illnesses in the detail they need. Jirojwong and MacLenna (2003) reported this factor in their study among Thai migrant

women in Brisbane, Australia. The findings in this study are also consistent with Lee and Vang (2010); Kristiansen et al., (2012) and Kwok et al., (2012). They all suggest that language barriers are an important influential factor concerning the use of screening programmes for breast cancer among migrant women.

In conclusion, this paper deals with the barriers to early breast cancer detection activities. There were many obstacles that discouraged Thai migrant women to attend these programmes regularly. The findings have implication for nurses and other health care providers. Breast cancer health information and information related to health prevention practices and intervention should be provided to Thai immigrant women. Documents and material should be made available where Thai communities are situated or in places where such people take part in communal activities. The use of the Thai language would be useful in increasing the understanding the prognosis of disease, its severity, its pathology, and early detection practices. Similarly, promotion through the media can increase the information available about breast cancer prevention to many Thai women. This would help publicise the value of participating in early detection procedures. This could therefore increase individual awareness and place more attention on the practice of early screening for breast cancer and establish it as a regular process.

Further attempts should be made that aims at building breast cancer prevention support groups for Thai migrant women in Melbourne. These support groups could provide a platform for all Thai migrant women to share their concerns about women's issues and related aspects of breast cancer. Local health professionals could work together to develop efficient groups that suit the culture and the migrants' way of life. Such support groups could have practical mutual benefits for these women through helping them to handle the difficult health issues they might encounter. Support groups and their activities could make it possible to promote effective health prevention practices and attendance at centres for screening for breast cancer. Attempt should also focus on determining how to reduce the existing barriers to breast cancer screening practices. This action needs the support of all parties, including nurses and other health care providers. They need to discuss these barriers and develop policies that are culturally sensitive to the women. This could help to alleviate the difficulties of access to early detection programmes.

In conclusion, this paper has provided insights into the barriers faced by Thai migrant women for participating in early detection practices for breast cancer. Although breast cancer screening is seen as the best way to reduce deaths from breast cancer among women worldwide, there are many barriers why Thai migrant women do not use these programmes. It is important for nurses and other health care providers to understand their perceptions and experiences. This will lead to the provision of appropriate health prevention programmes that will increase accessibility and meet the circumstances of migrant women.

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