

Cancer rates among BME communities

Currently ethnicity is not recorded systematically by cancer registries in the UK. The result is that the evidence available relating to potential cancer inequalities within and between BME communities is often produced through smaller studies, often at an area rather than national level. Examples of the growing evidence base in this regard include:

- x Breast cancer rates being lower among South Asian women
- x Breast cancer occurring at a younger age, and a more aggressive tumour type, among black women of African and Caribbean descent
- x Prostate cancer occurring at higher rates among Black African and Caribbean men
- x Higher rates of mouth cancer among South Asians

One factor that is likely to impact upon cancer rates among BME groups is that they are often made up of a higher proportion of those from younger cohorts. It may therefore be the case that, as these cohorts age, the cancer rates of BME communities will increasingly match those of the general population. Improved monitoring of ethnicity nationally would allow monitoring of any changes in cancer rates within BME communities.

Information and support needs of BME communities

Evidence suggests that BME communities have unmet need relating to the provision of cancer information. This has resulted in lower awareness of cancer risk factors, signs and symptoms and cancer services among BME communities.

Language can be a significant barrier to BME communities accessing health information and services. Studies have shown that among those with additional language needs a high proportion do not have access to a translator when visiting the GP and that BME cancer patients were less likely to understand their treatment options and diagnosis. English literacy may also be a barrier to accessing written information among older members of BME communities with many hospitals outside of urban areas not providing written information in other languages.

Health service utilisation among BME communities

Women from BME communities appear to have a lower uptake of cancer screening services than those from the general population. Attitudes to using preventative services and to specific diseases, as well as the (real or perceived) attitudes of service providers to BME individuals, may act as barriers to uptake of such services.

BME individuals may not have the information needed to understand their rights relating to health services or their cancer care pathways. At the same time it is important to remember that BME communities are dynamic between generations, with second generation migrants often having information and support needs more similar to the indigenous population, rather than those of their parents.

Next steps to reduce health inequalities between BME communities and the general population

There are gaps in our knowledge relating to BME communities, their experiences as cancer patients, and their needs for information and support. The first task should therefore be to undertake research in this area; specifically exploring implementing and evaluating ways of

systematically recording ethnicity in cancer registries. By doing this, the NHS, and related government departments, will in the future be able to develop 'good practice' guidelines in terms of implementation of services which meet the needs of BME communities.

In order for health care to be utilised by BME communities at the point of need it is important that services are provided in a way that ensures they are culturally sensitive and aware of the information and support needs of users. Cancer Research UK believes that through effective partnership working, between various stakeholders (including the public and charitable sectors) and the development of appropriately tailored information and support for those who require it, services can meet the needs of the UK's diverse population.

For more information contact Cancer Research UK's Public Affairs team on 020 7061 8360 or publicaffairs@cancer.org.uk

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