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The aim of this study is to understand mammography initiation and mammography screening barriers from the lens of African American women. A qualitative descriptive approach was used to describe the experiences of 15 African American women, aged 45 and above, using Black Feminist Thought (Collins, 2000). Black Feminist Thought was used to give these women a voice that gives rise to the validation of their experiences—from their individual perspectives.

Using the qualitative descriptive approach, participants provided detailed accounts of their mammography screening practices and their historical and present views on health, race, gender, and the influence of the African American church and pastor. This current study uncovered multiple layers of health and mammography screening decisions identified through 7 key themes: *staying healthy, why mammograms are important, the mammogram experience, accessing healthcare, mammograms in the African American community, promoting mammograms, and being an African American woman*. These themes were cross cutting and coalesced around four larger contextual areas.

This study adds to the body of literature in understanding mammography decisions and fills a knowledge gap. The BFT perspective may help researchers and other stakeholders develop and implement targeted approaches towards increasing mammography screening rates among African American women, which may narrow breast cancer mortality rates between African American and White women.

BREAST CANCER SCREENING PRACTICES AMONG AFRICAN AMERICAN  
WOMEN: A BLACK FEMINIST THOUGHT PERSPECTIVE

by

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Committee Chair

To my Lord and Savior Jesus Christ, I dedicate this degree to you because it was you who favored me and gave me new Mercies, I needed every day. I want to thank my chair, Dr. Debra Wallace for your guidance, leadership, mentorship, and words of comfort throughout this process. To my committee members, thank you for your expertise, time, and contribution in such a way that it strengthened, defined, and validated this research and future research. I am truly appreciative of the many individuals that have poured into my life—so many that I cannot begin to name. So instead, I salute each of you. I thank you for the prayers, both heard and unheard and your words of encouragement. I am deeply grateful to those who have planted and watered my seeds of progression within this program.

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Thank you, God, for the increase!

APPROVAL PAGE

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## **CHAPTER I**

### **INTRODUCTION**

According to the American Cancer Society (ACS, 2021a), approximately 281,550 women will be diagnosed with breast cancer; unfortunately, 43,600 women will not survive this diagnosis in 2021 across the United States. Early detection through the use of screening mammograms has significantly changed the landscape of clinical practice and stands as a testament towards its benefits, above all, reducing mortality rates. From a national standpoint, breast cancer incidence rates have slightly increased, and mortality rates have declined, thus owing to early prevention and detection strategies (ACS, 2019a). However, racial and ethnic breast cancer disparities remain a concern. Recent evidence illuminates that while African American women collectively have narrowed the breast cancer screening gap, progress to narrow breast cancer mortality rates remains stagnant (ACS, 2019a). According to DeSantis et al. (2016), from 2008 to 2012, African American women had a 42% higher mortality rate than White women. This survival inequity may involve delays to screenings, stage at diagnosis and treatment, access to optimal medical care, insurance status, and biological factors (Daly & Olopade, 2015), which could result in a later stage diagnosis (regional or distant; Wu et al., 2015) and higher mortalities. Therefore, increased attention focused on eliminating breast cancer disparities is vital to African American women's survival.

## **Background**

Breast cancer is defined as a group of diseases from which malignant cells in the breast multiply out of control (ACS, 2019a; National Cancer Institute [NCI], 2019). Breast cancer is the most common cancer among women, and it is the second leading cause of death (Centers for Disease Control and Prevention [CDC], 2019). The ACS (2019b) also recognized that breast cancer is the most commonly diagnosed cancer in African American women. Recent literature indicates that more than 3.8 million women live in the United States—surviving—after being diagnosed with breast cancer (ACS, 2019a; Miller et al., 2015).

National statistics for the rate of new breast cancers from 2013 to 2017 were 126.9 per 100,000 White women; 124.4 per 100,000 African American women; 94.2 per 100,000 Hispanic women; 95.5 per 100,000 Asian/PI women; and 74.3 per 100,000 AI/AN women. While the detection rates between White women and African American women are close, there is a distinctive difference in their death rates. In comparing national breast cancer death rates from 2013 to 2017, African American women's death rates were 27.6 per 100,000 women compared to 19.8 per 100,000 White women; 14.0 per 100,000 Hispanic women; 11.5 per 100,000 AI/AN women; and 11.4 per 100,000 PI/Asian women (U.S. Cancer Statistics Working Group, 2019). The differences lie within the inequities in survival rates across racial lines.

Mammography screenings have become a major tool for improving breast cancer outcomes. However, they remain underutilized among low-income and racial and ethnic populations (Ahmed et al., 2017; Nonzee et al., 2015). Mammography screenings

obtained at regular intervals increase early diagnosis of breast cancer, whereby survival outcomes are promising. Therefore, timely access to quality breast cancer care is vital as it improves overall survival rates, which, in turn, contributes to the elimination of breast cancer disparities. Delays to diagnosis and treatments stemming from personal barriers to injustices within the healthcare and political systems further complicate the Healthy People 2030 agenda for the nation. For example, according to Healthy People's 2030 objectives, planned efforts include the following: (a) increase the proportion of females who get screened for breast cancer from 72.8 to 77.1% based on the most current screening guidelines, and (b) reduce the female breast cancer death rate from 19.7 per 100,000 deaths to 15.3 per 100,000 deaths in females by 2030 (Office of Disease Prevention and Health Promotion [ODPHP], n.d.). Without improvements in accountability in the health, financial, religious, and political systems, the efforts to improve the survival inequity between White and Black women will likely remain unresolved. As advocates, researchers, and other stakeholders in the cancer community remain gainful allies in addressing the challenges faced by African American women.

### **Purpose of the Study**

African American women face significant barriers to routine mammography screenings, timely diagnosis, and cancer treatments (Daly & Olopade, 2015). Adherence to mammography screening intervals is shaped by obvious barriers and overt and covert discrimination among various systems, organizations, and individuals. Qualitative research is focused on individuals to generate findings that cannot be obtained by conducting research based on numerical analysis (i.e., quantitative research); therefore,

this approach could help understand the worldviews and experiences of breast cancer screening practices among African American women. Few researchers have used an Afrocentric feminist perspective, namely Black Feminist Thought (BFT), to understand mammography utilization. Therefore, the perspectives of mammography participation (and barriers to participation) from the African American woman's lens were explored in this study.

### **Black Feminist Thought**

Black Feminist Thought helps individuals understand more about individuals' experiences, through their lens, without distorting the truth, while giving a greater perspective of how society challenges their knowledge, skills, and place in society. Buried in the inner hearts, souls, and thoughts of African American women are hidden truths regarding beliefs and barriers to mammography access and utilization. An Afrocentric perspective has a way of manifesting situations and unique experiences that African American women may have felt too afraid to speak out, speak up, or speak against the structural and systemic barriers that prevent African American women from achieving health equity.

Smith et al. (2017) noted that the Black feminism approach has a way of unveiling social and health consequences among Black women. Considering multiple barriers impact mammography utilization, applying BFT and guiding principles to achieve equity and equality is salient. The inclusion of BFT can unlock factors that contribute to delaying or forgoing mammography screening. For example, the principle of race, class, and gender underscores the importance of examining how these domains

intersect and describe how these socially constructed identifications and individual factors and choices are beyond individuals' control (Smith et al., 2017), which may influence health outcomes in African American women.

The application of the unique experiences among a diverse group of African American women may help distinguish between the experiences of African American women and their White counterparts when accessing the healthcare system (e.g., mammography screening) and other societal systems (e.g., education, employment). Other guiding principles may serve as a beacon towards addressing issues impacting the disparities between African American and White women. Furthermore, by addressing the issues using a BFT perspective, the voices of an African American community of women will be heard. As such, critical opportunities to further explain and improve mammography screening behaviors could inform healthcare, research, and practice. Empowering women to become self-advocates and increase their self-efficacy in making informed healthcare choices would bridge the disparity gap.

The extent to which intersectionality (e. g., class, gender, race) “strives to understand what is created and experienced at the intersection of two or more axes of oppression” (Hankivsky et al., 2010, p. 3), this phenomenon could help recognize the power domains and characterize the vulnerabilities of the oppressed. These contributions help to advance health equity and social justice (López & Gadsden, 2016)., The benefit of integrating intersectionality is the studying of health and health disparities, which, in turn, generates more health data that could be useful in informing health practices and policies (Mwangi & Constance-Huggins, 2019). Knowing that African American women's ways

of knowing and their experiences differ from that of White women calls for greater attention to be paid to the injustices these women see and experience every day while living in communities where there are few resources. Mwangi and Constance-Huggins (2019) argue that not only is an intersectionality approach needed in research and practice to improve the health of Black women, but the inclusion of rurality is necessary.

### **Significance of the Problem and Justification**

Recent evidence shows a reduction in breast cancer mortality rates for African American women and White women since 1990 (DeSantis et al., 2016). In this regard, mortality rates have declined over the past decades; however, the survival gap has not narrowed between African American and White women (ACS, 2019a). According to DeSantis et al. (2016), in the 1980s, mortality rates between White and African American women were similar. Since that time, the body of literature has yet to pinpoint the cause(s) of nonadherence to routine screening mammograms specific to African American women. This gap in the research indicates that mortality is a huge disparity because it has not been reduced. This problem is addressed based on the currently available body of research. Research findings might reveal issues and barriers African American women experience from which strategies can be developed to promote adherence to life-saving approaches, such as mammograms.

The rising costs of breast cancer care across the continuum place heavy burdens on the healthcare delivery systems and the individual. The impact of economic costs for breast cancer treatment in the United States in 2010 was estimated to be \$16.5 billion (Mariotto et al., 2011), with an expected increase of \$4 billion by 2020 (S. Ryan, 2016).

In 2010, mammography screening costs in the United States totaled \$7.8 billion for 70% of women screened (O'Donoghue et al., 2015). As previously stated, lack of health insurance is a major barrier towards mammography participation (Chowdhury et al., 2016; Gathirua-Mwangi et al., 2016; Jemal et al., 2017; Nonzee et al., 2015; Wells et al., 2017). Economically, the cost of mammography screenings and treatments has a direct effect on healthcare decisions. Since African Americans, as a group, are more likely to be uninsured than White women (ACS, 2019a), this economic burden exponentially increases among low-income and uninsured women, which in turn may contribute to increased death and disability. Ultimately, racial differences in access to care play a crucial role in survivorship.

The significance of the problem is that many African American women present late to care, despite the increase in technology, free or reduced cancer screening programs, and government-funded programs—resources aimed to assist with early detection by increasing access to mammograms. A specific federal program purposed to increase timely access to screenings and diagnostic mammograms, follow-up, and treatment to low-income and uninsured women is the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). However, even when financial barriers are removed, free or reduced-cost screening programs are only useful if women choose to adopt mammography screenings. This implies that women must be aware of screening programs in their communities and educated regarding their importance. Extensive research studies have demonstrated that African American women underutilize the NBCCEDP. For example, national data showed that 36.4% of White women, 35.1% of

Hispanic women, 17.4% of African American women, 5.8% of Pacific Islander (PI)/Asian women, and 3.6% of American Indian (AI)/Alaska Native (AN) women received a screening mammogram from 2013 to 2017 (CDC, 2018a). African American women who screen within this program are more likely to be diagnosed with regional and distant stage breast cancers (Miller et al., 2015).

Historically, women diagnosed with early-stage breast cancer have favorable outcomes, while women diagnosed in the later stages have poorer treatment options and may have a less favorable prognosis. Sun et al. (2018) reported women diagnosed in the early stages (Stage I/II) have a better 5-year survival rate as compared to women diagnosed in advanced stages (Stage III/IV). The overall 5-year survival rate for a breast cancer diagnosis among African American women from 2009 to 2015 was 83% compared to White women at 92% nationwide (ACS, 2019a). Iqbal et al. (2015) suggest that White women are more likely to be diagnosed in the earlier stages of breast cancer when cancer has not spread into nearby tissues. National data from 2012 to 2016 showed that 66% of breast cancer in White women aged 20 years and older have local-stage breast cancer and 5% are distant, whereas African American women in the same age group and timeframe are more likely to be diagnosed with distant stages of breast cancer (8%) and are less likely to be diagnosed with localized breast cancer (56%) (ACS, 2019a).

A woman's decision to screen is an individual choice. However, that decision is compounded by personal, social, cultural, and economic factors that impact mammography awareness and early detection and treatment participation. Additional



factors that contribute to delays or nonadherence to routine mammography screenings include: (a) competing obligations (Nonzee et al., 2015; Wells et al., 2017); (b) lack of transportation (Corrarino, 2015; Wells et al., 2017); (c) fear and fatalism (Corrarino, 2015; Gullatte et al., 2010; Nonzee et al., 2015); and (d) spiritual beliefs (Daniel et al., 2018; Gullatte et al., 2010; Melvin et al., 2016). Lack of physician recommendations (Ahmed et al., 2017; Alexandraki & Mooradian, 2010; Corrarino, 2015; Farr et al., 2020), medical mistrust (Ahmed et al., 2017; Alexandraki & Mooradian, 2010; Corrarino, 2015; Farr et al., 2020), and structural racism (Pallok et al., 2019) are also factors that threaten the health outcomes among African American women. Adherence to routine mammography screening recommendations can improve the health status of women. However, such challenges to breast cancer preventative screenings and quality care across the cancer continuum negatively impact African American women's health, resulting in poorer outcomes.

Many researchers have documented intervention strategies to increase the uptake of mammography screenings such as spiritual and tailored messages (Best et al., 2016; I. J. Hall et al., 2015), pastors (Brown & Cowart, 2018; Lumpkins et al., 2013), physician and telephone reminders (NCI, 2015), breast cancer survivors (McQueen et al., 2011), media outlets (I. J. Hall et al., 2015; Watlington et al., 2018), community events (Reilly et al., 2018), mobile mammography (Mizuguchi et al., 2015; Vang et al., 2018), and nurses (Davis et al., 2015). While these interventions offered multiple strategies to facilitate mammography screenings, the fact remains that for this specific population of women, more research is needed to supplement the existing literature to decrease racial/ethnic

disparities. Promoting the health and wellbeing of African American women should encompass the implementation and ongoing evaluation of programs and policies designed to reduce barriers with an overall goal of improving access to timely services and positive patient outcomes. Zollinger et al. (2010) pointed out that African American women's demographics, clinical characteristics, age, religious beliefs, and educational level should be considered when developing interventions.

### **Problem Statement**

Breast cancer disparities take the shape of multilevel and multisystem injustices that fuel the inequities that African American women experience. The lines of social action, systemic, and structural barriers that paralyze individuals' health must be exposed so that ultimately marginalized populations will experience positive health outcomes. In 1966, Martin Luther King, Jr. asserted, "Of all the forms of inequality, injustice in health is the most shocking and inhumane." This powerful statement has opportunities for groundbreaking innovations to improve the health of the nation, such as the goals of Healthy People 2030 (ODPHP, n.d.) and reducing health disparities. Additionally, through discrimination and racism—inequality and inequity in healthcare, a continuous cycle of breast health disparities decreases a woman's chances of surviving and thriving after a cancer diagnosis. Therefore, this study could shed light on barriers African American women experience and could begin to frame future approaches that may prove cost-efficient, beneficial, and lifesaving.

### **Philosophical Underpinnings**

Efforts in generating knowledge, filling the knowledge gap, and seeking strategies to improve the health outcomes related to breast cancer of the African American woman are vital to preserving the family unit. The overarching perspective that could enhance understanding and elucidate the African American woman's experience is a feminist epistemology.

According to Collins (1990), Afrocentric Feminist Epistemology (AFE) asserts that knowledge is crucial for empowering oppressed people. As such, the experiences that individuals acquire are materialized in their daily lives. Collins (1990) identifies that in the past, knowledge validation took the form of a Eurocentric masculinist approach. An AFE employs that the trustworthiness and credibility of such experiences are valid, since knowledge was not obtained from the literature but from the primary source—the individual—who has experienced a specific event, issue, or challenge. In terms of mammography adherence, the benefits of utilizing an epistemology that focuses solely on the African American woman and learning from their experiences helps to identify and address the oppression and the oppressor that causes unwanted health consequences. Further, Black Feminist Thought (BFT) would help validate and clarify perspectives of their worldviews concerning mammography screenings and healthcare access and frame the context of findings.

### **Definition of Terms**

1. Black or African American—A person having origins in any of the Black racial groups of Africa (U.S. Census Bureau, 2018).

2. Spirituality—Relationship with a higher power (Cheadle et al., 2015).
3. Religiosity—Beliefs, lifestyles, and rituals related to organized practices (Cheadle et al., 2015).
4. Health beliefs—Beliefs about health (Ogden, 2012).
5. Mammogram—Breast x-ray used to detect cancer (ACS, 2021b).

### **Summary**

The impact of breast cancer mortality rates, affecting African American women compared to their White counterparts (ACS, 2019a), gives rise to the importance of developing culturally tailored interventions for the targeted population. African American women screen at lower frequencies than White women and present with late-stage cancers (ACS, 2019a; Miller et al., 2015; Scott et al., 2019), thus contributing to an outcome that leads to a decreased life expectancy, poor attainment of functional status and quality of life. The experiences of African American women are different than White women. Race, gender, and class have a lasting impact on the individual's health status and outcomes. The challenges of inequalities and oppression that African American women experience present health risks and less favorable outcomes.

Given the inequities in survivorship, more research studies are needed to understand mammography screening behaviors and barriers African American women experience, which may help bridge the Black-White disparity gap. Understanding African American women's perceptions give them a voice. Thus, an Afrocentric Feminist Epistemology is the perspective of the study. Within the AFE perspective, Black Feminist Thought was the specific guide for conducting the study and served as a context for

findings and foundational insight for culturally appropriate interventions to facilitate mammography screenings.

## **CHAPTER II**

### **REVIEW OF THE LITERATURE**

#### **Literature Search**

A detailed literature search was conducted to explore why low-income African American women are adherent or nonadherent to routine screening mammograms. Peer-reviewed journals were found using online databases such as CINAHL, PubMed, and APA PsycInfo. Key search terms such as low-income, mammography, and Black were used. Another strategy was reviewing references from other published studies. Studies were included if they were conducted in the United States and written in English between 2010-2020. A total of 73 articles were reviewed in the initial search. Articles were excluded if they were related to breast cancer survivors, women with co-morbidities, national and local programs, homeless women, or included other minority populations. Another search was completed, and peer-reviewed articles appearing to be more than 10 years old were excluded. Based on inclusion and exclusion criteria, 11 peer-reviewed studies published between 2015 and 2020 were included in this review. Additionally, research studies that have provided a foundation for traditional examinations of African American women and breast cancer screening and survival are included that validate the methods for the study.

Black Feminist Thought (Collins, 2000) was used to guide this study because it engages us in how we think about oppression. As a critical social theory, BFT generates

and validates knowledge from African American women in their voices (Collins, 2000). Although women share some commonalities, they each have different experiences (Collins, 2000), making BFT a true essence of their reality. Race, class, and gender are layers encompassing oppression and silencing the voices of the targeted population. Individuals of a certain age, sexual orientation, religion, and ethnic groups can be oppressed (Collins, 2000). Considering these groups, the connection here lies—a specific dominant group exerts power, and as a result, diminishes their worth, value, and voice. By understanding the perceptions related to early detection and screening mammography behaviors, culturally appropriate and tailored interventions could be developed to improve African American women's health outcomes.

This study may serve as an opportunity to understand more about mammography screening practices among African American women. Early adopters of routine mammography screenings have better health outcomes than women who delay or forgo screening mammograms. This gives rise to the importance of breast cancer education and prevention and bridging gaps in healthcare. Geographic disparities have been shown to limit a person's access to quality mammography facilities (Molina et al., 2015; Warnecke et al., 2019), healthcare services, and other resources. Additionally, social determinants of health such as access, insurance, and socioeconomic status restrict access to healthcare services, thus playing a crucial role in breast cancer disparities and mortality rates. Incorporating a BFT perspective can best deepen our knowledge of issues that influence mammography participation. This approach may help researchers understand how the intersections of race, gender, and class shape health behaviors and health outcomes.

### **Black Feminist Thought**

The Black Feminist perspective is a contemporary sociocultural school of thought that provides a specific context for understanding African American women's lives. The voices of African American women have been silenced, and the perspectives of others have overshadowed their visibility in society. Black Feminist Thought (BFT) unveils these negative images and patterns of inequalities through personal stories and narratives from African American women. Collins (2015) stated that in writing BFT, her goal was to speak truthfully regarding power relations, place Black women's experiences as the epicenter of analysis, and "highlight their interpretations of our social worlds" (p. 2349). By understanding the intersection of race, gender, and class from the lens of oppressed African American women, the diffusion of knowledge validated by African American women could result in empowerment within the context of social injustice (Collins, 2000) and disseminated through research and practice. The six primary features of BFT include:

(a) oppression and activism among a specific group of people, (b) common challenges and tension linking experiences and ideas, (c) connections between U.S. Black women's experiences and group knowledge or standpoint, (d) contributions of Black women intellectuals, (e) dynamic and significance of change, and (f) relationship to other projects for social justice. (Collins, 2000, pp. 22–43)

Few studies have used BFT to explore mammography screening behaviors. However, previously reported studies in other research areas have used BFT and have noted it to be a valuable framework. For example, Armour-Burton and Etland (2020) conducted a qualitative study using an intersectional approach to examine how race, gender, and class influenced the mental and physiological health of African American



women diagnosed with breast cancer. A sample of 10 breast cancer survivors aged 45-60 was recruited from breast cancer support groups, churches, and nursing organizations. A phenomenological design using interviews served as the method for data collection. Four themes were identified (a) altruism; (b) silent strength; (c) existential invisibility; and (d) marginalization. Study findings suggest that BFT does generate knowledge experienced by African American women. Perceived stress accounted for 80% of the participants' responses (Armour-Burton & Etland, 2020).

Early detection should be an important priority for women. However, regardless of the multiple modes of communication regarding early detection, they remain underutilized, especially among low-income African American women (Ahmed et al., 2017; Nonzee et al., 2015). A well-grounded approach towards educating African American women on culture, identity, breast cancer, and screening mammograms could be enlisted through Afrocentric magazines. On this point, C. Ryan (2007) examined how three Afrocentric publications such as *Black Elegance*, *Ebony*, and *Essence* disseminate and generate awareness on early detection and prevention, breast cancer, body image, and other health-related topics. The single most striking observation is that all three publications had a minimal discussion of breast cancer. This limitation and minimal depiction of African American women's susceptibility to getting breast cancer may create a misinterpretation of breast cancer incidence and mortality rates among marginalized populations. Hence, showing a mis(representation) that only White women get breast cancer and screening mammograms may not be as beneficial for African Americans and may result in nonadherence to mammography screening recommendations and guidelines

(Allicock et al., 2013; Passmore et al., 2017). C. Ryan (2007) also used BFT to analyze select narratives of African American women from these magazines (i.e., Black Elegance, Ebony, and Essence). Her findings highlighted the importance of continual dialogues regarding breast cancer prevention, treatment, self-advocacy, and other strategies aimed to increase awareness across diverse cultures, backgrounds, and populations.

The key to solving the complexities of the underutilization of mammography screenings lies in each woman's voice and experiences. Collins (2000) unapologetically states, "viewing the world as one in the making raises the issue of individual responsibility for bringing about change" (p. 290). The intersectionality perspective may help researchers understand how being African American, being a woman, and being low-income shape their health outcomes, offering insight into cultural-specific interventions to increase mammography adherence and potentially reduce or eliminate breast cancer disparities. Not only does systemic and structural barriers influence outcomes, but individual preferences contribute to the risks of dying prematurely and experiencing a poorer quality of life. As such, behavioral change is an important aspect of improving the health status of African American women.

### **BFT as it Relates to Mammogram Research**

It is important to acknowledge that where a person lives matters. Differences in race, class, and gender are a prescription for the health differences across racial and ethnic lines. Understanding how systems of power, oppression, and power imbalances lead to disparities can best be expressed from the African American woman's

perspectives. The BFT perspective can unlock factors that contribute to the nonadherence to mammography screenings. The impact of their experiences, attitudes, and beliefs could help frame culturally tailored interventions that are responsive to African American women's needs.

Furthermore, through the work of community partners and stakeholders in the cancer community, successful evidence-based strategies could be applied and integrated into the practice settings, thus promoting healthcare utilization, resulting in mammography adherence. In the true essence of reducing breast cancer disparities and improving survivorship, there is a crucial need to dispel breast cancer and screening myths, address social determinants of health, and implement targeted interventions. Empowering women to become self-advocates and increase their self-efficacy in making informed healthcare choices would help bridge the disparity gap. Thus, concerning African American women, provider trust and adoption of routine healthcare practices would help offset the influence of the existing power structures.

Breast cancer is a disease that does not discriminate; however, it is expressed and experienced differently by various populations. Therefore, using BFT will enable the exploration of systemic and structural barriers that influence specific patterns of injustices resulting in adverse health outcomes. To better understand women's perspective and their involvement in their breast health, more research is needed to explore their perceptions, attitudes, and beliefs regarding early detection and prevention and the impact of racism and discrimination. More specifically, how race, gender, and

class shape their mammography screening behaviors. These areas are discussed in the next section.

### **Spirituality**

A diagnosis of breast cancer disrupts many women's lives and highlighting the importance of early detection and prevention measures for African American women is crucial for discovering cancer in its most treatable stage. As previously mentioned, numerous factors contribute to mammography screening delays among African American women, including lack of health insurance (Chowdhury et al., 2016; Gathirua-Mwangi et al., 2016; Jemal et al., 2017; Nonzee et al., 2015; Wells et al., 2017), which, in turn, decreases access to healthcare, healthcare providers, and preventive screenings. Furthermore, spirituality, religiosity, and cultural affiliations have been found to positively or negatively influence mammography participation (Conway-Phillips & Janusek, 2014; Gullatte et al., 2010).

Terms such as religiosity and spirituality are used interchangeably. However, each word offers different explanations, beliefs, and personal fulfillment. Cheadle et al. (2015) and Conway-Phillips and Janusek (2016) distinguish between the two and recognize that both are important in African American women's lives. For example, spirituality is viewed as a relationship with a higher power (e.g., God), whereas religiosity refers to beliefs, lifestyles, and rituals related to organized practices (Cheadle et al., 2015). It is important to identify that spirituality frames many African American women's health behaviors and entrenched religious belief systems, which may influence a woman's decision to participate in routine screening mammograms.

African American women are the highest religious group across race (i.e., White and African American) and gender nationwide (Washington Post-Kaiser Family Foundation, 2012). Spirituality is significant and important in the lives of these women. In published studies where a connection lies between religiosity and spirituality, African American women who express increased spirituality were more likely to participate in health promotion behaviors (Conway-Phillips & Janusek, 2014, 2016; Gullatte et al., 2010). Women who believe that receiving a breast cancer diagnosis is God's plan (Daniel et al., 2018) and women who only consult with God to address their problems (Gullatte et al., 2010) were more likely to delay medical care. This external locus of control and reliance on a higher power or God may outweigh healthcare provider recommendations, adherence to treatment, or mammography screenings, which can cause late-stage diagnosis, poorer treatment options, and low survivorship.

Incorporating questions used to discover African American women's spirituality could help document the significance of spirituality and mammography screenings behaviors. Given that limited studies have evaluated spirituality related to cancer screening (Conway-Phillips & Janusek, 2016), understanding how spirituality affects mammography decisions is essential for a complete understanding of how to lower breast cancer mortality rates and increase survival. In a classical approach, there are numerous ways to discuss spirituality. A growing body of literature has described how spirituality relates to mammography and health using the Spiritual Health Locus of Control (SHLOC). A literature review on this topic showed that "passive and active" are the two dimensions that describe SHLOC. The "Passive dimension" involves the individual

relying solely on God to protect their health rather than taking action themselves and the “Active dimension” represents the belief that the individual works with God towards taking healthy actions (Holt et al., 2003).

In published studies utilizing SHLOC, African American women with active SHLOC were found to consume less alcohol (Debnam et al., 2012; Holt et al., 2015) and have higher fruit consumption (Debnam et al., 2012). Outside of the SHLOC scale’s representativeness, Allen et al. (2014) adapted the scale to examine cancer screening behaviors among Latina parishioners. The results of this study found that Latina women were more likely to possess active SHLOC. In another study comparing African American women and Caucasian women SHLOC in breast cancer information processing, researchers Leshner et al. (2006) found that SHLOC played no role in behavioral intentions (e.g., breast-self exams or mammograms); however, SHLOC was found to decrease behavioral intentions for White women when risk was high. In this same study, Leshner et al. (2006) recommended for health communicators to utilize the role of SHLOC in breast health messages, specific for African American women. Questions may help reveal variations of African American women’s own lives about spirituality and how this influences mammography decisions.

Religiosity and spirituality beliefs can affect a person’s medical and treatment decisions (Behringer & Krishnan, 2011; Koenig, 2012), which might lead to adverse outcomes. For example, Fowler (2006) pointed out that women used the Bible or referred to strong women in scriptures in making positive decisions regarding mammography adherence. Differently, some women would make mammography screening decisions

based on their faith and belief in God. Since two-thirds of African American women reported making personal decisions to follow-up on their breast symptoms (Jones et al., 2014), it is important to understand personal attitudes and beliefs that might promote positive behavior change or promote fear-based thinking relative to their spiritual and religious belief systems. Existing evidence points toward the African American church and the pastor as an important institution and figure, respectively, in the lives of the African American community with ties strongly to their spirituality. Aligning these concepts with BFT could explain how and if spiritual beliefs and pastors, a patriarchal figure, influence mammography screening decisions.

The African American church and pastor have historically been the thread of the African American community (Adksion-Bradley et al., 2005; Baruth et al., 2015). Numerous research studies have suggested that pastors are influential religious leaders who often impact their congregant's decision-making on numerous life choices (Baruth et al., 2015; Harmon et al., 2018). High rates of church attendance have been linked to African American women (Pew Research Center, 2020); however, their roles within the church have been limited. For example, according to Chaves et al. (2015), pastorship continues to be a male-dominated role. This patriarchal approach has traditionally been the functionality within the African American church doctrines, which has restricted women from certain leadership positions, wearing certain attire, and applying beauty enhancers (e.g., make-up) in certain denominations (Green, 2003). This form of oppression and gender inequality gives rise to an understanding of the power relations within the faith-based community and setting.

The literature findings emphasized that congregants would be more likely to participate if pastors communicate the importance of participation in church activities and health-related screenings. For instance, in a study by Clay et al. (2005), all women participants stated that they would obtain a mammogram if their pastor would recommend one. Similarly, Darnell et al. (2006) reported that women congregant's mammography participation was influenced by the pastor's communication, in addition to the repetition of hearing, seeing, or reading about mammograms in their churches. This suggests that the church and the pastor can exert significant influence in their congregation. Concurrently, there is a hidden danger in solely relying on the pastor's opinion about healthcare issues, especially if pastors only believe in spiritual healing and not medicine. Clark et al. (2018) noted that the more the individual was involved in religious behavior, the more they changed their position to believe that God controls their health outcomes. This may be due to the messages communicated through the pastor, other parishioners, and church activities that emphasize that God is the all-powerful one (Clark et al., 2018). From this standpoint, pastors operating in patriarchal positions to influence the decisions among their women congregants may compromise the health, quality of life, and life-expectancy among women within their congregations.

Conversely, because most congregations are female-dominated, the success of church programs depends upon their participation (Green, 2003). Also, African American women play a vital role in their family and church and can influence not only their health but the health of their own families and communities (Gross et al., 2018). These same researchers highlighted that African American women were the backbone of the African



American church, leaders, and women who overextend themselves to serve the church (Gross et al., 2018). To this end, African American women contribute and respond to the need of the church and family and may, at times, neglect their own health (Gross et al., 2018). This creates circumstances that may prevent the adoption of healthy behaviors and increase the likelihood of health risks.

Spirituality and religiosity are possible issues related to African American women's decision to have or not have mammograms. Because most congregations are composed of women (Green, 2003; Pew Research Center, 2020), it may be their perception of how spirituality could involve influences of the pastor and how that impacts mammography. Therefore, examining any connection of religious beliefs in this area of mammography utilization is fundamental to understanding African American women's decision making. Addressing these gaps may uncover other possible layers of mammography participation or barriers to routine mammography screenings among this specific population of women.

### **Health Belief Model**

An additional manner in which research views staying healthy is by understanding perspectives consistent with the Health Belief Model (HBM). The HBM assumes that people will engage in health-seeking behavior based on their personal beliefs that doing so will decrease the threat of a health concern or condition that would have adverse outcomes (Glanz et al., 2015).

Developed by social psychologists in the 1950s, the Health Belief Model (HBM) was used to understand why a secondary level of prevention initiative, using mobile x-ray

units, did not facilitate increased uptake in free tuberculosis screenings (Sharma, 2017; Skinner et al., 2015). The HBM includes six constructs that have been used to predict and explain changes in health behaviors. The first four constructs in the HBM's original model were (a) perceived susceptibility, (b) perceived severity, (c) perceived benefits, and (d) perceived barriers. The fifth construct, cues to action, explores triggers that prompt participation in health behavior (Rosenstock, 1974). The sixth construct, self-efficacy, was added in the 1980s (Sharma, 2017; Skinner et al., 2015). In 2008, Champion et al. evaluated the validity and reliability of previously established HBM concepts and other beliefs that affect African American women's adherence to screening mammography. Since that time, the HBM is the most widely used behavioral theory to predict and explain mammography adherence (Champion et al., 2008; Lawal et al., 2017). The overall assumptions of the model are that engagement in health behavior is most likely to occur if people believe:

(a) they are susceptible to a specific condition; (b) the condition may produce negative outcomes; (c) their behavior to taking action will provide positive benefits; (d) they can overcome perceived barriers that would prevent the adoption of a new health behavior; and (e) a specific behavior could be beneficial in reducing their susceptibility or threat (Skinner et al., 2015).

Screening mammograms are effective in detecting breast cancer. However, African American women possessing the belief that a specific action is effective in reducing the threat of disease, although that action may yet be inconvenient, expensive, unpleasant, painful, or upsetting (i.e., perceived barrier; Rosenstock, 1974), may have no intention of participating in mammography services. Therefore, understanding the

perceived barriers that African American women face specific to accessing mammography and other services will unfold new causes for delayed or avoided mammography. BFT could further unravel the threads of the injustice that might contribute to the underutilization of screening mammograms, thus contributing to innovative approaches towards reducing, if not eliminating, breast cancer disparities.

### **Mammography Screening Decisions**

Several studies that explored why women do or do not have screening mammograms will be discussed. Using a sample of 9000 medically underserved women in St. Louis, Fayanju et al. (2014) used the HBM to explain barriers as to why women, in general, may or may not adhere to routine screening mammograms. Fear of pain, fear of the unknown, and unmanageable costs across the cancer continuum were primary barriers to screening participation, specific to African American women. This finding further illuminated the concern for nonadherence to screening recommendations, which cause survival inequities between White and Black women. As a suggested way to increase adherence, these same researchers concluded that peer-to-peer recruitment might be a unique strategy to expand mammography utilization in St. Louis among the medically underserved. In their telephone survey study, Wells and Thompson-Robinson (2016) used the HBM to identify barriers to repeat mammography screenings among a sample of 21 Black women residing in Las Vegas. Among this sample, 24% of women were not rescreened in a two-year time frame. In this study, few barriers to repeat screening mammograms were found. The most cited barriers were pain and fear. However, most

participants reported strong religious faith and believed that they would be healed if breast cancer was diagnosed.

Overall, findings from these various studies suggest the value of asking African American women how they take care of their health. Including questions that offer African American women a voice could explain women's health behaviors, personal beliefs, and preventive health actions.

### **Social Determinants of Health**

Another way BFT frames the intersectionality of race, gender, and class is identified through exploring the Social Determinants of Health. According to the World Health Association (2020), Social Determinants of Health are defined “as the conditions in which people are born, grow, live, and work, resulting in health inequities” (p. 1). The intersections of geographical access, healthcare access, and socioeconomic status influence clinical outcomes and disparities in survivorship between African American and White women. Receiving equitable and optimal healthcare services is paramount to optimal health and longevity. The social determinants that shape health outcomes are heavily weighted on social, economic, and political decisions and policies (Baciu et al., 2017). This racial mapping and discrimination set the tone for what could be preventable deaths—to deaths that reflect differences in race and class because race and class intersect. Additionally, the harboring of deep-rooted prejudices that are either covertly or overtly expressed makes health equality and equity difficult to obtain across all populations.

Socioeconomic conditions impact the health of women whose incomes are disproportionately lower than those with higher incomes (Coughlin, 2019). Studies have shown that African American women were more likely to be uninsured or on public insurance (i.e., Medicaid)—22.7% compared to White women (8.4%) (Jemal et al., 2017). The socioeconomic inequities between African American women and White women raise valid concerns regarding vulnerabilities such as increased stress, lack of healthcare access, and built environments that contribute to less favorable health outcomes. These built environments infuse susceptibilities to chronic diseases and illnesses, in addition to reinforcing higher stress levels linked to surviving a breast cancer diagnosis (LaVeist & Isaac, 2013).

Prior research studies suggest a potential socioeconomic condition that may influence adherence to mammography screening is educational attainment (Alexandraki & Mooradian, 2010; Chowdhury et al., 2016; Patel et al., 2014). Individuals possessing higher levels of education may better understand the importance of breast cancer prevention strategies and, therefore, may present to obtain a mammogram as recommended (Chowdhury et al., 2016). Coughlin (2019) explained that African American women receive less income than White women, even when they have the same educational level. This inequality in pay may reflect a woman's housing affordability, restricting them from renting or buying in certain neighborhoods that may enhance their life expectancy. Barriers to care are more likely to be driven by poverty, a lack of resources, and inequities in policy decisions. In many instances, the connection between health, illness, and mortality revolve around power and privilege from healthcare

providers, the healthcare delivery systems, and political systems. Economically, where financial barriers exist, the delay in timely screening may increase the likelihood of late-stage diagnosis, thus creating higher healthcare costs. A critical point in the literature is that race, education, SES, insurance status, and income affect disparate outcomes (Ahmed et al., 2017; Coughlin, 2019; Kohler et al., 2015), which contribute to poorer health for African American women.

Considering socioeconomic factors impacting African American women, it is imperative to help bridge the disparity gap across the breast cancer continuum through accessibility and timeliness to quality cancer care, pivotal to the continued survival of women. Under the Affordable Care Act (ACA), many health insurance plans cover screening mammograms at no cost to the individual (ACS, 2019a). Through these payors, accessibility to mammography screenings have widened, yet a gap in mammography adherence remains a public health concern. Failing attempts to narrow the racial divide is often reflected in insurance status and income (Chowdhury et al., 2016; Gathirua-Mwangi et al., 2016; Jemal et al., 2017; Nonzee et al., 2015; Wells et al., 2017), which play important roles in accessing proper healthcare such as mammography. Screening programs to improve health outcomes, such as the NBCCEDP, provide services to low-income, underinsured, and uninsured women (Lee et al., 2014) are grounded in opportunities for mammography screening similar to women with private insurance, public insurance, and women who can self-pay.

As previously mentioned, the NBCCEDP 2013-2017 national data indicated discrepancies in adherence across racial and ethnic groups of women, especially African

American women. These differences in screening rates contribute to the potential of health consequences and the targeted population's wellbeing. Medicaid offers mammography coverage based on specific criteria. Nonetheless, statistics reveal continued lower mammography participation rates among low-income women. Tangka et al. (2017) found that Medicaid recipients, representing African American women and American Indian/Alaska Native minority groups, had lower adherence rates than White women in 30 out of the 44 states. Overall, the connection lies in the fact, that lower income, underserved African American women screen at lower frequencies, even when costs have been potentially eliminated. Initiatives aimed at eliminating barriers and addressing social determinants such as Mobile Mammography and Patient Navigation have major advantages toward improving morbidity and mortality rates among African American women at risk for breast cancer.

Challenges persist with mammography participation because of existing barriers within weakened communities due to their geographical boundaries. For many African American women who are low-income and uninsured, accessing timely mammography screenings may be significantly delayed because of the reported barriers and health behaviors. One method, a community-based intervention that is central to removing barriers to care across the cancer continuum, is patient navigation (H. P. Freeman & Rodriquez, 2011). Patient navigators can be non-clinical members (i.e., lay navigators) from the community (H. P. Freeman, 2006) or clinical personnel (e.g., nurses) that involve supporting women after being diagnosed with cancer (National Academies of

Sciences, Engineering, and Medicine, 2018). In either case, this approach decreases barriers and improves timeliness to care by reducing gaps in service delivery.

Patient navigator programs have successfully facilitated the uptake of screening mammograms and specifics of improving access (Riley & Riley, 2016). To illustrate, Marshall et al. (2016) conducted a randomized controlled trial to evaluate the effect of patient navigation on mammography screenings among African American women Medicare recipients. A total of 1,358 Medicare beneficiaries aged 65 and older were included. Study participants were recruited from community centers, health clinics, health fairs, mailings from Medicare lists, and telephone calls. A total of ( $n= 638$ ) Medicare beneficiaries were randomized to the intervention group (i.e., patient navigation and cancer screening educational materials), and ( $n=730$ ) beneficiaries were randomized to the control group (i.e., educational materials only). Study findings indicated that African American women in the intervention group had higher odds of having had a screening mammogram than African American women in the control group (OR=2.26, 95% CI = [1.59–3.22]). Furthermore, Marshall et al. (2016) concluded that a focal area of patient navigation should include women who are not current on their scheduled mammograms.

Phillips et al. (2011) used a quality improvement intervention to evaluate the effect of patient navigation on adherence rates among women receiving biennial screening mammograms. All women aged 51-70 years, who received care at the inner-city medical center, and whose last screening mammogram was more than 18 months ago, were eligible for the study. A total of 3,895 women were randomized to either a



phone-based intervention ( $n=1817$ ) or a control group ( $n=2078$ ). Biennial screening mammograms were assessed at baseline and post-intervention. Study results showed the mean age was 60, and most participants were African American women (i.e., 47%). At baseline, both groups showed no difference in adherence rates (78%). However, after the 9-month intervention, there was a significant increase in mammography adherence among the intervention group (87%) compared to the control group (76%). Based on these findings, the role of patient navigation affords opportunities to explore other intervention strategies further to improve women's health outcomes. Ultimately, both studies demonstrate the impact patient navigation interventions offer in improving timeliness to mammography screenings. However, although patient navigation programs have shown promise in improving timely access to screenings and treatments (Marshall et al., 2016; Phillips et al., 2011; Riley & Riley, 2016), these programs have limitations such as internal delays are communication barriers in the healthcare delivery systems (Ramachandran et al., 2015). This high priority of patient navigation programs helps bridge the gap between the patient and provider to better provide quality care and improvements in the health status of women. As such, efforts to sustain such programs should become a primary focus for healthcare policymakers (Phillips et al., 2011).

### **Neighborhood Characteristics**

In a systematic review conducted by Khan-Gates et al. (2015), most studies demonstrated that geographic access facilitated increased mammography screenings and decreased advanced staged breast cancer diagnosis while other studies found no statistically significant association. Previous research has shown that low-income African

American women who reside in disadvantaged communities with limited access to breast services were nonadherent to routine screening recommendations. For example, Millon-Underwood and Kelber's (2015) cross-sectional exploratory study was purposed to investigate mammography screening practices and their characteristics between women nonadherent and adherent to mammography screenings. An investigator-designed questionnaire was developed to obtain data regarding breast cancer risks, breast cancer screening, neighborhood characteristics, and the availability of breast cancer resources within their communities. The study sample consisted of 5648 women aged 40-74. Among this sample, most women reported having insurance, in addition to receiving a mammogram. Race-specific characteristics were not obtained. Study findings demonstrated that nonadherence to screening mammograms was the greatest among women who were uninsured, less than age 50, had no family history of breast cancer, resided in low-income and inner-city neighborhoods, and resided in communities without facilities providing breast care services. Nearly 57% of women residing in low-income neighborhoods compared with 51.9% and 43.6% of women residing in middle-income neighborhoods and upper-income neighborhoods, respectively, had not obtained a mammogram. These mammography screening behaviors support the need to explore further factors that decrease the utilization of breast services. Researchers Millon-Underwood and Kelber (2015) validated this need for additional research involving women who are current and those who are not current on their screening mammograms.

Moreover, other solutions involve strategically designed interventions and programs for women residing in inner-city and low-income neighborhoods and

nonadherent to screening mammograms. In Dailey et al.'s (2007) seminal article, the relationship between neighborhood-level socioeconomic status and mammography screening adherence was explored. This prospective study included a sample of 1,451 African American and White women aged 40-79. Baseline and follow-up data were collected using a structured 45-minute telephone interview. Approximately 29.4 months after baseline data collection, a total sample of 1249 women (i.e., 86%) completed follow-up interviews. Results showed that African American women were more likely to be single, have lower incomes, have lower educational attainment, and live in a lower socioeconomic neighborhood than their White counterparts. Other definitive evidence affirms that White women were more likely to adhere to mammography screening recommendations than African American women (African American, 53.7%; White, 43.9%). Overall, comparison data showed that individuals living in disadvantaged neighborhoods (e.g., African Americans) compared to those who do not are more likely to be nonadherent to routine mammography screening guidelines. The team of investigators concluded that disadvantaged neighborhoods have a profound effect on the health outcomes of residents and may extend to health prevention behaviors (Dailey et al., 2007).

Several experts have addressed the overall challenges of lower socioeconomic communities. Neighborhoods characterized as low-income tend to diminish the health outcomes for the individual and the community as a whole because in such an environment, people tend to focus on day-to-day survival needs as opposed to preventive care measures (Kim et al., 2015). Low-wage jobs fuel greater exposure in lower

socioeconomic communities, which create barriers that prevent residents from seeking health-related services. Neighborhood characteristics such as the lack of existing medical facilities, lack of trained healthcare providers, and geographical isolation also influence women's ability to connect to accredited mammography facilities and other high-quality and state-of-the-art healthcare and provider services. In 2015, lead investigator V. A. Freeman and her team of researchers provided a comprehensive overview of the rural hospitals. The report indicated that typically rural hospitals offer outpatient screening mammograms; however, chemotherapy is not included. As critical touchpoints, most rural hospitals (86.7%) and urban hospitals (91.5%) offer women an avenue to obtain mammograms. However, research findings demonstrated that rural hospitals located in isolated geographical areas were less likely to provide screening mammograms at 75.8% (V. A. Freeman et al., 2015). This places a hardship on the woman and support systems when trying to face the diagnosis and navigate the complex health systems typically located outside of their immediate communities.

The combination of low socioeconomic status, poor geographical access, and limited access to transportation places a heavier burden on mammography adherence. With the widespread focus on expanding mammography services to engage women in hard-to-reach areas (e.g., rural and poor communities), establishing accessibility to healthcare services could be a revolutionary way to improve mammography screening rates and breast cancer disparities. Mishra et al. (2012) agreed that offering women multiple services in one office visit may be a viable way to provide women with needed services. These studies are more identical and practically the same as they explore a vital

need for additional resources and screening programs in or near communities so that equitable health and outcomes can exist not only in higher-resourced communities but also within lower-resourced communities.

### **Healthcare Access**

Much attention has been given to breast cancer disparities. The integration of public policies would seem to be an obvious approach to address gaps in early detection. White women have fewer barriers to accessing healthcare services and, therefore, are less likely to be diagnosed with late-stage breast cancer than African American women (ACS, 2019a). For African American women experiencing barriers, inequities in achieving timely mammography screenings and follow-up care due to race and class status, have shown shortened the survival rates and health status difference between groups.

Mobile mammography has become an innovative community-based initiative by which breast cancer screenings are brought to the women, representing a more local strategy to improve women's health. Prior studies have examined the use of mobile health units to improve accessibility and convenience to screening mammograms for women experiencing barriers such as costs, childcare, and transportation (Mizuguchi et al., 2015; Patel et al., 2014; Vang et al., 2018). More specifically, through organizational and community level partnerships, mobile units have serviced women where they live, worship, and work (Mizuguchi et al., 2015). This local level of access brings about the potentiality of increased adherence through the early initiation of mammography screenings by bringing the service to women in their communities. Although mobile units face many challenges, such as logistical and operational costs, image transfers, and loss

to follow-up, mobile unit programs have offered local access to women (Carkaci et al., 2013).

While mobile mammography units have increased the uptake of breast cancer screenings for the underserved, uninsured, low-income, and minority populations (Brooks et al., 2013; Carkaci et al., 2013; Stanley et al., 2017; Vang et al., 2018), there is paucity concerning overall low utilization (Vang et al., 2018), tumor stage (i.e., African American women stage of II-IV (61%) versus White women (18%) (Brooks et al., 2013), and follow-up after an abnormal finding (Stanley et al., 2017). A challenge for women who utilize mobile mammography is to return for follow-up because they would need to access follow-up services at a cancer center or other clinical agency (Stanley et al., 2017). On this point, transportation and financial barriers may be a major factor in adherence to follow-up recommendations. Consequently, women who do not return for follow-up or who are lost to follow-up may have delayed care and, as a result, may have a late-stage diagnosis and an unfavorable prognosis.

Possible ways to increase adherence to routine mammography screenings using mobile mammography is to partner with churches, offer weekend options (i.e., Saturday) and flexible scheduling (M. B. Hall et al., 2017), and include patient navigators (Stanley et al., 2017). Although the findings of mobile mammography outcomes vary, they still serve as a platform to increase access by removing barriers, thus improving the overall survivorship of women in underserved communities. Not only is timely access to healthcare services important, but receiving optimal and quality healthcare is significant.

For example, the quality of mammography facilities and their screening effectiveness is essential to providing high-level services for all women.

Researchers Rauscher et al. (2012) found variations in the skill levels of breast imaging specialists, inconsistencies in the use of the latest technology advancements, and inappropriate tracking of patients for follow-up in accredited and non-accredited facilities. Molina et al. (2015) and Warnecke et al. (2019) reported that low-income, uninsured, and minority women tend to screen more at lower resourced and non-accredited mammography facilities and typically experience diagnostic delays greater than 60 days and surgical treatments than White women (George et al., 2015). Gullatte et al. (2010) reported that follow-up intervals of 3 months or longer are associated with negative survival outcomes. In terms of travel distance, Zahnd et al. (2019) found few low-income women residing in the Lower Mississippi Delta Region states had more than a 30-minute drive to their appointments compared to women with higher incomes. Therefore, inaccessibility to healthcare and quality care are concerns among non-accredited screening facilities.

There are many explanations for disparities such as socioeconomic, biological, access, costs, and the fragmentation of the healthcare system (Daly & Olopade, 2015; Singh & Jemal, 2017) that exist in the United States between African American and White women. Yet, there remains a plethora of insufficient explanations for racial health disparities. This has led researchers to investigate further variations in knowledge and screening practices such as provider recommendations, attitudes, and beliefs, which may also explain the survival differences between African American and White women.

O'Malley et al.'s (2001) research focused on the connection between physician's mammography screening recommendations and women's race/ethnicity and socioeconomic status using a sample of 1,933 African American and White women. Data were collected in two phases among a sample of women aged 52 years and older in 10 rural counties. A 45-minute questionnaire was administered in the homes of the participants. A distinct comparison between provider recommendations among African American women and White women was found. In this instance, White women (55%) were recommended more for a screening mammogram than African American women (45%). Additionally, White women were less likely to report a lower socioeconomic status, lower educational attainment, and lack of healthcare access than their African American counterparts.

Gonzales et al. (2016) used National Health data from the 2008 and 2013 interview survey (NHIS) to review changes in reports of mammography screening recommendations after the U.S. Preventative Task Force (USPTF) issued their recommendations in 2009. A random sample of  $n=16021$  women aged 40-74 with no history of breast cancer was included in the study. Among women without a recent screening mammogram, survey data explained that White women versus non-White women (i.e., Black, Hispanic, Asian) were more likely to report mammography screening recommendations from their providers. An even greater source of concern is that multiple studies have confirmed that African American women would likely obtain a mammogram screening if they were advised by their providers (Corrarino, 2015; Farr et al., 2020; Nonzee et al., 2015; Passmore et al., 2017; Ragas et al., 2014). This gives a



formal and practical solution towards adherence to routine screening guidelines.

However, it is fundamental to note that having regular access to safety net providers and practices is essential for mammography referrals, follow-up, and continuity of care.

According to the Association of American Medical Colleges (2020), most providers are White. Feagin and Bennefield (2014) suggest that racialized provider-patient relationships impact the population's health and well-being. Breast health disparities between African American and White women have been clearly outlined throughout the literature. There is literature on healthcare providers' racial attitudes and implicit bias, which could result in unfavorable outcomes, thus contributing to the existing disparities between African American and White women (Penner et al., 2014; Smedley et al., 2003). The decision-making process among providers with racial overtones typically results in African Americans, in general, receiving differences in medical treatments, lower quality of care, and ineffective communication (Penner et al., 2014); ineffective patient-provider interactions can result in inequities in breast outcomes (Feagin & Bennefield, 2014). Overall, these studies substantiate patterns of missed opportunities for African American women to obtain a mammogram because of provider bias, which may suggest a lack of mammography referrals and could be related to nonadherence to mammography screening, resulting in survival differences.

According to Penner et al. (2014), to improve racial disparities in healthcare, bi-directional interaction between provider-patient must occur. Other strategies to strengthen relationships between patients and providers involve consistency of contact and the establishment of trust overtime with a healthcare provider because the African American

community, in general, hold trust issues regarding the medical community stemming from a history of non-ethical experiments performed (Lewis et al., 2018). Additionally, increasing the proportion of minority healthcare providers (Smedley et al., 2003) would likely promote greater adherence to provider recommendations and practices.

Furthermore, concerted efforts in understanding bias in the healthcare system and how it impacts the population's health are paramount toward reducing racial disparities (Penner et al., 2014). On the other hand, while minority providers are essential (Smedley et al., 2003), research has shown that minority clinicians experience racism and discrimination from their patients (Acosta & Ackerman-Barger, 2017). As such, educating providers and patients on race and racism could help minimize power struggles and conflict.

To address disparities and improve health outcomes among African American women individually and collectively, improved medical education through structural competency (Metzl & Hansen, 2014) may be an effective way to ensure closing knowledge gaps, cultural competency, and a possible change in provider attitudes. In this regard, healthcare providers should understand the social determinants of health and the structural factors that exist within specific communities in which their patients live. Given the inequities in breast cancer outcomes, many providers must move beyond their racial lens and legitimize African American women as a human being with certain life perspectives and health needs.

### **Screening Recommendations**

Mammograms have saved the lives of many women. Despite its limitation of detecting 85% of cancers (ACS, 2019c), it is the most effective screening tool and has

been shown to reduce mortality rates by 19% (Pace & Keating, 2014). Screening mammograms are x-rays of the breasts that use low dose radiation to visualize suspicious areas within the breast (ACS, 2019a; ACS, 2021b). Mammograms can target areas that are non-palpable to the human touch in asymptomatic women. This basic early detection method is a significant screening strategy toward improving breast cancer outcomes.

Along with the American Cancer Society, the U.S. Preventive Task Force (USPTF) has published guidelines for routine mammography screenings. For instance, the U.S. Preventive Task Force 2016 guidelines recommend that women aged 40-49 years should base their decision to screen biennially on their individual preferences. In turn, the Task Force recommends biennial mammography screenings for women at average risk beginning at ages 50-74. “Average risk” women tend not to have the following characteristics: (a) a history of personal breast cancer, (b) a family history of breast cancer in first degree relatives (i.e., maternal side), (c) any inherited genetic mutations, or (d) exposure to radiation therapy to the chest as a child (Oeffinger et al., 2015; Qaseem et al., 2019). There is currently insufficient evidence to assess the benefits and consequences of mammography screening in women aged 75 and older (U.S. Preventive Task Force, 2018).

In contrast, the American Cancer Society 2015 screening guidelines recommend that women between the ages of 40 and 44 should have opportunities to begin annual screenings and that women at average-risk should screen annually starting at age 45. Women aged 55 years and older should screen biennially or annually if opportunities exist, and screening should continue as long as their health is good and their life

expectancy is 10 years or longer (Oeffinger et al., 2015). Screening recommendations from the National Comprehensive Cancer Network (2019) and the American College of Obstetricians and Gynecologists (ACOG, 2015) support screening mammograms beginning at age 40. These findings demonstrate that while screening practices are varied, there is a lack of clarity on which recommendation addresses the issue at hand—improving screening rates, survival rates and eliminating breast cancer disparities. A 2015 report from Farley et al. indicated that recommendations from the ACS appear to contribute to earlier breast cancer diagnosis, an increase in 5-year survival rates, and lower costs among low-income African American women versus the USPTF. However, these findings need to be further explored since this study reported the ACS previous screening guidelines beginning at age 40 (Farley et al., 2015) and not under their current screening recommendations of age 45 (Oeffinger et al., 2015).

The concern for these screening guidelines lies in the fact that the recommended guidelines may not only be confusing to providers (Haas et al., 2016) but to women (Farr et al., 2020). Specific to African American women, the media portraying that White women only get breast cancer may also delay mammography screening (Allicock et al., 2013; Passmore et al., 2017). Age has been found to affect personal beliefs. For example, older African American women were found to have higher fatalistic beliefs (Zollinger et al., 2010), and African American women aged 58 and older believe that they should not talk about breast cancer (Daniel et al., 2018). The fact remains that a woman's decision to screen is of a personal choice. However, that decision is compounded by social, cultural, and economic factors that influence mammography awareness and early detection and

treatment participation. On a broader level, it is vital to understand why many African American women present late to screen despite the increase in technology and resources focused on early detection and prevention.

Ultimately, the reasons why low-income African American women underutilize screening mammograms remain unclear and make survival inequities between African American women and White women more concerning. Nevertheless, national legislation and local community initiatives like mobile mammography advocate and represent services that show promise as models for addressing African American women's screening needs. Furthermore, other programs such as Medicaid, Medicare, Patient Navigation, and the NBCCEDP remain viable resources to increase accessibility to screenings for low-income, underserved African American women.

### **Gaps in Current Literature**

As illustrated above, being a woman causes increased risks of developing breast cancer. However, being an African American woman presents the risks of developing breast cancer at a younger age, having aggressive tumors, and risks of dying from breast cancer at any age (ACS, 2019a). Early presentation to mammography screening is paramount to surviving and thriving after a breast cancer diagnosis. Extensive research has been conducted to explore racial disparities in breast cancer and interventions designed to remove barriers to care. However, the underutilization and timeliness of mammography screening in low-income African American women remain concerns. This research gap shows a difference in mortality rates between African American and White women. This disparity could be related to systemic gaps because research is not being

utilized based on current recommended strategies that may be due to costs or systems of power.

Embracing one's culture and belief systems is highly significant in understanding the decision-making specific to African American women. Following the standard of practice as outlined by various professional agencies (e.g., ACS, USPTF, etc.) provides researchers and other stakeholders with crucial data to improve screening rates and breast cancer outcomes. Mammography screening beliefs that may be passed on from generation to generation may negatively affect the African American woman's health status. The African American church and the African American pastor are great influencers in many African Americans' lives (Adksion-Bradley et al., 2005; Baruth et al., 2015). Using spiritual and religious overtones within this study could help clarify African American women's beliefs regarding who is in control of their health and decisions.

Breast cancer disparities is an ongoing public health challenge. It is important to respect a woman's decision to adhere or not adhere to routine screening guidelines. Similarly, it is also important to acknowledge that many screening decisions are based upon numerous factors that erupt from belief systems and other societal systems that either promote, deny, or delay mammography utilization, which, in turn, cause late-stage diagnosis. Discussions regarding decisions to obtain a mammogram—or not—were published in the work of Passmore et al. (2017). This work highlighted the perception that White women are the priority population for breast cancer and that African American women and their communities were the least impacted by breast cancer (Passmore et al.,

2017). This perception may be an alternative explanation for African American women's beliefs about the importance of mammograms.

Similarly, perceived discrimination in healthcare has vital implications for positive screening experiences and following mammography screening guidelines (Adegboyega et al., 2019). A recent study by Adegboyega et al. (2019) found socioeconomic conditions and past negative healthcare experiences due to race were found to influence mammography participation. While mobile mammography can reduce barriers and improve screening gaps (Vang et al., 2018), this streamlined service delivery method was less popular with this group of African American women because of perceived discrimination. Participants recognized that insurance and income were factors that influenced the way they perceived how they were treated and the level of care they received. Reports of substandard equipment being used in lower income communities compared to higher income communities were highlighted (Adegboyega et al., 2019).

As previously stated, a goal of Healthy People 2030 is to increase the proportion of females who receive a breast cancer screening based on the most recent guidelines from 72.8 to 77.1% (ODPHP, n.d.). Although professional organizations differ in screening guidelines (i.e., age, timeframe), they concur that mammography screenings are important. In this case, according to the Behavioral Risk Factor Surveillance System 2018 data, 81.0% of White women ages 50-74 in North Carolina reported receiving a mammogram within the past two years versus 74.3% of African American women. In the same time frame and age group, 19.0% of White women did not receive a mammogram

compared to 25.7% of African American women who reported not receiving a mammogram.

Barriers to mammography screenings among African American women have been established in numerous studies, though rarely from a BFT with women's voices. This current study sought to add to the literature by providing a unique perspective of screening mammography decisions and barriers to those decisions among the targeted group of women. More importantly, it was essential to clearly understand African American women's perceptions regarding their health, race, and previous experience with the healthcare system and mammography facilities. These findings revealed untapped strategies that could then be developed and delivered in healthcare organizations, including the faith-based. The knowledge gained by addressing barriers and gaps can help increase mammography utilization and narrow survival disparities between African American and White women. An understanding of the health inequities and injustices through the voices of African American women was salient. Therefore, utilizing a qualitative approach guided by BFT may have provided a deeper level of awareness of the everyday experiences from the lens of African American women.



### **CHAPTER III**

### **METHODOLOGY**

A qualitative research study served as an opportunity to explain and capture a deeper level of what constitutes African American women's decisions to obtain a screening mammogram. According to Creswell and Creswell (2018), qualitative research is focused on individuals to generate findings that cannot be obtained by conducting research based on numerical analysis. The central phenomenon of African American women's perspectives and attitudes toward preventive health screenings is relevant because the focus is subjective as opposed to an objectively statistically based research approach. Qualitative research was used in this study to explain and outline the inequalities and inequities African American women experienced due to systemic barriers, structural barriers, and personal barriers, with responses collected from the demographic questionnaire and qualitative interviews in the naturalistic setting of the participant (Creswell & Creswell, 2018).

Semi-structured interviews addressed how being an African American woman and a certain class status have directly impacted them. Furthermore, other issues that contribute to the impact of spirituality, religion, social determinants of health, and differences in treatment, behaviors, and healthcare access were explored through these narratives. The major sections of this chapter proceed in the following order: Research Questions, Design, Setting and Sample, Recruitment, Data Collection, Data Analysis,

Data Security, Human Subjects, and Summary. Each section's detailed information conveys this study's approach and methodology in exploring mammography adherence among African American women.

### **Research Questions**

1. What are African American women's views on how race and gender influence how they take care of their health?
2. What do African American women view as influences on their decisions to have (or not to have) a mammogram?
3. What are the perceptions of African American women's experiences with healthcare providers and mammography screening facilities?

### **Research Design**

According to Sandelowski (2000), "Qualitative descriptive studies have as their goal a comprehensive summary of events in the everyday terms of those events" (p. 334). Additionally, the representation of events includes the humanness of the people involved in the events. This approach is suitable for the study because it recognizes the importance of understanding each woman's different worldviews specific to the issues of breast health and mammography screenings. Therefore, to understand health behaviors and address breast cancer disparities, qualitative descriptive research could render itself effective because it is the least theoretical and allows the researcher to remain close to the data (Sandelowski, 2000).

### **Philosophical Underpinnings of Qualitative Descriptive Research**

According to Bradshaw et al. (2017), philosophical underpinnings in qualitative descriptive studies (a) provide a clear picture of what is being studied and can generate new knowledge and develop a conceptual and/or theoretical framework; (b) recognize that each individual has their perspectives and recognizes the different experience of the participant and researcher; (c) emphasize understanding and describe the phenomenon; (d) ensure the researcher is actively involved in the research process; (e) takes on an emic perspective (insider perspective) in the words of the research participants from their experience; and (f) recognize that data collection occurs in the participants' natural settings. It is essential to understand these principles by emphasizing the phenomenon under study as it represents a core value, and that is necessary to inform practice.

### **Setting and Sample**

Qualitative descriptive research uses various sample sizes and approaches compared to other research traditions (Colorafi & Evans, 2016; Sandelowski, 2000). For instance, Sullivan-Bolyai et al. (2005) pointed out that numerous qualitative description studies have included as many as 50 participants, while O'Reilly and Parker (2012) stated that the sample size should answer the research question. Creswell and Creswell (2018) argued that the sample size depends on the qualitative design. Moreover, Braun and Clarke (2013) reported that the average sample size in qualitative research is 15-30 participants.

Given that the goal was to understand the diverse perspectives of African American women's adherence or nonadherence to mammography screenings, the study's

initial goal was to recruit 15-20 African American women residing in North Carolina utilizing a convenience sampling approach. Recruitment continued until data saturation was reached. Inclusion criteria include women who self-report they (a) have never had a mammogram; (b) have not screened within the past year; (c) have screened within the past year; (d) can communicate in English; (e) reside in North Carolina; (f) are aged 45 or older; (g) born in the United States; and (h) identify as African American. The inclusion criteria for the frequency of mammography use and age were based on the American Cancer Society's (ACS) screening recommendations (Oeffinger et al., 2015). Exclusion criteria were (a) African American women with a history of breast cancer; (b) African American women who are less than 45 years old; (c) African American women who were not born in the United States; and (d) White women and other racial/ethnic minority groups (i.e., Asian, Pacific Islander, Hispanic, Indian).

### **Recruitment**

Traditionally, the literature confirms the most effective sites of recruitment for African American women include churches, nail salons, and hair salons (Daniel et al., 2018; I. J. Hall et al., 2015; Wells et al., 2017). Also, online recruitment has gained interest (Santiago-Rivas et al., 2019). Therefore, after obtaining approval from the University of North Carolina Greensboro (UNCG) Institutional Review Board (IRB), recruitment strategies included outreach to churches, face-to-face, word of mouth, and a listserv of individuals to ensure that there was an adequate sample of women. IRB-approved flyers explaining the study's purpose and the PI's contact information were distributed and posted at community sites and posted on webpages, such as the PI's

Facebook page and on the Facebook page of other select friends. Flyers were forwarded to a listserv of individuals. The sharing of the flyer was encouraged.

### **Face-to-Face Recruitment**

For face-to-face recruitment, the PI read the IRB approved scripts for each participant. Next, each participant was given an information sheet, or the information sheet was read aloud. After conducting a brief onsite eligibility screening, each interested participant was given a copy of the information sheet and flyer. Potential participants were allowed to ask questions and schedule a convenient time to conduct an in-depth interview (i.e., telephone or video conferencing).

### **Detailed Flyers**

Interested participants who personally contacted the PI after obtaining information about the study from various outreach approaches were screened for eligibility. If study participants met eligibility requirements (i.e., inclusion criteria), a mutual time was scheduled to conduct the study. Due to the SARS-CoV-2 (i.e., Coronavirus, COVID-19) pandemic, several options for completing the study were explained. Study participants were given the option of using video conferencing through UNCG's platform (e.g., Webex or Zoom) or telephone using voice. Information sheets were emailed or read out loud to study participants. Face-to-face interviews were not conducted but were considered as an alternative if the sample size could not be obtained using video conferencing or telephonically. However, member checking did occur face-to-face with select participants to ensure credibility. The PI abided by university policy

and procedures using COVID-19 personal protective equipment, social distancing, and other logistics for the PI's and study participants' safety.

### **Data Collection Method**

As a qualitative study, procedures involved data collection from a representative sample of 15 African American women. At the agreed-upon location and before the interview process and data collection, any questions were answered. Prior to starting the interview, the PI completed a demographic questionnaire for the participants consisting of 14 items, some of which was partially adapted from the Behavioral Risk Factor Surveillance System (BRFSS) (CDC, 2018c). Demographic questions included the women's characteristics and social determinants of health (marital status, age, education, employment status, income level, insurance status), mammography frequency, neighborhood characteristics (travel time, transportation mode), spirituality practices (church frequency), and health perceptions.

The PI emailed or read the information sheet to the telephone participants and completed the demographic questionnaire for the study participants. The demographic questionnaire took no longer than five minutes to complete. Two handheld recorders were used to collect data. To help avoid missing data, the PI reviewed the questionnaire for completeness and encouraged participants to complete the missing items. Due to the COVID-19, a special plan was approved by the IRB and the Office of Research & Engagement and initiated to protect the researcher and participants using personal protection equipment and other safety measures during the conduction of interviews.

## **Pseudonyms**

Efforts to avoid disclosing protected health information and information that was collected during the interview process were rendered. Additional efforts such as the use of pseudonyms were also utilized to protect the confidentiality of the study participants. Pseudonyms that will be used within this study include *Asenath, Bernice, Candace, Deborah, Elizabeth, Esther, Eve, Hannah, Mary, Miriam, Naomi, Priscilla, Rachel, Ruth,* and *Sarah*.

## **Interview**

Semi-structured, in-depth interviews consisted of nine open-ended questions and prompts. All interviews were recorded using two handheld devices or through laptop or mobile device software capabilities. Interview questions and their probes were developed from a Black Feminist perspective, which is focused on understanding real-world experiences that are exponentially crucial to our understanding of mammography-seeking behaviors among African American women. This semi-structured interview format was flexible, could be improvised, and allowed participants to talk freely about the topic (Kallio et al., 2016). In the interest of facilitating rapport and trust for the interview process, the first question was broad—which was to help the participants feel relaxed (Braun & Clarke, 2013).

As the researcher (i.e., the instrument) in data collection, the focus was to allow African American women to express their real-world experiences, including discussion of some topics such as cultural factors, healthcare access, and geographical disparities and discrimination. These perspectives highlighted the participants' lives and experiences

regarding their race, gender, and class related to mammography screenings. These questions were created to give African American women a voice in understanding their mammography screening decisions. This clarified to what extent—if any—these events play in adherence or nonadherence to routine mammography screenings. Each interview lasted 30-60 minutes. After each interview, field notes were written to capture the participant's non-verbal expressions and cues to help enhance an understanding of their responses and reactions. Interviewer reflections following each interview experience were included.

### **Data Analysis**

While there are various ways to analyze data, content analysis is the most flexible and the least interpretive (Colorafi & Evans, 2016; Polit & Beck, 2017; Sandelowski, 2000). Content analysis involves coding, which is a method of identifying aspects of the data that are relevant to the research question, in addition to analyzing patterns and themes (categories), which are used to describe the data phenomenon or idea (Creswell, 2013; Polit & Beck, 2017). Before data analysis began, each fieldnote and manually transcribed interview was organized and read several times for clarity and ideas. Additionally, transcripts were numbered line-by-line as a way of referencing cases and quotes. A five-step process was used to analyze the data using Elo and Kyngas's (2007) method of content analysis (i.e., open coding, coding sheets, grouping, categorization, and abstraction).

To illustrate, once the data were organized, first open coding was utilized. Each transcript was read for clarity. New ideas, notes, and headings were written in the



margins to describe the data. Second, headings were collected from the margins of the transcripts and transferred to coding sheets (Elo & Kyngas, 2007). In this case, after coding was completed, the derived codes from the text were sorted using a color schematic document (Creswell & Creswell, 2018; Elo & Kyngas, 2007). Third, categories were grouped under the headings in an attempt to reduce the number of categories. Fourth, categorization helped to bring the data together, which increased understanding and generated knowledge. Finally, the abstraction of similar categories occurred, which helped to describe the topic of interest through the generation of categories into main categories (Elo & Kyngas, 2007; Elo et al., 2014). The recruitment of participants continued until no new themes emerged (Creswell & Creswell, 2018). Saturation was confirmed during data analysis. Descriptive statistics were utilized only to describe the sample. SPSS Version 25 (IBM Corporation, Armonk, NY) was used for analysis.

### **Validity: Rigor and Trustworthiness**

Dependability, credibility, transferability, and confirmability were employed to establish rigor and trustworthiness of naturalistic inquiries in this qualitative study (Creswell & Creswell, 2018). Credibility required the integrity of the data and its interpretation. This was accomplished through random member checking by re-contacting participants to clarify responses during data analysis further (Polit & Beck, 2017). Ongoing peer debriefings to enhance validity were established (Creswell & Creswell, 2018) and included a regularly scheduled review of the evolving categories and thematic structure. Transferability refers to a way in which findings can be transferred to

similar studies. This criterion was addressed using an audit trail consisting of tape ID numbers, transcript numbers, and participant pseudonyms, and by providing a detailed account of the sample characteristics, settings from which recruitment was successful, and circumstances of the study such as timing and strategy for interviews (Braun & Clark, 2013; Polit & Beck, 2017). Similarly, to ensure the findings reflect the participant's voice (i.e., confirmability), the same audit trail and use of direct quotes as exemplars from participants were included (Polit & Beck, 2017) for each theme or category. Attempts were made to ensure all categories within each theme and participant were represented in the findings.

Transcripts were checked for accuracy against the tapes to ensure dependability, with corrections made before analysis. Second, transcripts were first read independently by the principal investigator to immerse herself in the data. Bias can be reduced and minimized through reflexive journaling regarding decisions, actions, and the justification for those decisions that may influence the interpretation of the data (Creswell & Creswell, 2018). Third, a second reader listened to, reviewed, and coded selected interviews. Then, a discussion with the primary reader ensued for dependability and verification at three levels of coding and analysis. Field notes were analyzed using basic content analysis and complemented or validated the transcripts.

### **Data Security**

Using a personal firewall and password-protected computer, all data were loaded on password-protected laptops. Furthermore, all electronic data were loaded onto a secure online file storage system (Box.uncg.edu). Audiotapes were retained until data from the

transcripts had been checked for accuracy. Furthermore, only the PI, members of the dissertation committee, and transcriptionists had access to the collected data. Personnel providing transcription services signed a confidentiality statement. Online transcribing services were utilized. All documents were destroyed based on university and IRB policy.

### **Human Subjects**

This dissertation study consisted of 15 African American women residing in North Carolina. All researchers completed the Human Subjects CITI training as required by the university policy. Upon approval by IRB, participants were given a copy of the information sheet. Participants interested in the study were allowed to ask any questions of the PI for clarity. Pseudonyms were utilized, and the principal investigator, the dissertation committee, and transcriptionists had access to data (e.g., audiotapes and field notes).

The information sheet contained information regarding voluntary participation and withdrawing from the study at any time without losing employment, income, or benefits. The study involved minimal risks. Participants were not subject to any harm but may have been subject to the embarrassment of not knowing or having thought about mammography issues or not having had a mammogram on regularly scheduled intervals.

All collected information (i.e., questionnaires and recordings) were kept in a locked file cabinet at the PI's home to ensure confidentiality and privacy. After the study, all collected data stored in a locked box were destroyed based on university and IRB policy. A \$25.00 incentive in the form of cash or gift card was offered and mailed to study participants.

### **Summary**

This chapter explained the purpose of this qualitative study, which was to explore African American women's perspectives on mammography participation (and barriers to participation). A qualitative descriptive approach was used to capture richness in understanding the diverse perspectives of mammography screenings from a select group of African American women. The sample and setting were included to establish the context of the proposed study. As shown, recruitment procedures were strategically coordinated to obtain the targeted sample size. Data collection and data analysis were outlined, further highlighting methods and procedures. Data security and the importance of conducting ethical research and strategies aimed at protecting human subjects were included.

## **CHAPTER IV**

### **FINDINGS**

The purpose of this qualitative descriptive study was to explore African American women's perspectives on mammography participation (and barriers to participation) using a Black Feminist Thought perspective. Black Feminist Thought helps to validate these African American women's experiences, thus contributing to the generation of new knowledge and opportunities to explore how power and privilege shape health outcomes of the individual, families, and communities. The goal was to understand how mammography decisions are made, how race and gender influence and contribute to their overall wellbeing and health, and to explore their overall experiences with healthcare providers and healthcare systems.

This chapter uncovers meaningful responses and provides an emergence of themes that may help to understand the differences and similarities of African American women's experiences.

#### **Sample**

In this study, a convenience sample of 15 African American women from various socioeconomic levels was interviewed. Due to the pandemic, each participant was offered to be interviewed using a telephone or Webex platform. As such, all semi-structured in-depth interviews were conducted telephonically between October and November 2020 and lasted between 30 to 60 minutes. Data saturation was met after completion of the 15

interviews, and no new information was generated (Creswell & Creswell, 2018). The collected data was carefully analyzed to bring forth each participants' voice and life experiences. The findings of this research study attempt to answer the research questions.

The demographic characteristics among the participants are shown in **Table 1**. The ages of the 15 African American women ranged between 45-75, with the majority of the participants being 65-74 (40%). More than half the sample (53.3%) were married, (26.7%) were never married, and (20%) were divorced. As shown in **Table 1**, approximately (33.3%) of participants reported annual income levels between \$13,000-\$24,999, and (26.7%) were above \$50,000, with most women being insured with Medicare (53.3%) or private insurance (33.3%). Most respondents were college graduates (46.7%) or attended some college (40%). The distribution of employment status was similar. Seven participants (46.7%) worked full-time, and seven (46.7%) were retired. All participants answered that they have had a mammogram and have a regular place to receive a mammogram, as shown in **Table 2**.

Table 1

Demographic Characteristics ( $N = 15$ )

Demographic Characteristics	<i>n</i> (%)
<b>Marital Status</b>	
Married	8 (53.3)
Divorced	3 (20.0)
Never Married	4 (26.7)
<b>Age Range</b>	
45-54	5 (33.3)
55-64	3 (20.0)
65-74	6 (40.0)
75 and above	1 (6.7)
<b>Educational Level</b>	
Some high school	1 (6.7)
High school diploma/GED	1 (6.7)
Some college (university or technical)	6 (40.0)
College graduate (4 or more years)	7 (46.7)
<b>Employment Status</b>	
Full-time	7 (46.7)
Retired	7 (46.7)
Receiving disability	1 (6.7)
<b>Yearly Income</b>	
Less than \$13,000	1 (6.7)
\$13,000-\$24,999	5 (33.3)
\$25,000-\$34,999	3 (20.0)
\$35,000-\$49,999	2 (13.3)
\$50,000 and above	4 (26.7)
<b>Insurance Status</b>	
Uninsured	1 (6.7)
Medicare	8 (53.3)
Private Insurance	5 (33.3)
Medicaid and Medicare	1 (6.7)

Table 2

Health and Social Characteristics ( $N = 15$ )

Health and Social Characteristics	<i>n</i> (%)
<b>Have you ever had a mammogram?</b>	
Yes	15 (100)
<b>When was your last mammogram?</b>	
0-6 months	6 (40.0)
7-12 months	3 (20.0)
13-23 months	2 (13.3)
2 years or more	3 (20.0)
Missing Data	1 (6.7)
<b>Do you have a regular place to receive your mammogram?</b>	
Yes	15 (100.0)
<b>Time it takes to get to a mammography facility</b>	
0-10 minutes	5 (33.3)
11-19 minutes	8 (53.3)
20-29 minutes	1 (6.7)
30-60 minutes	1 (6.7)
<b>Mode of transportation</b>	
Personal Car	13 (86.7)
Bus or Van	1 (6.7)
Neighbor, family, or friend	1 (6.7)
<b>How often do you attend church?</b>	
Never	1 (6.7)
Monthly	2 (13.3)
Weekly	5 (33.3)
More than once per week	7 (46.7)
<b>How would you rate your health status?</b>	
Excellent	1 (6.7)
Very Good	4 (26.7)
Good	7 (46.7)
Fair	2 (13.3)
Poor	1 (6.7)
<b>How would you rate your health compared to other people your age?</b>	
Excellent	1 (6.7)
Very Good	5 (33.3)
Good	7 (46.7)
Fair	1 (6.7)
Poor	1 (6.7)



## Themes and Context

The seven themes—staying healthy, why mammograms are important, the mammogram experience, accessing healthcare, mammograms in the African American community, promoting mammograms, and being an African American woman—articulate participants’ diverse experiences and perspectives on health and prevention, inform about participation or nonparticipation in screening mammograms, and factors that inform health preventative behaviors in which they engage. In fact, several of the themes were cross-cutting and coalesced around four major contextual areas. The four contextual areas were: Staying Healthy: Agency, Barriers, and Preventive Care, Breast Health: Breast Self-Exams and Mammography, The Influences on Family, Beliefs, and Access on Routine Mammography, and Promoting Preventive Care in African American Communities: Church, Media, and Healthcare Providers: Supports and Barriers. Together, these findings reveal multiple truths and diverse perspectives. Study participants used their collective voices to emphasize and enhance our understanding of possible delays and barriers in screening and access—all that may contribute to differences in health outcomes.

African American women face many challenges, and therefore it, becomes important to recognize these challenges and confront oppression and the injustices that deny these women access and opportunities to achieve health and wealth. “When we get treatment, we get information, but often, our pain or what we feel is not validated, or it is an assumption that we are ignorant.” As such, it may be that we engage in meaningful discussions about the lived experiences among African American women so that healing,

health, and holism can be actualized. Using their voices, these women shared their stories—their daily walk, while living in the United States.

**Contextual Area: Staying Healthy: Agency, Barriers, and Preventive Care**

**Theme: Staying Healthy**

One area that coalesced was about “*staying healthy*.” This theme was related to the various activities that contribute to their overall health. The incorporation of diet and physical activity in participant’s daily routines were key lifestyle approaches for staying healthy. Self-care, spiritual health, and breast self-exams were also combined strategies that influenced participants’ overall health and wellbeing. Most participants ascertained that they go to the doctor once or twice a year and rely on test results and reports from the doctor to inform them of their overall health. Most of the women (46.7%; 26.7%) rated their health status as good or very good, respectively. Most participants were intentional about staying healthy and proactively engaged in health habits.

Esther, a grandmother of one who was proactive about staying healthy, indicated that was a priority. She participated in routine testing and was acting in ways that support not only her physical health but her mental health. She stated:

Um, I based, if I’m healthy, number one on um how I feel. Also, I based if I’m healthy on um going to doctor’s appointments and um being tested. Uh, normal routine testing, getting a um broad check-up on everything that is what I base my being healthy on. How I eat, um the exercise that I do, and my mental health, my mental status.

Miriam, a married woman, maintains she is healthy because she makes healthy lifestyle choices. These choices also include pharmacological and non-pharmacological approaches as measures to maintain her health. She says:

I know that I am a healthy African American black woman by the way I take care of myself. I eat properly, uh I eat the right things, uh I exercise, I walk, I take my uh vitamins and other medicines that I'm supposed to do. I get plenty of sleep at night, and so that's why I consider myself a healthy - a healthy black woman.

Pre-existing conditions may lead to ongoing health issues and other associated health risks. They could also play an important role in a woman's attitude towards her health and wellbeing. Deborah verbalized she was healthy because "I've never been diagnosed with any pre-existing conditions," while Eve explained, "I have uh some pre-existing conditions . . . I have hypertension, and I'm overweight. So those two things I consider make me unhealthy." Women saw themselves as in good health because of how they physically felt and because of regular medical care and the absence of a diagnosis. In contrast, some women relied on their physical symptoms to detect health needs, as Candace, who is married, indicated how important she thought it was to be attuned to your body, listen to it, and seek out help when the body is sending messages that something is wrong.

I know how I feel, and I feel healthy. If I wake up in the morning and I'm not feeling well, and I have a headache or something, then I know I need to figure out why would I wake up with a headache or something. But on the average, I've been waking up feeling good. (Candace)

Though participants did acknowledge that “what you feel like, maybe missed by how you feel,” a single woman stated,

Well, I know how I feel, and I feel good. So that’s how I assume I’m healthy. I know there are things that you can’t see, or you can’t feel, but just based on what I can see and what I can feel, I feel healthy, so I think I’m healthy. ... I don’t have symptoms of any kind, of any obvious ailment or illness. I do get regular medical care, so based on that, I feel as if I’m healthy. (Elizabeth)

This statement is reflective of the potential risk to women—as preventative care is to prevent illness, and when women feel ill, they engage in their care. Staying healthy was important to all women. Some focused on the role of preventative care, health habits to maintain their health, and others did not articulate beliefs and did not specifically engage in preventive practices.

### *Preventative Care*

Most women indicated that diet and exercise were two important methods for staying healthy. Many women discussed the variations in which they participate in regular physical activity to improve their overall health in the following ways:

I play [pickleball] 3-4 times a week at a retirement uh recreation center and we play. I get there about 4:30 and I’ll play until it gets dark. (Bernice)

Dancing. Um, and walking. But I - you know, at my age; I don’t hardly do much, to be honest. (Naomi)

I enjoy um walking [and] listening to music. I enjoy class aerobics, intermingling with other um African American women as well as Caucasian women. Uh, I like roller-skating, I like bicycling, I like working outside [and] I love reading. (Miriam)

As women managed the impacts of the COVID-19 pandemic, they noted that the shutdown and the need to social distance brought challenges to maintain fitness routines. Although activities may have been reduced, many sought out alternatives. Rachel, a woman who enjoys a dance and fitness workout, stated the challenges with participating in the organized fitness program was with the pandemic. However, she was trying out other alternatives:

Um, well, since - since um COVID has hit, I'm not as active as I used to be because I'm just trying to stay in, and you know, stay um away from a lot of people. But um I do like to um well I used to um go to Zumba, and that was an activity, as well as um meeting other people, and it also gave me a chance to exercise as well. But since the COVID, I have not been able to do that. But I just try to walk around the neighborhood, that's something that I can do um, you know, by myself and um, kind of stay free of big crowds or whatever.

Many African American churches provide activities and programs in support of the needs of the ministry. In addition, some African American churches have instituted fitness ministries in an effort to improve the health of the congregation. Since COVID-19, some churches have been managing the pandemic using this outreach ministry centered around health and provide opportunities to continue.

Um, we have uh a exercise program at our church uh that we do on Sundays. And even with the pandemic now, um, we still have that where you can tune into YouTube or Zoom, or however um to have that done. (Miriam)

Other than church activities, many women found additional places and sites to exercise.

A married woman, Asenath described,

Walking has become a pleasant activity. Um, bike riding but COVID - this whole pandemic has got me looking at opportunities that I hadn't really looked at before. I normally went to the gym.

Not only were physical activity and diet a behavioral and lifestyle approach to maintaining health, the integration of spiritual beliefs and self-care were also ways to achieve health. Moreover, incorporating a comprehensive approach to health and seeking out additional supports to maintain wellness are vital in response to staying healthy.

I think definitely, uh, taking care of my body, um, taking care of my mind as well. Um, I think exercise is important. I think eating right is important. I think also um as far as the mental health um definitely having something to anchor me. As far as uh—um spiritually, um having something to trust in besides myself. (Esther)

You can stay healthy by taking care of your body, um, your mind, your soul, as well as your spirit. Um, and if you do have um, high blood pressure um and problems with breast cancer, there are ways and people where you can seek out for help. You know there's the doctor, uh, and also by talking with other African American women. (Miriam)

### ***Barriers to Staying Healthy***

As stated above, COVID-19 was not a barrier towards engaging in physical activity, and many women found various types of physical activity fulfilling. However, two women expressed personal barriers from either engaging in physical activity or participating in other types of aerobic exercise.

A divorced mother stated, So, I mean - I would love to swim, but the barrier to that is my hair. You know African Americans try to find that perfect swimming cap so not to get our hair wet. I would love to do that every day. (Bernice)

A married mother of three said,

I mean, I enjoy going to the gym, but and um, there's no barriers other than myself just being lazy that's stopping me from going. Because I can go, I can physically go, and it's just me, mind over matter. Just make myself get up and go. That's the only barrier is myself. ... Um, I guess it's motivation um, to get up and go. I work sometimes 12 hours so I'm extremely tired when I get home. So, by the time I get home and get unwind, I don't get off the couch to go; it's just laziness, I guess. So, I could be walking and go before I even get home. But I used to do that, but then I stopped. And I could walk at work on my lunch break, but like I said, mind over matter. I choose not to over getting up and just doing it. (Mary)

Many African American women are faced with many obstacles. But yet, they find ways of staying healthy. Many of their newer adoptive approaches to staying healthy were cost-effective, safe, and managed very well in this pandemic. Specific stressors that life and its daily challenges that are present in the lives of African American women call for ways to manage stress and the stressors. The protective factor that was commonly displayed among many of the participants was church attendance. The integration of the spiritual health component and the mental health component was described as effective ways of staying healthy.

### **Contextual Area: Breast Health: Breast Self-Exams and Mammography**

Another area under the context—where a theme coalesced—was the “*mammogram experience*.” This discussion by the women continued from the previous theme of “staying healthy” but was more specific to breast health. In addition, maintaining a healthy lifestyle and staying healthy also involve participation in regular patterns of breast self-awareness and mammography screenings. Breast self-examination is an approach to finding suspicious tumors within the breast early on. Similarly, “breast

awareness” is another approach to identifying and reporting immediate changes within the breast to a healthcare provider—which can be achieved by visually inspecting and palpating the breast (ACS, 2019c). Furthermore, breast self-exams encourage women to be active advocates in their breast healthcare. Mammography and participation in the screening procedure are effective in detecting abnormalities within the breast. These health behaviors were identified as important steps in finding breast abnormalities and a prominent way of staying healthy among participants within this study. As such, other approaches to “staying healthy” mentioned by a few of the participants were performing breast self-exams, in addition to scheduling and receiving routine mammography screenings.

### **Breast Self-Exams**

While breast self-exams have become routinely less recognized, few participants still incorporate this tactile technique as their method of choice to identify changes within the breast. Women reported that breasts should be examined “once a month” and could be performed in the “shower.” Candace stated that if “they do feel any type of lumps or whatever they should then contact your doctor to - doctor who would then determine if they need a mammogram.” In one case, while a lump was found, prompt medical attention did not occur.

When my sister-in-law found out she had cancer, it was a huge blow on our family because, number one, she looked normal. And it was her husband that found it first. Ah, he felt a lump on her breast and, actually, it was a year before she actually had it checked out. (Esther)



Unfortunately, it is not uncommon for African Americans to delay or forego mammography screenings because of many barriers (Chowdhury et al., 2016; Wells et al., 2017) regardless of access (Nonzee et al., 2015). As research regarding screening mammograms among African American women continues to expand in the body of literature, more insights are needed to provide a deeper understanding of screening decisions among this population of women. The mammogram experience may be an aspect worth exploring.

### **Theme: The Mammogram Experience**

The first mammogram experience, the friendliness of the mammography facility staff, a woman's discomfort level, or comfort level could become a facilitator or barrier towards the uptake of screening mammography. A single woman stated her first mammography experience "was not that good because I had to get up on my tippy toes; also, the machine was hurting me, and she was like um you'll get over it." (Priscilla) Miriam expressed, "Well, the first time I had one, it was kind of frightening because I didn't know what to expect. But after the first um time, they just became normal and regular, you know, I wasn't afraid to get them at all or anything."

Another major concern is the discomfort of the mammogram. Some participants expressed that their mammogram "was easy; it didn't hurt" or "it wasn't something that was painful or something that made me feel like I never wanna have that done again." In contrast, other women described that it was the "mashing down on the breasts" or "the squeezing is what hurts." This painful experience could be a barrier towards participation (Alexandraki & Mooradian, 2010; Highfield et al., 2014).

The comfort level within the mammography facility was not viewed as a barrier among women within this study; however, embarrassment is recognized as a barrier (Nonzee et al., 2015). The screening mammogram procedure requires women to expose their breasts—one at a time—which allows the technician to take x-rays of the breasts. However, such procedures make some women feel “vulnerable,” “embarrassed,” and uncomfortable because of the physical touching of one’s breast.

Esther, who receives yearly mammograms, described her feelings towards the mammogram procedure and the vulnerability that screening mammograms causes.

I think that also, the area of where you can feel a bit vulnerable because you have somebody, uh another doctor, woman, or man you know positioning your breast and having you hold your arms in a certain way. It makes you feel vulnerable, and it makes you feel like uh there is no privacy. (laughs) Uh, that’s what I found from the mammogram. But to me, that’s what I found necessary.

Mary, who has a family history of breast cancer and who also receives yearly mammograms, talked about how screening mammograms can make a woman feel uncomfortable. She describes her experience as:

Um, I guess even though all women have the same thing, it’s still kind of intimidating and kind of embarrassing to go in there and have to put your breast in the machine and then another female touching you like that. It can get a little weird feeling, but you know, I guess it’s just in my mind.

### **Mammography Screening Facilities**

Mammography screening facilities should be certified in addition to meeting quality standards respective to facility personnel, equipment, and patients. It is expected that mammography continuation could be based on a woman’s overall healthcare

experience within the mammography screening facility. On this point, all participants expressed that their mammography screening site was welcoming and the location was easy to get to. They discussed their perspectives and experiences across the different mammography screening facilities.

One woman talked about the patient-staff interaction and relationship:

When you do go for a mammogram, they treat you just like you're a prince - a princess. Because that's - it's just a warm atmosphere. And that if you are nervous, you know by the time you get in there, all your nerves are gone. They make you feel very - very comfortable. (Sarah)

Miriam and Asenath spoke about the mammography facility's location and the complementary items that are provided:

I like where I go better now. I was going to Hospital X, but actually, one of my girlfriends told me about the imaging center, where you get in and get out. You can park. You don't have to worry about paying and walking through the long hospital and so I'm glad she did because I prefer this place better. You know. I look forward to it, you know. You have magazines, you have coffee, you ... The place is clean and all, and so we have no problems. (Miriam)

The location I went to went out of their way to make it an inviting, very, very um warming. There are roses, and [they] gave you a rose when you left. (Asenath)

Eve talked about the diversity of women:

I liked the environment because it was a mixed group of women, mixed ages, a very diverse group. Um, and I laugh when I go, because um, you know, most of the ladies are over 40 or so, and I always get a kick out of how all of us seem like we're all dressed alike, even though we're from different ethnicities, different age groups. Seems like there's just a look that women over 40 look like, but um, that's just - I've had a good experience where I get my mammogram at.

Indeed, breast self-exams and routine screening mammograms are important health promotion measures for many of the participants. Choosing to act upon abnormal findings within the breast or choosing to follow the provider's mammography screening recommendations are driven by many issues. Accessibility to healthcare services plays an integral part. However, the overall mammography experience may be a facilitator or a barrier towards obtaining a mammogram. Essentially, making informed choices and being proactive in one's health is complex, which makes it even more challenging and necessary to explore factors that compromise the health of the African American woman. Breast cancer can be terminal, but it does not have to be. Therefore, understanding influences for mammography participation becomes even more vital.

#### **Contextual Area: The Influences on Family, Beliefs, and Access on Routine Mammography**

This overall contextual area is where two themes coalesced and had commonalities. These themes were "*why mammograms are important*" and "*accessing healthcare*." Women noted that breast-self exams could be an important part of staying healthy. However, in the absence of self-breast examinations, mammograms were seen as important. Women recognized that screening mammograms are important for prevention and were aware of how often they should be done. Women also acknowledged family history as a motivator in addition to the prodding of healthcare providers. Participants acknowledge the fears women can have, but that was something all women needed to do, even if afraid.

### **Theme: Why Mammograms are Important**

You need to be able to do that, so everyone can know what is going on with their bodies, so instead of being afraid. (Priscilla)

I think uh they are preventive measures to um signal women if there are any uh, any breast cancer going on in the body, and um, I think we should take advantage of it. Um, I never understood why we were afraid of getting mammograms. (Miriam)

A crucial component in screening mammography is to identify confronting issues and attitudes that may cause nonparticipation in regular screenings. Indeed, early detection helps to find cancer in its early stages; however, women must first present to screen—to rule out malignancies. All women responded to the importance of obtaining a screening mammogram even though a few of the women were late to care. Approximately 60% of women reported having a mammogram within the past year, thus confirming their regularity in screenings. A single woman explained,

Um, I'm very diligent about taking - about having my mammogram. It's something that's, you know, being instilled in me early on. And I try or I do. I do make sure that I do get my mammogram every year. It's just like clockwork. (Rachel)

Another single woman expressed her decision to obtain a screening mammogram and how often she receives them: "I believe in mammograms, so I get one every year" (Elizabeth). Study participants also shared how they make decisions to obtain a mammogram. Individual decisions were based on having a personal connection through the understanding of having a family history, risk of illness, or knowing a family member or friend with breast cancer.

## Family History

Few participants described why having a family history had an impact on their decision to screen:

A divorced woman shared ... My sister, who didn't see a doctor for 31 years, and by the time she went, she was in stage um 3 of breast Ca - No, stage 4 of breast cancer. ... I've actually been getting mammograms since um, the 20s. Since I was in my 20s - mid-20ssince there is a family history. Both of my sisters were diagnosed at the same time. One is in remission and the other one passed away. My mom [also] died of breast cancer. (Bernice)

A married woman pointed out; I'm all for it. I have a history, um family history of breast cancer. So, I've been uh, having mammograms since I turned 35. My sister had breast cancer, and she had a mastectomy done, and my mom passed away from um breast cancer. (Mary)

Ruth, a married participant, reflected on her decision to be screened, which also included an interaction with a healthcare provider:

I was at um Dr. L's office and I told you my sister had it [breast cancer], my uh aunt had it [breast cancer] and every thang, and um so I was cleaning her office and she asked me, "have I ever had one [a mammogram]," and I asked about it and stuff and um so she asked me did I - would I like to have one [and], so I told her, "yeah."

Ruth also shared a specific conversation she had with her, which sister creates a pause as to why early detection is important:

Yeah, um, my sister had cancer. First, she had um, let me see, ... she had cancer breast cancer, then it went to her lungs, and then you know it started spreading and stuff. And I had asked her, I said um ... "had you had your mammogram and stuff?" And she said, "No." And I said, "Um I don't understand why you didn't do it while you was real young, you know, and stuff." But she said she just didn't never do it. And every since then, you know, when I found out she had cancer and

stuff, and my aunt and them had cancer and stuff, that's where ... to let me know that I need to go and have myself checked out, you know. ...

She asked me, "How long has it been since I had a mammogram?" I told her, I said, "it's about, I gets mine every year. I don't miss no year. I gets mine every year." And so, she said, "Oh," she said, "I wish I would of did that." She said, "but it's too late for me now."

### **Family Member or Friend**

Not only is family history a deciding factor, knowing a family member or friend who battled breast cancer would cause some women to screen:

Because I've had the experience of seeing it firsthand with my sister-in-law first and then with my very best friend, that definitely made me haste, you know, put some haste about getting checked. I felt like, um before that, it was about the age thing; after a certain age, I definitely needed to have that done. But watching them and them being so young, in my opinion, definitely put a fire under me to have the mammograms done. (Esther)

Other factors that prompted women to have mammograms was because of working at a "post-mastectomy boutique," "being influenced most by uh my own mother," or "because it was just part of a wellness physical." The increasing issues of socioeconomic disparities and social determinants of health also need to be fully addressed so that access and equity can be experienced by marginalized populations. In this instance, it then becomes pivotal to understand screening delays and barriers to care among African American women in order to reduce, if not, eliminate breast cancer disparities.

## Screening Delays

The majority of participants reported having some type of healthcare coverage, so access was not an issue for study participants. Although many women were aware and knowledgeable about the importance of yearly mammograms. Screening delays cannot go unnoticed.

Many African American women have to balance their everyday responsibilities and sometimes fail to balance their schedules due to competing obligations. Sarah, who usually screens once a year, explains why she has not received her screening mammogram for this year.

I haven't had one this month, but I plan on having one because uh I - I get one every October. ... I've um, I've been taking my daughter to work, and I just told her last night. I said I've got to schedule my mammogram, and I haven't done so because I don't have your schedule in my phone. So, I was telling her last night that. It's something that I got to do for myself. I said, even if you have to catch an uber, you need to let me know your schedule so I can take care of my business.

While having access along with the knowledge and understanding about the importance of screening mammograms does not necessarily mean mammography participation.

Asenath explains that other health issues may take priority and therefore, mammography screenings may be a low priority. She states,

Um, just didn't put it - just didn't put it in my to-do list. Um I know uh like, when I went to my check-up, yesterday, actually, was my check-up, and she mentioned it. Um, and she actually wrote it in my um report, "due for mammogram, need that." That's - that's part of my, you know, physical exam result information. Um, but it really - have to, you know, really have it on my calendar, and have it - that sort of thought to make that appointment. Uh, I'm more likely to do an OB/GYN appointment than I am to do a mammogram. It's not something that is front of mind for me.



### **Theme: Accessing Healthcare**

The costs of healthcare are rising, and many Americans cannot afford the costs of insurance, which, in turn, lead many Americans; more specifically, African Americans. As such, healthcare may be delayed because of their inability to pay for healthcare services. Accessing healthcare is driven by many factors such as personal, structural, and systemic barriers. These multiple layers impact survivorship and quality of life in the lives of many African American women. Few participants shared other elements that impact access to care among African American women.

Deborah said,

We know that there is a larger percentage of lower income black females. And with that comes inherited problems. Access to insurance, access to Medicaid, um, which gives them access to healthcare. Some of it is cultural, and it depends on how that female was raised, her family structure, education level, um, all those things play a role.

Elizabeth shared the factors that are associated with not only access but also conditions that place African American women at higher odds of having higher deaths and diseases as compared to other women. She explained,

Accessing healthcare services is so much driven by economics, having a job, having insurance, having transportation, having services located in your community. There are so many things that impact that. So, um, these things will weigh heavily on how a woman will respond in the community.

Eve shared a different perspective on accessing healthcare. She suggests the differences in factors that influence health disparities:

African American women uh access to services is varied, um and sometimes, even though you have access, you don't necessarily have equity. So, it's not always about having access, as it is the kind of access and the treatment you get from that access. It's a difference between somebody helping you because you have an appointment to being somebody treating you as a person when you have an appointment. It's two different things.

Eve raised another concern:

I - I think uh access to insurance, contrary to what we hear in the media—I think most women who work keep some type of health insurance. Um, I know that health insurance is very expensive ... where we're in our community, we have lower-paying jobs, and we have to get subpar insurance or less insurance. Because we can't afford it, and I think oftentimes, when it's a choice between feeding family or keeping a high-priced insurance, of course, we have to do what we got to do. So, a lot of times, we are under-insured, or less-insured um than others, or we don't want the insurance because we don't trust the system anyway. So, we avoid appointments and seeking medical care altogether. Um, I think we're getting better about it now as a community, but I think we still avoid care and health insurance simply because of the treatment we get when we go to the offices.

Because health disparities are prominent in African American communities, addressing factors that influence such disparities will be major steps towards improving health outcomes in this population. Deborah provided suggestions on how to improve access and health:

But there has to be removed discrimination in healthcare when it comes to Afro Americans that need care. Um, doctors, nurses, different people that's in healthcare and how they perceive people when they're treating them. Um, their understanding of the cultural differences. And how they speak to and how they even diagnose and treat. I think a lot of Afro Americans are ignored when they have a complaint. ... The healthcare system has got to make a concerted effort to be culturally aware to organize their treatment and their services to be more sensitive to the needs of the Afro American community.

## Screening Barriers

Unequal treatment in terms of goods and services creates issues of poorer health among African American women. Social determinants of health in African American communities are more likely to create disparities in survival outcomes. Neighborhood characteristics, income, structural barriers, and personal barriers also play a role in mammography participation.

Priscilla explains the likelihood of mammography participation when women are faced with barriers:

What I think is that anything that we get. that they are giving us, we need to be proud to take it and not be too proud not to take it. Because it's a lot of women that needs to get to a doctor, but they won't go because they don't have the money or they just being stubborn, you know, they won't go. They may not have transportation, or they don't have the clothes or other means, or they don't have no one to watch their kids. With this COVID-19, you can't take the kids with you.

Fear of the unknown may discourage participation in breast cancer prevention screenings and programs. In this study, participants did not express a personal fear of receiving mammograms. However, few participants gave other accounts of events that may hinder or limit access to healthcare:

There's people that I know that are scared to do it, and I tell them, don't be scared, just go ahead ... and do it. (Priscilla)

Priscilla also stated,

Women may be scared because they hear such statistic when it comes to Black women, they try to stereotype us that we are not healthy, and we don't take care of our bodies.

Bernice explained,

Uh, we as African Americans, we have a thing about —some of us—about going to doctors. So, some of us feel that going to a doctor, they don't want to hear—they're scared they're gonna hear something bad.

Lack of awareness regarding resources and screening programs within the community that is aimed to improve access may be a barrier. Esther and Mary drew their conclusions,

Um, I don't think we have in my perspective; I don't think I've had a problem accessing uh healthcare services. I think that we have access to it, um, we just don't sometimes look for it ourself. I do think that there are programs out there that help us to um have those resources that we need. However, I don't think we always know where to look. I think we always have to look, but I don't think we always know where to look. But I do think that it's provided to us. As minorities, as a whole, I think it's provided. I don't think it's always great healthcare, but I think that we do have access to it. (Esther)

Is it hard to access? I don't think it is if you have information. The information is there. The services is there. It's just the matter of the African American community of getting that information and actually going, getting there. There's different resources out there that people don't know about. (Mary)

Having personal knowledge of a family member or friend with breast cancer or having a family history may be deciding factors for many African American women, but not for all. Even past employment, family influences, or just because it is part of a physical, may also be encouraging for some African American women to obtain a screening mammography. It cannot be emphasized enough that African American women experience many barriers to care and must be addressed in order for racial disparities to be nonexistent. Because fear impacts mammography screening decisions (Corrarino,

2015; Nonzee et al., 2015), utilizing patient navigation to increase timely access to routine mammography screenings may be warranted (Riley & Riley, 2016). Another approach to reducing breast cancer disparities and improving outcomes is increasing education and awareness through mass media.

Health information is delivered in various formats and platforms. Accessing health information is important because it can help individuals to understand medical information, in addition to keeping abreast of current information and cutting-edge interventions. However, the information received should be from credible and trusted sources, in addition to integrative approaches that do not place one race above the other. It is important to consider that the church, the health community, and the media are powerful resources and sources of health information. Nonetheless, their portrayals and communication do influence the initiation or continuance of breast cancer screening practices.

**Contextual Area: Promoting Preventive Care in African American Communities:  
Church, Media, and Healthcare Providers: Supports and Barriers**

**Theme: Mammograms in the African American Community**

The two themes, “*mammograms in the African American community*” and “*promoting mammograms*,” that coalesced under the larger contextual idea was related to the importance of mammograms in the African American communities and why communication is important. The African American community in general has different health outcomes as compared to other populations. When we look at breast cancer disparities in the African American community, we find differences in death rates. Knowing this unfavorable outcome, it seemed salient to inquire what mammograms mean

in the African American community. Several women expressed that mammograms in the African American community mean “survival, “life-saver,” and “less people would die from that particular ailment and also a healthier community.” Equally important and central in the lives of African Americans is the African American church.

### *African American Church*

One of the important aspects of life in the African American community is the church. The church has the capacity and the capability to reach a multitude of people, especially, the African American woman. The cohesiveness among this group is that they attended church regularly (46.7% more than once per week; 33.3% weekly). Many described what mammograms mean in the African American church. Hannah commented, “It means a healthy - a healthier um membership for the female members of the church.” Elizabeth responded in a different way:

Since the African American church still has a strong voice in the community, it’s important that the church promote mammograms within the congregation. For both, well, for women in particular, but in our congregation, I do know of a male who has had breast cancer.

Eve provided a different perspective of why many African American churches may not communicate mammography screenings. She explained:

Uh, I still think uh having mammograms and talking about things of that sort in the African American community is—particularly in church—is still a little taboo. I think uh, it’s coming to the point where churches are getting a little more progressive now talking about it. But not as much as I think um, they need to.

With the changing landscape of church culture, Eve was asked to explain more about taboo,

Um, I think because breast cancer's dealing with the breasts, and it's a body part, um, the church tends to sexualize it, um rather than just realizing that it's a disease that can affect your body.

### ***Activities in the African American Church***

Because many African American women attend church, then the church may be looked upon as a faith based—a religious organization that provides not only spiritual health and wellness, but also an important resource that communicates health information (i.e., mammograms) to improve the lives of women congregants. When asked participants how often mammograms are communicated within the church, several participants stated in their particular churches it may be “once a year,” “only the month of October is stressed about it,” or “we have a Sunday where everybody wear pink. Even the men wear a pink tie or pink shirt or something to remind um the members to participate in having a mammogram.” Further, of fundamental interest is the role and the influence of the pastor.

### ***Pastor Communication***

Few study participants discussed how often their pastors communicate mammograms. One participant stated that her pastor usually communicates the importance of mammograms, “once a year, when it's breast cancer month,” and another congregant expressed that her pastor “announce uh from the pulpit um reminding people to get a mammogram.” This is also communicated during the month of October.

Pastors who have a personal connection with someone with breast cancer may be more inclined to talk about it. Miriam discusses her pastors' connection,

He always mentioned the fact that his mother is a survivor and she's always present whenever she can be.

It is important to note that some participants reported that their pastor does not communicate mammograms within their congregations. Considerable attention must be paid to the fact that the majority of the study participant's pastors were male. As such, "*who*" to communicate and promote the importance mammograms within faith-based must be addressed.

Ruth, a married woman, reported a gender preference for promoting mammograms:

Because I don't know, I guess I - I feel like when a man be talking about stuff like that, I feel uncomfortable and stuff. But with a woman, I know she got the same thang I have. I'm kind of all right with that and stuff. But when a man be talking about it, I feel kind of uncomfortable.

Not surprisingly, some married pastors do allow their wives to speak about mammograms. Miriam and Mary spoke about how their first lady addresses women's health issues specific to breast cancer screenings within their respective congregations.

Um, our first lady will-you know talk that - comment about October, where it will be put in our bulletin that you know October is the month for uh uh breast cancer awareness and what all we will be doing. We will be bringing in speakers, uh we'll be having ladies to testify, we-we-we dress up in our pink, uh um basically that's what we do. (Miriam)



Even if he doesn't speak um, his wife, the first lady of the church. She um, would come up and - and speak and encourage women to do that. Um, get their get their mammograms done. (Mary)

Because promoting mammography screening in some African American churches is little or no priority, then the health of women congregants may be in jeopardy if she is depending upon the church and her pastor to deliver not only the "Word" but also biblical principles and practical ways of improving her health and the communities in which they live and serve. Therefore, future resources aimed to improve the health of African American women and eliminate breast cancer disparities would need to involve positive strategies that encourage mammography participation. The promotion of preventative health screenings should become a priority.

**Theme: Promoting Mammograms**

Educating the public about screening mammograms can come through different sources such as television, radio, newspapers, magazines, social media, and other platforms. These specific interventions can be instrumental in the facilitation of screening mammograms. Such communication may come from the media and the health community.

***Media***

The media has various forms of communication outlets to deliver information to the public. Conflicting perspectives among the participants about the visibility and effectiveness that the media has been in promoting mammography screenings in the African American community were mixed. Ideas and thoughts are described by the participants:

Um, I really don't - I don't see where it's; the average one that I have seen has not been directed towards just Afro - Afro American women. It's basically women overall. I don't think that it's - they have targeted black women in some ads that I've seen. (Rachel)

Nowadays, you have access to TVs, radios, um you have the little the um health truck that comes around now to do those. Uh, most of them are done free, even if you don't have insurance now. Um, you have the Y that offers that. You even have your own church now that have so many health workers in the church now to make sure that women uh are getting that screening. So, really it isn't - not an excuse for someone to say, "Well, you know, I don't know about it. I haven't heard about it" because uh any given neighborhood now uh libraries, you know they're offering this. So, it's no excuse why we aren't getting one. If you're just doing a wellness every - every year. Uh, there again, that should be one of those things that [are] included in your health [and] wellness. (Miriam)

### ***Media Barriers***

The images and communication regarding mammography screenings that are seen in the media do not target a specific race—even though African American women have higher mortality rates as compared to White women. Elizabeth explained,

As far as media advertising and that sort of thing, I don't see any of that targeting specifically African American women. There's a limited amount targeting women in general, but I do not see in visual media, or on the internet, or other places where African American women are being targeted specifically.

Asenath felt strongly about the current communication that is centered around mammography.

Uh, I think they do a good job for the general population, just in general. The conversation around breast cancer and mammography, not necessarily targeted to African American women but targeted to, you know, readers anyone who wants this information. Um, so I would say in general, yes. Uh, I'm not sure how people get their information. Some people, you know, only go to ethnic resources, and I don't know if a lot of the African American resources are going to have

information. But I think; generally, there's a lot of information on breast cancer and mammography, having it done.

The frequency of the media promoting mammograms to the public was brought forward by Bernice:

Um, the commercials that you see on the news today ... primarily what you see if its there's - if its breast cancer month or breast cancer week. Okay and then there's - there's a lot. But after that, you don't see a lot of advertisement, you don't see a lot of flyers coming in the mail. There's, I don't think there is enough communication that um mammography's are should be done - conducted on women. There's not a lot of advertisement at all. So, in other words, you see more commercials on um, how I want to say it, erectile dysfunction than you do on breast ca - on mammography's.

Mary provided a context that was centered on the frequency of the media educating the public about mammograms. She also indicates how much the health community is involved:

Uh no, I don't. Uh, really, they only talk about it during breast cancer month. Other than that, you really don't even hear about it unless you go to the doctor. You know you see the posters, but as far as them advertising it, um, you don't hear anything about it until breast cancer month. And the rest of the month, they don't talk about it.

### ***Health Community***

The health community, more specifically, the medical community, has a footprint in the community. The relevance and visibility in the community have brought direct attention to their contributions of meeting the needs of the individual and community through outreach and patient-centered care. In terms of whether or not the health

community is doing a good job in promoting mammograms in the African American communities, participant responses were also mixed.

They could do a little better. Uh, with you know like going door to door telling the importance of getting checked for the mammogram. (Priscilla)

Um, there again, you even have um-um sororities that um have um health fairs and things of that nature. So, I really don't think it's an excuse for African American women not to have a mammography because somewhere—someone, you know somebody is getting one, and its free. It used to be you didn't have insurance, you know. You had to have insurance to have mammography's. Now, it's free. (Miriam)

### ***Health Community Barriers***

The health community plays a critical part in ensuring the health of individuals, families, and communities by providing awareness on health promotion and disease prevention programs to maintain and sustain health. However, threats to the health of African American women can be seen through the multiple disparities across racial lines.

Deborah described that the health community has opportunities to grow:

I think that there is room for improvements. But I think that about all the diagnoses that generally affect Afro American women. I just think there needs to be improvements from the healthcare, uh, perspective. It needs to be more targeted.

Deborah further explained,

Well, I see it as this way, we're looking at social determinants of health. We're looking at preventative care. I don't ... there's not enough directed specifically to Afro Americans or Black females, and there probably or there should. And when I say that, like mammography, the ... that one is to have mammograms. But there's not a lot of education specifically directed towards Afro American females. So that's basically what I'm saying. But I'm looking at when it comes to

hypertension or diabetes or kidney disease plus some of these other things, so there needs to be more education directed towards the Afro American female.

Eve, a married woman, shared her perspective on the health community and their promotion of mammography in the African American communities:

I - I don't feel like they put enough emphasis on the fact that we are really, really high-risk. I think most of the glimpses that I see is just women in general, but I - I don't know that I've seen a lot of advertising specifically geared towards African American women.

Many women talked about what is lacking in the health community and what needed to be added by the health community to increase awareness, promote cultural awareness, and possibly increase mammography participation. Bernice suggested,

[I] recommend something as small as uh billboards um comer—adding more commercials, um flyers to get the point out. People still do get excuse my air quote (junk mail), have it being distributed in people's mailboxes. Um, people are still getting robocalls so as far as, it's the things like that, or our emails, um when they go to the doctors, um that's another way, cause that is - it's also not um, how I want to say, we're also not informed as much in the doctor's office, you don't even see when you go to the doctor's office when you're sitting into your - into the waiting room, exam room, you don't see a lot of posting or posters.

When asked if she does see any posters in the healthcare provider's office what they look like, Bernice replied, "They're um, White Americans." And [it] makes me feel like we're exiled. Feels—yeah, we're here, but we're not here." Deborah discussed changes that are needed in medical school, nursing school, and across the healthcare system:

Well, it has to be done to – how doctors are taught in medical school, how nurses are taught in nursing school. It also goes to the large healthcare system, the hospital system, uh it goes to; I hate to use the word, but it does go to sensitivity

training. Uh, you have to understand the people that's walking through the door. You have to understand that you may deliver information one way to a certain ethnic group, but you have to deliver that same information differently to another group.

Clearly, the United States is home to millions of people who are of different cultures, races, and ethnic groups. Therefore, healthcare providers cannot provide care that uni-cultural in this multicultural society we live in today. Provider attitudes and bias in the healthcare setting may cause individuals not to seek healthcare services, which in turn, lead to disparities in health.

Deborah echoed this concern:

You can look at that while looking at immigrants from different countries, of different cultures ... different religions. You also look at that when you look at a minority population, such as Afro American. Um, on top of that, it's really when training doctors and nurses in how to do that in that bedside manner and it also should be taught for them to take the time to listen to people instead of talking at people.

### ***Pastor Influence***

There are many ways to disseminate breast health information to the public. The African American church and the African American pastor are important in the lives of many African American women. Pastors are highly regarded, and their influence among their congregants is highly favorable. In response to pastors influence on participants mammography screening decisions and women in general, below is what some women reported:

It would influence me to get one. (Priscilla)

There's a close connection to the pastor. Pastors are more looked at um, I want to say, like a father figure. But a closer figure to God. And I think that they're respectful, and I do believe that if they said the pastor said to do this, then it must be okay. Because he's a man of the cloth. (Bernice)

Well, I suppose because he does say something from the pulpit, or she, if there's a female pastor at the church. Um, since um, the black community, especially black women, are so in line with um church recommendation and church activities, I'm sure that that is a positive influence for people to participate in getting a mammogram. (Hannah)

Mary discussed how collaboration between the faith based and health community could increase the visibility of the medical community as well as increase congregant's knowledge about mammograms.

That's another good way that you could say how the health community - community can better um get the word out is through the church. Maybe they can put pamphlets in the church for um people to pick up or have some type of um event at the church to get the word out.

### ***Barriers with Pastor Communication***

Pastors are respectful and are influential leaders in the African American church. However, in certain congregations, pastors may not communicate mammograms for various reasons. For example, not "being a part of the church mission" or simply being only concerned with their congregant's "spiritual health." Bernice, Naomi, and Candace gave their perspectives as to why some pastors do not communicate mammograms. Bernice stated,

They're not. Um, the educating part and their uncomfortable. Being uncomfortable about it.

Candace provided a brief synopsis as to why her pastor did not communicate mammography screenings within their congregation.

Cause probably none of the women ever approached [him] to suggest that he talk about that.

Naomi shed light on the fact that early detection and prevention measures was not a topic of discussion within her ministry.

I would think, at my church um, if he didn't discuss it, it probably wasn't a big issue for a lot of the members within the church. Or he wasn't; he didn't have anybody in his family or anyone close to him that was experiencing that, I don't think. That's my opinion.

The efficiency and the effectiveness of promoting of mammograms in the African American community using the media, the health community, and the pastors are essential in helping to promote participation in mammography screenings. These conduits can be beneficial and successful in many ways; however, their outreach in targeting specifically African American women have been limited. It is clear that the media, the health community, and the pastors can have a profound effect on the health of women. The dissemination of health information, specifically screening mammograms and programs aimed to improve access by reducing associated costs, is needed. Launching awareness campaigns and educating the public on early detection and prevention is necessary; however, targeted messages that reinforce the importance of mammography screenings are vital to the African American woman and her community. Coordinated efforts to provide a comprehensive approach in the care of the African American woman



and her life experiences require a greater understanding of what it is like being an African American woman.

### **Theme: Being an African American Woman**

In order to fully understand the challenges and the full existence and presence of African American women in today's society, participants in their collective voices, provided personal testimonies and perspectives of the challenges of being an African American woman. Participants stated that being an African American woman is "the most beautiful thing in this world." However, being an African American woman can be hard. A few participants reported there were inequalities in "pay" and "job promotions," while other African American women believed that society looked at African American women differently. A few women explained their perspectives:

It's kind of hard. There are certain things that you can do and certain things you can't do. ... The way people look at you. Like their superior. (Priscilla)

So, I would say that's probably been my biggest, you know, question mark as an African American woman, looking at other folks, and how they - they want to define us or discuss our problems without really having walked in our shoes. (Asenath)

Eve provided a comprehensive depiction of being an African American woman. She explicates the hurt and the pain that many African American women may feel working and living in the United States.

That's a [laughter]—it's—it's isolating, but it's—it's isolating. I don't feel like, as a group, we are valued and appreciated as women. Um, it's hard, because I don't feel like our pain, or our experience, or our work is ever validated at any point. So, it's a challenge to be an African American woman, whether it be the workplace, in the hospital, or socially. It's a challenge.

Continuing with the same discussion, Eve further explains how stereotypes produce negative feelings, thus resulting in emotions that are expressed silently by many African American women:

We always hear about our deficiencies, um the negative, uh as far as about health, you know, with our families, society. Everything always comes to us in a negative connotation. Um, like we need, in other words, we get, you know, everything comes at us like we need to teach you how to raise your children. We need to teach you how to have good health. We need to teach you how to make sure you have screenings. Everything comes at us like we have to be taught how to do—we have to teach you how to raise your children, like we don't have—like we don't value our families, or our health, and our society. When asked how that makes her feel? she replied, Well, “Little angry, yeah-little angry.” (Eve)

Two women talked about what is expected from African American women. Bernice stated:

It takes us - it takes us - we constantly have to do more than what is expected to get to where we need to be. So, let's look at, and let's look at um Kamala Harris. Um look where she is now, and she still - still because she has that - she is considered [as] the first um African American or brown-skinned that is going for that position she's still coming—they're still coming at her. It's still not enough. Everything that she's done, it's still - it's still not enough. The society is like, Nah, we just don't - we don't care. One you're a woman—one you're Black, you're just Nah it's just - it's not enough. So, she's, it's like she's always gonna have to defend herself—always. We're always gonna have to defend ourselves. Always have to explain—why.

When asked how it made her feel, Bernice replied,

Um, sometimes it's very frustrating because we're all in the same bucket, and it's just that why does one batch have to fight more so than the other to get to the same batch of cookies.

Esther commented,

I think that it's hard being an African American woman because we have to be the all in all sometimes. We have to be the mom, we have to be uh the wife, or we have to be you know the significant other, and we also have to be the breadwinner sometimes. Sometimes we can get the jobs that our African American men cannot get because of their color. Uh, but we have to be the all in all. And sometimes, we are the spiritual leader in our home. We are the soft place for our children to land. You know we have to be. We're the nurturers. Um, we're the ones to take care of the home. So, it can be difficult.

The African American woman has to sometimes wear many “hats” in her family as she transitions through life. Esther had this to add:

However, I think that we are so strong as women- -as African American women. We are strong because we have to bear so much. I think sometimes we are the stepping stool for our men. We are the ones that when they come home uh after they have been treated badly out in the world, they have to come home, and again, we are that soft landing that they have to have. And so, a lot of times, we're overlooked. And we're underappreciated. But those are the things that have made us strong throughout the years and wouldn't wanna be anything else but an African American woman.

Again, the daily life challenges and struggles place some African American women at the crossroads—the intersection of health and wellness or illness. Participants provided detailed accounts of the juggling act for family, work, and life responsibilities.

Naomi, a single woman stated,

I think being an African American woman is very difficult because we have to be strong and independent, and you know, aware of a lot of things in this world, um, if you don't have a support system, it's just extremely hard. (sniffing)

She further added,

Because you don't, I mean, I just think you don't have a support system, you still have to go through life dealing with everything your children, your job, your finances, and it's still a hard situation for one a black woman. If she doesn't have, you know, have a lot of friends, it could be very hard.

Sarah, a married woman, discussed the reality of being an African American woman raising children:

But then being parents, you know, being mothers, we have a tendency to take care of the whole family. And we put our health on the back burner. But - but we have to, you know, we have to - nurturing the whole family. But we - but we have to nurture ourselves as well. So, we always have a busy schedule but some kind of way, we, we, we, we handle it. We have to do it. It's just - just, I think that's just the way God created the woman - to take care of, you know, to take care of ... and her family. So, we make sure everybody gets their appointment and we just—we're just—we're just—Superwoman. (laughs)

Deborah, another married woman, alluded to the fact that African American women experience many struggles and therefore may lack a higher quality of life, success, or happiness as compared to other women.

Well, it's always been hard. Um, but then again, access to healthcare, poverty, um, discrimination, race disparity, I mean you name it. (chuckles) I think Afro American women have experienced it and continue to experience it to a great extent in just their everyday lives. A lot of single mothers raising children on household income, um, employment. Just about everything.

Persistent implicit bias displayed by providers in healthcare settings has caused many people to delay care. Stereotypes and beliefs about a specific individual, group, or population because of someone's complexion creates health differences between races of

people. In addition, the type of care receive that is based on race, gender, and income—intersectionality—denies a person the opportunity to achieve equitable health and reach “Self-Actualization,” as defined in Maslow’s Hierarchy of Needs. Historically, African Americans have been oppressed, and women are not excluded. Collins (2000) example of “controlling images” helps to elevate the measure in which Black women experience oppression in healthcare.

I was talking to my doctor about having a tubal ligation, and I asked him at my last appointment before I delivered, you know, I wanted to sign the papers to get a tubal. And we were in our appointment and he said, “Oh, I’ll have to check with Medicaid.” Now, I’m an African American woman. He’s a White male, and I said, “I don’t have Medicaid. I have, you know, Blue Cross and Blue Shield. ... It was an assumption from him what kind of service I was going to get, based on my insurance, never listened to me that I wanted to get a tubal. It was more important for me he needed to hear what I was saying and what I need. But he assumed that I had Medicaid. And he put me off and went out the room a couple times and he was treating me like I was a Medicaid recipient, but I have private insurance. He assumed because I was Black, I didn’t have private insurance, and then—so his treatment of me was based on what he thought I wasn’t—what he thought I had—um, but that’s for me. But not - not uncommon in my community (Eve)

Even though race is a social construct, it clearly defines privilege, power, and purpose:

When I was in high school, I’ll never forget, my teacher asked us, “If it was one thing that we wanted to be what would it be?” And one of my classmates said, “She would like to be White.” And the teacher asked her why and she said, “Because White women are the best, they have access to everything, um they get the better jobs, um they get the better things in life.” That’s all. It’s ironic how I still think about that because in some aspects they do, but with Christ in my life, I cannot change all things, and it’s nothing um in my life that I cannot ask HIM and know that I need and that I need and that I cannot obtain. So, I don’t let color ... my color stop me from being who I am. (Miriam)

While many participants described the marginalization of the African American woman, they also expressed moving beyond the stereotypes and injustices—to feeling liberated to discuss who African American women are.

### **Who We Are**

Esther recognized the strengths as well as obstacles impacting African American women. But still, African American women are able to rise and be empowered through each other's strengths.

I think that we are bright, I think that we are colorful, I think that we are intelligent, I think that we are overlooked as well. ... I think that we are so strong as women, as African American women. We are strong because we have to bear so much.

Sarah felt compelled to speak life into her children by creating positive and powerful images that suggest a world of opportunities and success:

My thing is, is that a Black woman can be anything that she wants to be. Because there's enough resources out here, there's enough tools out here that she can be whatever she wants to be. Look at our new Vice President that we have. So, there's nothing out there that can stop us from being number one. Like I told my daughters the weekend, I said, "Look at Michelle Obama. The first African American first lady." I said, "Uh look at Mrs. Harris, the first African American vice president." So, you can be anything that you want to be. Just go for it. The sky's the limit.

A precise message that ultimately creates a climate for change, perseverance, and humanity was shared by Elizabeth stating,

Being an African American woman has - has its experiences that helps you to be strong, that helps you to be resilient, that help you to overcome so that you can exist and have a productive and fulfilling life.

In the fabric of society, African American women have been identified as a culture of women that are not ideally respected, given “labels” which do not define who they are. Participants talked about who depends on them, what is expected of them, and their importance in life. While many participants agreed that their husbands, children, grandchildren, family, and friends depend on them.

### **Who I Am**

Naomi expressed additional supports:

Well, my daughter still lives with me and she - she’s an adult but she still thinks that I’m supposed to take care of her. Um, my - my dog depends on me but that’s all I have. And um - my job, I work at a daycare with children - they depend on me to take care of them and love them while I’m there. That’s it.

Priscilla and Esther discussed their expectations:

It’s expected of me to do everything in my power to push other people and tell them, you know, “Let’s go do this. Let’s go get it.” (Priscilla)

I feel like I am expected to be a provider - number one that’s for my children. I am expected to create an environment that is felt safe and healthy, and happy for them. Um, I think that I am expected on my job to do you know whatever my job requires. And I think that I’m expected to do it to an efficient level, more than an efficient level to just be recognized. You know um, I think that my church life, I am expected to live a clean life that people can see—to be a light, to be a beacon. I’m expected to be that role model, um, that is what I think is expected of myself. (Esther)

Many of the participants talked about their importance as it relates to their families. Other participants expressed having other needs to fulfill in life:

The importance of the church is for everyone um to get along. Cause no one’s perfect, but at least try your best to walk like Jesus. (Bernice)

Um, I feel like my importance is to be a good steward. Um, to be the best person that I can be. To help others the best that I can to my ability. Uh, to be kind um, and just be, you know, a good model citizen. (Rachel)

To be of service. To be a servant to those in need. (Miriam)

It is clear that bias within the healthcare delivery system negatively impacts the health of individuals who are disproportionately disadvantaged because of their race, gender, and income status. The consequence of such expression creates long-term health problems, impacts survivorship, and the inability to fulfill obligations and aspirations as an African American woman.

### **Summary**

Seven key themes have emerged from the data. Additionally, several of the themes were cross-cutting, and as a result, they coalesced around four major contextual areas. The incorporation of diet and physical activity in participant's daily routines were key lifestyle approaches for staying healthy. In addition, the integration of self-care, spiritual health, and breast self-exams were also combined strategies that influenced participants' overall health and wellbeing. Furthermore, it is important to note that COVID-19 was not a barrier towards engaging in physical activity or mammography participation among study participants. While all participants expressed breast cancer knowledge and the importance of mammograms, several women were not current on their screening mammograms, even though many of the women were insured and had access to a conveniently located mammography screening facility. Specific to this group of women, family obligations and mammograms not being a priority were cited barriers towards mammography participation.



An overwhelming majority of participants described the African American community and the church, as playing a significant role in the lives of many African American women. Pastors and their wives were identified as trusted sources to deliver health information. However, in some churches, the pastor does not discuss women's issues or mammograms within their congregations which is an area of concern for few participants. Gender preference was addressed. Furthermore, across the three areas of support for mammograms (i.e., the media, the health community, pastor influence), their promotion of mammograms, visibility, and effectiveness within the African American community are mixed. Few thought they were effective, while others thought they focused on women in general, and therefore, more efforts are needed to target African American women. On this point, when looking through the racial lenses of survivorship, African American women mortality rates suggest a continuing need to explore interventions aimed to improve the health status among this targeted population of women.

A major shifting in the interview process was their overall experience of being an African American and a woman at the same time. The participants shared their everyday experiences using their voices, which helped to crystalize how race and gender impact health outcomes. It was through these women's voices that gave "light" to the darkened issues of conflicts, policies, and injustices that weakens the family structure and community. Essentially, a further examination into the underutilization of mammography screenings and possible solutions to increase adherence is salient. The BFT perspective brought awareness, empathy, understanding, and challenges many African American

women face. A commonality expressed among the participants within this study was oppression; however, many felt empowered and strengthened.

## CHAPTER V

### DISCUSSION

The purpose of this qualitative descriptive study was to provide 15 African American women a voice to describe their experiences in mammography participation or non-participation in mammography services. In this chapter, the research questions are addressed—across themes—that bring to light African American women’s experiences within the context of their everyday life experiences and healthcare utilization, especially mammography screenings.

Black Feminist Thought served as the overarching framework for this study by incorporating the African American woman’s ways of knowing, in addition to her experiences and perspectives of injustices, unfulfilled needs, and other factors that may impact their health. Seven key themes that emerged from the study include *staying healthy, why mammograms are important, the mammogram experience, accessing healthcare, mammograms in the African American community, promoting mammograms, and being an African American woman*. The seven themes coalesced around four contextual areas. The following discussions are based on the research questions and the study’s emerging themes which the women contribute to the understanding of truths and validation by allowing their voices to be heard.

### **What are the African American Women's Views on How Race and Gender Influence the Ways They Take Care of Their Health?**

Across several themes and the larger contextual areas, the perception of one's personal health status may have an impact on healthcare utilization and engaging in healthier lifestyles. Study participants described their perception of their health status and perceptions of their health status in comparison to other people in the same age group. Findings in this study revealed the majority of participants (approximately 85%) rated their individual health status from good to excellent. Similarly, they rated their health to other people in the same age group from good to excellent as well. In contrast, this 85% measurement does not reflect the findings from Brandon and Proctor's (2010) study. In that study, although part of a larger sample involving both races, their results showed 68% of African American women perceived their health to be good to excellent. Nonetheless, a commonality among women in both studies I noted is that diet was a viable way of staying healthy. Physical activity was recognized as another way of staying healthy among this study's participants; however, physical inactivity was more common in Brandon and Proctor's (2010) study. Furthermore, according to the ACS (2021), physical activity decreases the risk of breast cancer; therefore, these results reflect that many women are engaging in activities that could help reduce their chances of being diagnosed with breast cancer.

Many of the women were physically active, despite the closing of exercise facilities due to the COVID-19 pandemic. They reported finding alternative ways of engaging in physical activities and staying healthy, such as Zoom exercise sessions or walking in their neighborhoods. Moreover, because exercise sessions were offered

through the church ministry, these findings widen our knowledge that churches are finding ways to keep their congregants socially engaged, healthy, and whole during this pandemic. Typically, African American women report barriers to physical activity such as lack of available exercise facilities and costs, not having a support person, safety reasons, and family responsibilities (Joseph et al., 2015). However, with regard to these study participants, the above items were not reported barriers. What is consistent throughout the body of literature is the lack of motivation, lack of time, tiredness (Joseph et al., 2015), and haircare (Gaston et al., 2020; Gathers & Mahan, 2014) are barriers to physical activity among African American women. Not surprisingly, hair maintenance and motivation barriers in the previous study mirrored the findings in this study. Gaston et al. (2020) reported that women with chemically relaxed hair were less likely to engage in physical activity versus those with natural hair. Yet still, those with natural hair may not engage in physical activity. Although the issue of hair was not addressed directly in the interview questions, concerns about hair maintenance emerged from one study participant about a barrier to participating in other types of physical activity. Bernice said, “I mean, I would love to swim. But the barrier to that is my hair. You know African Americans try to find that perfect swimming cap, to not to get our hair wet. I would love to do that every day.”

Among the sample of 15 women, diet and exercise were not the only lifestyle approaches that emerged from this particular theme of “Staying Healthy.” The women reported mental health, self-care, routine physicals, and spiritual health to be ideal ways of staying healthy and finding balance. Furthermore, health encompasses not only the

physical but could include mental and spiritual wellness (Stoewen, 2017). Several of the participants noted that staying healthy and keeping a right frame of mind revolved around “having something to anchor me,” “by taking care of your body, um your mind, your soul, as well as your spirit,” having “Christ in their life,” and by talking to “Jesus” about life. These findings show that spirituality and religiosity are crucial components in their everyday life. That said, the majority of participants attended church (46.7 % more than once per week; 33.3% weekly). In fact, because of COVID, several reported attending services more frequently because they are online.

Another important finding that emerged in this study was the performance of breast-self exams to stay healthy. Many participants in this study expressed that the female breasts should be examined “once a month,” and they can be performed in the shower. Another encouraging finding is that Candace noted the importance of breast self-exams and advised that “if they do feel any type of lumps or whatever, they should then contact your doctor to—doctor who would then determine if they need a mammogram.” This is interesting because while many women would seek prompt medical attention for such abnormal findings, many other African American women may present late to care even when an abnormality is found by performing a breast self-exam. Esther stated, “My sister-in-law was diagnosed with breast cancer, and it was her husband that found it—first. He felt a lump on her breast, and actually, it was a year before she actually had it checked out.” Unfortunately, care was delayed, which is consistent with the body of literature suggesting that many African American women have screening delays and barriers to care (Chowdhury et al., 2016; Nonzee et al., 2015;

Wells et al., 2017). Delay in seeking care continues to be an important issue for many African American women.

The issues related to inequities in healthcare utilization, the healthcare experience, healthcare access, and the quality of care and treatment between African American women and White women are clear examples of why breast cancer disparities exist. Many women expressed that “Mammograms in the African American community”—another theme—means, “survival,” “life-saver,” “equitable health,” and “less people would die from that particular ailment and also a healthier community.” While mammograms could be viewed as a way of staying healthy, personal circumstances that are present may cause women to put their health on the “backburner” by “taking care of their family first before taking care of themselves,” as expressed by the study participants. This expands our understanding and consistent with the work of Gross et al. (2018) that African American women respond to the needs of others and, in turn, abandon their personal health and mammography seeking behaviors.

Strong motivational factors that cause women to engage or not engage in health seeking behaviors were reported by several participants. Many study participants agreed that the social determinants of health and social economic status play key roles in “Accessing Healthcare,” which is another emerging theme. Participants identified that “transportation,” “finances,” “childcare,” “job,” “education,” “access to insurance,” “family structure,” “culture,” “medical mistrust,” and “having services location in your community” were many factors that drive access to healthcare services. Many of these perspectives are comparable to numerous empirical studies in which lack of accessibility

to healthcare services impact health outcomes (DeSantis et al., 2016; Gillispie-Bell, 2021; Jemal et al., 2017; Molina et al., 2015; Warnecke et al., 2019). Other influencing factors that may limit African American women from accessing healthcare services are because of having “subpar insurance,” “being stubborn,” “don’t have the clothes,” or because “with this COVID-19, you can’t take the kids with you.” On the other hand, a few participants expressed that African American women could indeed access healthcare services. Hannah stated, “Some people feel like they don’t need to have healthcare services.” Other participants reported that “the government has services,” there’s different resources out there that people don’t know about,” or “we just don’t sometimes look for it ourself.” For example, some women may not feel comfortable using a computer to access information, and they may not have access to a computer or sufficient bandwidth. Moreover, someone may not reach out to find appropriate information about resources and healthcare access. Taken as a whole, two women reported not having problems accessing healthcare services, and many participants within this study had access to healthcare and were insured, which could have caused these mixed perspectives.

Further, there are several layers of healthcare access that need to be further unraveled. As Eve stated, “Sometimes, even though you have access, you don’t necessarily have equity. So, it’s not always about having access, as it is the kind of access and the treatment you get from that access.” This response to health inequity is not unique for the African American community as a whole. Because minorities are more than likely to receive inadequate treatment even after initially accessing healthcare



(LaVeist & Isaac, 2013) or receive care that is based on a woman's skin color or insurance status as described by Eve, then staying healthy or being healthy become nonexistence. This essentially presents a distinct disparity of survivorship and the quality of breast care and breast cancer services between African American women and White women. While many participants confirmed that going to the doctor was a practical way of staying healthy for them, access to healthcare services across the health continuum and the resulting health outcomes remains a prevalent issue within the African American communities (Gillispie-Bell, 2021).

**What do African American Women View as Influences on Their Decisions to Have (Or Not to Have) a Mammogram?**

Specific to African American women, the bridge that could help close the gap in breast cancer disparities is understanding their decisions to have (or not to have) a mammogram. Emerged from this study was the theme: "Why Mammograms are Important." A marked observation from the data is that participants expressed that mammograms are important as "they were a valuable prevention measure," "so everyone can know what is going on with their bodies, instead of being afraid." Women also addressed the timeliness of having a mammogram, more specifically, obtaining yearly mammograms. Many women reported that they were encouraged to obtain a screening mammogram because of provider recommendations, the positive influence of others, or just by making mammography screenings part of their health and wellness visits. Other screening decisions were based on having a personal connection through the understanding of having a personal family history, risk of illness, or knowing a family member or friend diagnosed with breast cancer. What unfolded in this present study and

consistent with the findings of Davis (2020) is that having a family history or friends with breast cancer were deciding factors to have or not to have a mammogram.

Study participants reported having access to a mammography facility, and most of the women had insurance and transportation. For these study participant's access was not an issue. Surprisingly, COVID-19 did not present as a barrier to mammography screenings being that national organizations such as the American Cancer Society were recommending for screenings to be temporarily postponed (ACS, 2021). Further, approximately 60% of participants reported obtaining their annual screening mammograms within the past year. Reported delays in screening mammography were scheduling conflicts and mammography screenings not being a priority, which is consistent throughout the breast cancer literature (Nonzee et al., 2015; Wells et al., 2017). Unfortunately, delays in mammography seeking behaviors could lead to late-stage breast cancer diagnoses, poorer outcomes, and poorer quality of life (DeSantis et al., 2016; Mille et al., 2015). This discussion demonstrates that we need to emphasize more extraordinary efforts in raising awareness and educating African American women about the importance of mammography screenings.

An important and striking theme to emerge from the data was "Promoting Mammograms" in African American communities. The media, health community, and faith-based organizations have a powerful presence in the lives of many African American women. Many women verbalized that the media and the health community public service announcements, if any, occurred once a year. Moreover, this kind of information did not specifically target African American women but women in general,

even though African American women have a higher death rate than White women (ACS, 2019a). In addition, a specific discussion with Bernice highlighted the fact that most mammography information posters seen in providers' offices represented White women as opposed to minority women. When asked how it made her feel, she stated, "Um [it] makes me feel like we're exiled. Feels—yeah, we're here, but we're not here." This suggests a subtle yet, clear message to African American women that marginalized their healthcare concerns. As noted in chapter 2 of this dissertation, Passmore et al. (2017) addressed this mammogram messaging disparity as prevalent in supporting the perception among African American women that White women are the priority population for breast cancer, screening, diagnosis, and treatment. In responding to this problem, researchers Allicock et al. (2013) and Passmore et al. (2017) recommend the development and implementation of more culturally tailored and targeted approaches for reaching out to African American women. Furthermore, communicating breast health information through more traditional modes of public broadcasting tends to be more effective among the general African American population. I. J. Hall et al. (2012) pointed out that the dissemination of breast health information to the broader black audience was particularly effective through radio. Coughlin's (2014) study echoed the inclusion of black radio stations to address and deliver tailored health information (e.g., mammograms), specifically targeting communities of color. Strikingly, Eve pointed out that communication from the media, in general, is a facilitator towards encouraging mammography participation. Further, as will be addressed in the following section, cues

to action that may encourage mammography adherence involve increased awareness in community settings (Ragas et al., 2014).

While participants mentioned the use of “health trucks” and “free screenings,” they did not identify or express knowledge about the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), the function of which to increase timely access to breast and cervical screenings to low-income, uninsured, and underserved women (Lee et al., 2014). This particular gap in conversation could have been because they were insured and had a regular source of healthcare. However, this finding substantiates the need for increased visibility of the program through diverse media outlets. Specifically, by increasing awareness of the NBCCEDP through various modes of media messaging for women who delay care because of associated costs or who need an appointment reminder, may feel more inspired to seek care.

The need for this collaborative approach of faith communities and health communities working together was expressed by many of the participants. An expected finding is that some pastors promoted mammography screenings, while others did not. For pastors or religious leaders who promote screening mammograms to their congregations, women congregants were more likely to obtain a mammogram (Clay et al., 2005; Musa et al., 2009). Their wives played influential roles in promoting mammography participation (Clay et al., 2005). Similarly, some of this study’s participants confirmed that their wives encouraged mammogram screenings and were highly received on this point. An unexpected finding was the issue of gender preference relative to discussions about mammograms in the church setting. Ruth expressed her

preference for a female— “the wife”—because “she has the same thang;” (meaning they share the same female anatomy). It could be assumed that women parishioners had not cared which gender promoted mammography screenings in the church setting, mainly because traditionally more pastors are men (Green, 2003). In addition, to the issue of gender preference, it is concerning if the pastor does not promote mammograms, is not married, is only concerned with the “spiritual health,” and does not allow any health programs within their church, then women may continue to lack the knowledge about early detection and prevention.

### **What are the Perceptions of African American Women’s Experiences with Healthcare Providers and in Mammography Screening Facilities?**

#### **The Mammogram Experience**

In this theme, “The Mammogram Experience,” study participants discussed their personal views and experiences within their specific mammography screening facilities, both past and present. Most women within this study were screened at a close mammography facility that was near their home. In fact, Eve stated her specific mammography screening site was “maybe about 10 miles from my home.” On this point, Celaya et al. (2010) found that longer travel times to mammography facilities could contribute to late-stage diagnosis, while another empirical research study disagreed with that finding (Henry et al., 2011). The connection here lies in the fact that women in this current study reported traveling 20 minutes or less to a conveniently located mammography screening facility by car, which is consistent with the study conducted by (Onega et al., 2014). In addition, the frequency and regularity of screenings among African American women is another factor in addressing breast cancer disparities.

Specific to the participants in the study, at least three women reported not screening for up to four years, while national recommendations promote screenings of one to two years.

Participants in the current study did not express problems with appointment scheduling, inconvenient scheduling, or reports that the facility had rescheduled their appointments due to COVID-19. A participant stated, “I had to cancel my appointment previously because I had gotten sick and I just went up to reschedule my appointment, and the lady asked me if I could have my mammogram then [and] I said yes, and I just went on and did it.” Here, it is important to note that this participant did not state this rescheduling was Pre-COVID or during the pandemic. However, these findings for mammography participation could represent factors such as most participants were retired, their jobs were flexible, or various mammography sites may have incorporated extended hours due to the pandemic. There was no lack of insurance or lack of access issues to mammography screening among most of the study participants. Although Naomi was current on her mammogram, she stated that she needed a mammography referral in order to be seen, or she would not be able to obtain a mammogram because of her inability to pay. This statement further supports the importance of removing financial barriers for mammography. Although long wait times have been reported to be a barrier towards mammography adherence (Ahmed et al., 2012), that was not true for women in this study. This reiteration of barriers and disparities among African American women is intended to ground the third research question on study participant’s actual perceptions and experiences in the area of breast health.

Study participants reported that most of their mammogram experience was primarily positive. Many confirmed that their specific mammography facility had good access and had a warm and inviting atmosphere. For example, one site gave “roses,” while another site made the woman feel like a “princess.” A comment was made about the diversity of the patients, which was found to be positive and affirming. Participants indicated that the staff was knowledgeable, and they were able to ask questions comfortably and received appropriate responses. Eve said, “They were glad that I was asking and willing to provide information. I felt like the questions I had got answered, and they were really direct with me about follow-up and everything.” This comment supports the continuation and continuity of care that should exist within all healthcare systems and organizations if findings suggest that follow-up is necessary.

Although a portion of the women reported that mammograms were “uncomfortable,” “embarrassing,” and they did not like “other people touching their breast,” none of them stated that these experiences were deterrents to their returning for ongoing mammograms. In addition, a feeling of discomfort (i.e., pain) was expressed during the mammogram procedure, but no study participant indicated that pain would stop them from receiving mammograms either. It should be noted an experience of pain could be a barrier to non-participation (Alexandraki & Mooradian, 2020; Highfield et al., 2014). Women did, mention before their appointment or on the day of the procedure, their facility verified their insurance. Overall, within this group of mainly low-income women, very few discussed negative experiences within a mammography screening facility. On this point, two of the participants reported having a negative mammogram

experience. These past experiences consisted of the insensitivity of the staff to validate their pain and not providing an appropriate size gown—to not bringing in the appropriately sized “plates” for the mammographic procedure (e.g., embarrassment). As such, while negative healthcare experiences could have caused these women to avoid screening mammography as documented in the body of literature (Adegboyega et al., 2019), it has not been present for this study.

### **The Healthcare Experience**

Perceived discrimination within the healthcare delivery system can have long-term effects for the African American woman, her family, and community, but more specifically, breast cancer disparities. Several study participants expressed how society views the African American woman in a negative way. These negative perceptions include the notion that “we don’t take care of our bodies” and “they have to be taught how to raise their children, how to have good health, and how to make sure you have screenings.” As described by Collins (2000), these perceptions promote a stereotypical approach that reinforces inferiority and marginalization among African American women. Two study participants specifically expressed concerns about medical racism. Eve expressed that her physician thought she was a Medicaid recipient. As such, she perceived that the type of care she was going to receive would be based on her insurance coverage which is “not uncommon in my community.” This view is supported by the body of literature asserting that race, gender, income, and insurance were factors in determining the level of care and type of service a person will receive (Gillispie-Bell, 2021; W. J. Hall et al., 2015). This perception of a “Medicaid Recipient” could be viewed



as a controlling image similar to that as a “Welfare Queen” described by Collins (2000). Another perceived experience of medical racism was addressed by Pricilla. She concluded that she had seen someone of the opposite race see the eye doctor ahead of her, causing her to have a long wait time before she was seen. The perceptions of bias within the healthcare setting and health systems reinforce the sense of inequality and unfair practices for minority populations and the African American community in particular (Gillispie-Bell, 2021; W. J. Hall et al., 2015). While this study focuses on African American women and the issue of mammography participation and non-participation, the discussion must be expanded to address what it means to be an African American woman in contemporary society—beyond the discussion confined to healthcare. Essentially being an African American woman today implicates issues of inequity across her life experiences, which is represented by participants within this study.

### **Being an African American Woman**

This essence of the women was truly revealed in this theme, “Being an African American woman.” Many participants described being an African American woman “as beautiful,” “a great feeling,” and “it’s something that you don’t really think that’s any different from being any other kind of woman.” At the same time, the question “Is being an African American woman hard?” brought out several emotions and feelings that caused some of these women to pause and reflect on the injustices and discrimination experienced in the lives of African American women. Collins (2000) pointed out that “the identification of race and gender may be analytically distinct, but in Black women’s everyday lives, they work together” (p. 269). A few women expressed that being an

African American woman was “hard.” They described the feeling of being “overlooked,” to feeling as though “there are certain things that you can do and certain things you can’t do” and feeling “like we’re always gonna have to defend ourselves. Always have to explain—why.”

Eve described being an African American woman as hard and isolating, and she “did not feel like, as a group, we are valued and appreciated as women. Esther pointed out that “our children take us for granted. We love, for the most part, really hard, and we give, and we give, we give out, and a lot of times, we don’t receive back. Nobody is putting into us what we give out. I think that we as women support each other, and that is where a lot of our you know, kind of getting back comes from.” Naomi expressed that “if you don’t have a support system, you still have to go through life dealing with everything your children, your job, your finances, and it’s still a hard situation for one—a Black woman. If she doesn’t have, you know, have a lot of friends, it could be very hard.”

Another commonality these women shared was trying to balance and juggle their everyday responsibilities, which is not uncommon in the lives of many African American women. Mary stated, “As they say, we’re the backbone of the family, so we share a lot of burden on us and trying to raise a family, keep everything at home, work, raise the children, keep your spouse happy. It’s a lot – it’s a lot.” Sarah stated, “We’re just—Superwoman.” Black women as superwoman have been addressed in numerous empirical studies that acknowledge the numerous roles and responsibilities that tend to override individual healthcare concerns; thus, validating this connection of the Superwoman

Schema to healthcare issues among African American women (Abrams et al., 2014; Abrams et al., 2016; Woods-Giscombé, 2010).

Another interesting development from this study came from the insights of Elizabeth when she recognized that “society is not always supportive,” thus suggesting “that very fact that we have to have this conversation would show that there is a discrepancy or a disconnect from society in its concern and care for women of color.” Concerns of inequities in “hiring practices,” “healthcare,” “pay,” gender preference, and performance in the workplace were also expressed. Esther expressed gender inequality in pay, even though they are performing the same job. She stated, “It makes me angry.” “It also makes me feel like I have to work so much harder than someone else that’s not an African American woman or not a woman that is a minority. It makes me feel like I have to work hard and then my work never ends.” Further insight was shared by Miriam, who reflected back to her high school experience. She described one of the classmates wanting to be a White woman “because White women are the best, they have access to everything, um they get the better jobs, um they get the better things in life.” This statement and others alike are supported by the work of Collins (1990), making valuable claims of oppression.

Another important feature emerging from the data was “Who we are.” Many participants felt liberated and acknowledged that African American women are “bright and colorful,” “educated,” and “a Black woman can be anything that she wants to be because there’s enough resources out here, there’s enough tools out here that she can be whatever she wants to be. Look at our new Vice President that we have.” “Who I am,”

another observation to emerge from study findings, identified the very nature, the reality, the presence of the African American woman in our society. The church, the family, the home, and the community are ultimately important in the lives of many African American women. Study participants expressed their roles of being a “role model,” “to conduct themselves as a great citizen,” “to be a good steward,” “to be a servant to those in need,” “to mentor,” and “to do everything in my power to push other people and tell them, you know, “Let’s go do this. Let’s go get it.”

Understanding a woman’s experiences gives healthcare providers and other stakeholders opportunities to learn more about the stigma, oppression, and perceived discrimination that are experienced in the everyday lives of the African American woman. Such issues should be identified in an effort to achieve the best outcomes for this population. Furthermore, because of such historical and present factors that influence healthcare decisions and outcomes, increased attention is needed to further explore strategies to improve equitable services. With a greater degree of equity in such areas as timely healthcare access and optimal treatment, opportunities could be realized through a reduction in morbidity and breast cancer mortality rates among African American women. In fact, Deborah asserted that education and training for healthcare providers (i.e., doctors, nurses) and healthcare organizations should address systemic racism so as to improve the policies and practices by addressing racial and ethnic disparities. This statement supports results similar to Metzl and Hansen (2014) and Wells and Gowda (2020) in that structural competency and cultural competency are needed to understand

factors that influence health outcomes, in addition to guidance to improve outcomes as well.

This study unveiled the personal strengths of each African American woman. Many of these women's stories were similar and connected to the variations of experiences that shape health differences. There were multiple layers to their stories, wherein the linkage that impacts African American women's lives through race, gender, and class is oppression. These women stories took us through the matrix domination (i.e., structural, disciplinary, hegemonic, interpersonal) described by Collins (2000)—to experiences that were meaningful and rich. These experiences sharpened our understanding of how these women were resilient in the face of discrimination and were motivated to maintain health and wellbeing; despite the stereotypical ideology, that African American women do not take care of their bodies. These uncompromised women stories added new knowledge to the body of literature that general health and breast health are fundamentally essential and valued. Such perseverance and their ability to adapt and adjust to the changing times permeates an African American woman's way of knowing, which validated substantive knowledge development. The uniqueness of this study has a resounding effect of the lived experiences of each woman. BFT provided an Afrocentric Epistemology way of knowing, and the women validated their positive and complimentary stories related to screening facilities and how they keep themselves healthy even in the pandemic. They know they are strong and resilient, which is the essence of human strength, connection, and will.

Among the study participants, many were deeply rooted and grounded in cultural traditions, to where the “God” or “Jesus” reigned supreme in their lives. Participants found that their strength lies within the family, church, and community. They understood their place in society and identified extraordinary ways to achieve personal health, success, and goals. Even though injustice may continue to exist in the lives of many African American women, through faith, many found inner peace and hope for a better tomorrow may one day be realized. The church and beliefs in a higher power create a sense of calm in a world of chaos directed towards people of color, especially African Americans. Indeed, individuals are responsible for their health; however, that responsibility is also determined by laws and policies that disconnect marginalized populations from obtaining goods and services, which creates differences. Such differences in health outcomes must be manifested in order for everyone, every human, to fully benefit, health equity.

### **Conclusion**

Many of the study’s participants; health behaviors demonstrate awareness of the importance of mammography screenings in addition to maintaining their health and wellbeing through diet, exercise, spiritual health, mindfulness, and other preferences. Participants identified a hierarchy system that makes them feel invisible, silenced, and “overlooked.” These women want their voices to be heard and not from people who “want to define us or discuss our problems [African American women] without really having walked in our shoes. This is why Black Feminist Thought was essential for this research study because this framework crystallized their voices.

Findings around these research questions, specific to influences on African American women's decision to participate in breast cancer screenings, demonstrate the need to expand all delivery modes of information that might contribute to meeting the needs of the individual, community, and the greater African American population. These three communication channels, including the media, health community, and church together, can provide cultural, educational, and targeted healthcare information to underserved women who may lack knowledge of early detection and prevention measures, community resources, or how to navigate through the complicated healthcare system. Another consistent finding and validated by the works of numerous researchers' is that God and church are central in the lives of many African American women (Adksion-Bradley et al., 2005; Baruth et al., 2015; Clark et al., 2018; Washington Post-Kaiser Family Foundation, 2012). As such, these facilitators can play crucial roles in early detection and prevention. This research also seems to support the idea for frequent communication regarding mammograms—instead of once a year. In linking the levels of prevention to early detection, it is through the primary prevention level of education that women could be expected to learn about mammograms through the dissemination of small media and public service announcements; thus, increasing awareness to promote health equity.

This study provided further evidence that having personal connections to someone diagnosed with breast cancer was indeed a major factor for screening uptake. This evidence is consistent in the work of Adegboyega et al. (2019) and Davis (2020). The study also highlighted that not having a family history would cause some African

American women not to “stress getting it done every year,” as described by Mary. This supports the need for continued work in this area in regard to the importance of timeliness to screening mammograms. Further, the systems that are in place need to be dismantled and restored by integrating education and training throughout the healthcare delivery system.

### **Implications**

Nursing involvement in policymaking specific to mammograms would be a highly productive strategy for improving equity issues that involve access, provision of information, and patient care. As skilled healthcare workers, nurses can better support the needs of African American women in terms of bridging knowledge gaps. Moreover, by moving upstream, nurses can use their skills to assess, diagnose, plan, implement, and evaluate policies that are needed to improve the health of women from prevention to survivorship. From a cultural standpoint, nurses working in both hospital and community settings need to understand the influence of religiosity and spirituality on African American women’s decisions to comply with mammography screening recommendations. The implication for nursing involvement on a broader and deeper scale is that nurses can help create policy that drives access and sustainability of programs. Nursing activism and advocacy could be the starting points in gaining momentum towards policy changes. All systems, decision-makers, and communities should work together to eliminate breast cancer disparities through informing policy and practices that can guide evidence-based interventions. In addition, the media, the health community, and the religious community could all play a role in promoting the dissemination of



information and access to mammography screening programs that are culturally specific and with cultural specificity and humility.

In this regard, cultural aspects that influence mammography screening behaviors involve the understanding of preferences, values, and beliefs towards screening mammograms. Numerous studies have reported that churches are a trusted source of information (Ragas et al., 2014) and pastors are highly influential and respected (Harmon et al., 2018), which is why establishing partnerships between the African American church and healthcare providers should be considered. This partnership recommendation confirms the works of Zahnd et al. (2018) and Holt et al. (2017), stating that many churches have become partners with the health community by allowing mobile mammography units, community representatives, and health professionals to deliver breast cancer information and other health topics within their congregations. Given the extent that breast cancer disparities negatively impact the wellbeing of African American women, it is vital to expand the research on the impact of cultural beliefs on attitudes towards healthcare and breast health in particular. Specific to gender preference in discussions of African American women's breast health, additional research is needed as well. In addition, few participants have maintained that pastors do not promote mammograms for several reasons such as "being uncomfortable," "it wasn't a big issue for a lot of the members within the church," or "none of the women ever approached [him] to suggest that he talk about that." Therefore, educating, and engaging pastors then becomes essential in order to create a "healthier church community."

To complete the discussion involving implications and the cultural elements that impact healthcare for African American women, it is crucial to address the social determinants of health, remove bias within the healthcare settings, and implement targeted interventions. With Black Feminist Thought as the underlying epistemology of this study, participants were able to cultivate narratives regarding their personal experiences with mammography screenings along with culturally based suggestions on how to improve breast cancer disparities. It is through the lens of these women's lives and experiences that knowledge was generated regarding the provisions and standards of care pertaining to their health, along with insights as to how to increase breast cancer awareness. They addressed topics including *culturally sensitive education and training, utilizing churches and pastors, minority-targeted communication and marketing approaches through the media and health community, going door to door to educate about the importance of screening mammograms, not limiting breast cancer awareness to once a year, and integrating breast cancer screening reminders through the use of "robocalls and email," just to name a few*. These suggestions create part of a larger conversation regarding the integration of these suggestions in practice settings. Further, these reminders could also be seen as "*cues to action*" that are needed to increase mammography participation among African American women. Interventions that have been found to facilitate the uptake of participation include telephone reminders, physician reminders, and tailored letters (NCI, 2015).

Further, education should address topics such as implicit bias and ongoing healthcare inequities specific to African American women. Taken into consideration, lack

of access, travel time, and participation in regular screenings, future studies are needed to address the particular points of disparity in order to promote and facilitate the use of mammography screenings in the African American community. Awareness of the ongoing need for researchers concerning barriers to mammography utilization would highlight existing barriers several participants may not have acknowledged was a problem for them.

### **Future Research**

The importance of understanding African American women's beliefs and their experiences in society and healthcare across the continuum is paramount. Future studies are needed due to the fact that African American women are dying at higher rates—42% (DeSantis et al., 2016). Understanding *who or what* they consider as their motivation to obtain a mammogram can reveal untapped strategies that can then be developed and delivered in clinical settings and community settings, including the faith-based settings. The findings from this study indicate there is more work to be done in an effort to improve equitable health. While few women acknowledged screening barriers, it still important to continue the conversation regarding mammography participation and non-participation. In addition, more emphasis should be placed on targeted interventions that are specific to African American women. The use of targeted inventions should focus on early detection and prevention (i.e., mammograms) strategies through multiple media formats, which is inclusive of social media, the internet, or culturally specific resources. One participant mentioned that she did not “see in visual media, or on the internet, or other places where African American women are being targeted specifically,” and

another participant mentioned that “some people you know, only go to ethnic resources, and I don’t know if a lot of the African American resources are going to necessarily have information.” Therefore, more research is needed in these areas to assess participation and non-participation in the uptake of screening mammography.

This study helps future research because it validates the knowledge claims expressed by the African American women within this study. This study was intentional with attempts to fill knowledge gaps and care gaps of mammography participation and barriers to participation. As such, healthcare providers and others can build upon their creative ways of healthy living. The use of BFT can be enhanced through the use of storytelling. More specifically, African American women could use their personal testimonies in the church to share with other women about the importance of early detection and prevention. Miriam states in her church, “We have testimonies about women that have - that are breast uh survivors, breast cancer survivors.” These personal testimonies have the potential to remove fear-based thinking, increase knowledge, increase mammography participation, and reduce breast cancer disparities. While this concept is not new (e.g., The Witness Project), it can serve as another level of prevention context. As a standpoint theory, BFT can pull from all narratives and take on the collective experiences, which in turn create a theoretical standpoint regarding African American women. However, more research is needed to understand its true impact, especially during and after this pandemic.

The use of other research theories (e.g., nursing) may offer additional opportunities to increase the knowledge base and creative strategies to improve

participation, diffuse targeted health communication, and improve health outcomes among African American women. Utilizing different theories may help frame the spiritual connection of acceptance, power, and beliefs through the renewing of minds—a changed mindset. Again, healthcare providers across multiple disciplines could better help to encourage, if not influence mammography participation by understanding the deeper level of connection between spirituality and religiosity among African American women. Understanding this connection shapes the knowledge by affording opportunities to learn more about how health, wellness, and illness give meaning, purpose, and direction towards participation in health preventive screenings. By infusing cultural and spiritual competence in research, more evidence-based interventions or best practices could be integrated in healthcare settings, thus promoting health and wellbeing of the African American woman.

### **Practice and Systems**

The injustices where systems of power have systematically disenfranchised African Americans require primary and secondary levels of prevention strategies specific to education and screening programs. The ability and willingness to recognize the experiences of an African American woman give healthcare professionals and other collaborators the opportunity to gain additional knowledge about other challenges that are unique to her existence. Such issues need and should be identified in an effort to achieve the best outcomes. As such, the integration of these approaches should be ongoing whereby evidence-based and best practices can be implemented in both hospital and community settings.

The effort to bridge the racial and ethnic survival gap is a matter of changing the lenses of individuals who are in positions of power to create healthier communities. Ultimately, more research studies like this one are needed in order to understand the experiences of African American women, specific to mammography screening and breast health. As previously stated, culturally tailored interventions designed to further contribute to nursing science and healthcare policymaking are needed, in particular, to inform research and practice and keep moving the science forward. Miriam agreed, stating, “I think this [this study and other studies like it] will help a lot of African American women—just panels or discussion of mammography, the importance of them, why we should get them, and if we have a breast cancer in our family.” Additionally, conversations regarding screening recommendations from leading experts in breast health across the continuum should be continuing because of the differences in tumor characteristics and health outcomes between African American and White women.

### **Black Lives Matter in Women’s Healthcare**

Recent studies showed that the incidence of breast cancer is higher in African American women (23%) as compared to White women (16%) who are less than 50 years of age (Rebner & Pai, 2020). Additionally, according to Harvey (2020), most healthcare providers follow the USPSTF screening guidelines of initiating screening mammograms beginning at age 50. In contrast, the ACS (2019a) noted incidence rates of breast cancer were higher among African American women before age 40; hence, the age before the recommended screening guidelines among average-risk women. In Harvey’s (2020) editorial, she indicated that mammography screening guidelines should be reevaluated.

Martin and Wingfield (2012) agreed with their research study indicating that the USPSTF did not consider how their screening guidelines would impact African American women because of the overwhelming inequities that affect this specific population. Their conclusion highlighted that the USPSTF screening guidelines may be inappropriate for African American women, and as a result, providers should consider what is appropriate for the women they serve. This might include individualizing the frequency of mammography screenings specific to age, race, and multiple factors that cause African American women to have larger tumors and poorer outcomes. Based on research findings such as these, survival inequities between African American women and White women remain a priority for researchers and leading organizations who are committed to reducing breast cancer mortality rates.

### **Limitations**

This study had limitations that need to be acknowledged. This researcher recognized that conducting face-to-face interviews would be limited because of the COVID-19 pandemic. In addition, this researcher also understood that some potential participants may have had limited access to computers and limited knowledge on how to navigate virtual platforms. Therefore, a telephone option was given. All interviews were conducted telephonically. Dropped calls, reception of the call, and distractions from the participant were challenges during the interview process. Another limitation is that this study was limited to participants living in North Carolina, aged 45 and above. The experiences that these women face may not represent the views of other women who are younger and who may live outside of North Carolina and across the United States.

Another limitation that was purposeful by design was that it represented the views of only African American women, which may not reflect perspectives of other races or marginalized groups of women. Finally, the voices from these women were mainly from those who were insured, educated, and attended church regularly. The experiences from other women who may be uninsured, unemployed, have less than a high school education, not attend church, may not share similar ideas and beliefs. Therefore, additional research may be needed to expand the knowledge base of mammography adherence in the African American community. Moreover, other researchers may want to isolate studies to other women of color or ethnicities. Considering the unrest in the country with the Charlottesville riot, the killing of George Floyd and Brianna Taylor, the Black Lives Matter movement, the 2020 election with Fake News, in addition to COVID-19, may have impacted the sample and results.

### **The Researcher's Perspective**

As an African American woman and health professional, I found myself compelled to do a great deal of reflexive journaling because I am all too familiar—both personally and professionally—with many of the experiences expressed by the study participants. These experiences showed up in the form of personal stories and common knowledge about the African American community. By conducting this research, the findings demonstrated to me that there is a critical need for women and nurses not to be silent—but to rise—and be included in decisions and policies that could contribute to changing the trajectories of death, disability, and poverty among African American women and the communities in which they live. Clearly, as revealed in participant's



honest and insightful stories, I assert that power structures must understand the community of people in which they are providing, delaying, or denying services.

### **Chapter Summary**

This study used the Black Feminist Thought perspective, which proved to be useful in understanding and validating breast cancer screening practices among African American women. Screening delays or the avoidance of routine screening mammograms impact both the individual and healthcare delivery systems. Therefore, issues surrounding participation and non-participation in screening mammography must be explored to achieve the best and optimal health outcomes for women. Here, participants unlocked factors that disrupt effective and optimal treatment for the African American woman.

This study *imparted* knowledge to the participants and, reciprocally, provided insights to me. The use of BFT gave them a voice to fully express their diverse perspectives and hidden truths regarding their everyday experiences, beliefs, and unfairness in the society that sometimes brings disharmony and unequal treatment. “As each individual African American woman changes her ideas and actions, so does the overall shape of power itself change. In the absence of BFT and other comparable oppositional knowledges, these micro-changes may remain invisible to individual women. Yet collectively, they can have a profound impact” (Collins, 2000, p. 275). Although participants diverged across age, income, and other sociodemographic characteristics, they lifted their voices and provided approaches towards dismantling the effects of race-based thinking and improving healthcare services.

Failure to acknowledge barriers perpetuated by the hierarchical systems currently in place (e.g., healthcare, political) diminishes the voices and the needs of African American women. Consequently, communities of color, in general, will continue to experience breast health disparities. Many African American women live the reality that their health is dependent upon the color of a person's skin and where they live. This matter takes the shape of the differences in health outcomes, quality of life, and life expectancy. Race-specific death rates between African American and White women are disproportionate (ACS, 2019a). This growing public health concern gives rise to further explore ways to increase the underutilization of screening mammography among low-income and uninsured women. However, by denying that inequities exist in access, treatment, and mortality, the policies, and systems currently in place will continue to encourage breast cancer disparities that plague our nation. There is much work to be done, and nurses are in positions to help uncover the oppressors through a critical lens.

### **Black Lives in 2020**

This study was conducted in the seventh and eighth months of the COVID-19 pandemic. The year 2020 has brought unprecedented events in America, as well as the resurgence of police brutality against African Americans and communities of color. The lives of African Americans have been devalued for many centuries, and while the message of inequality and racism has not changed—and the killing and suffering among African Americans is not new—the method by which such violent acts are committed against African Americans has morphed into a different level of brutality, thus leading to untimely deaths. The country has witnessed the killing of George Floyd—the 8 minute

and 46 seconds—knee on the neck death—to the unjustified shooting and killing of Breonna Taylor. With the turmoil and racism in the U.S. today, trouble times among many people, especially African Americans, are even more concerning. The injustices that are experienced by African Americans give rise to understanding more about being powerless in a dominant White race hierarchal system that is systemically structured to oppress people of color, more specifically, the African American woman (Collins, 2000). Some may disagree, but in this researcher’s opinion, The Black Lives Matter movement is necessary in order to shed light and bring justice to the lives of African Americans. The momentum of the people who carry the torch to help bring awareness and social justice through peaceful protests is encouraging; however, it also brings incitement and actions of further abuse and misuse among people of color.

Moreover, in 2020, the presidential election was also a time where society experienced political decisions that created more division among the races and the spread of a pandemic (i.e., COVID-19). In this study, participants did not discuss the violence against George Floyd or Breonna Taylor. However, Sarah discussed the election and the 2020 president (i.e., Trump).

She stated, Yes um, even with this weekend, um, you know, with the elections and everything; like I tell my girls and I tell my boys also, you don’t have to like a person, but you can be cordial to them, you know. And I - and I often tell them that speaking is just common courtesy because they tend to be shy sometimes. And I said speaking is just common courtesy. You can speak to a person, you don’t have to love them, but you know, it’s good to love everybody. But I think you can speak to people

and just like with everything that's happening in the world today, how one of the um - um sports newscasters was saying that he was - so he was - he was so afraid if his sister goes to Walmart, somebody might retaliate against her. I said this isn't - this is not what America is about. I said America is one of the greatest nations in the world. I feel, and I feel like we can be cordial to each other. And this change that's going on in the White House, I said, "I think it's a good thing for all of us." I said, because uh, we need - we need peace on this Earth, you know, and I think change in our leadership is going to do all of us good. Whether some of them like it or not, it's going to be good for everybody. Because just like um president-elect Joe Biden said, "He's going to be president for all of the people whether you voted for him or not." So, I just - some of the things that this other leader that he had - would say on TV and I said, "Oh my God, what - what - what in the world happened?" You have to lead by example.

Certainly, this pandemic has caused a major shift in the way healthcare is provided. The differential health outcomes experienced by African Americans due to COVID-19 have exposed the vast differences of inequality among African Americans as compared to other races and other populations. For example, African Americans tend to have the highest mortality deaths due to COVID-19 (Strickland et al., 2020) even though they make up approximately 13% of the population (U.S. Census Bureau, 2019). This exposure among deaths in communities of color is somewhat similar to breast cancer disparities impacting African American communities, knowing that systemic and structural racism leads to unfavorable outcomes. Therefore, prescriptive solutions instead of restrictive solutions are needed to break the cycle of poverty and oppression that these

African Americans see and experience every day while living in communities where there are few resources. Innovations that could increase the life expectancy among African American women include providing and linking women to community resources, ensuring timely access to mammography screenings, and by providing culturally congruent and optimal healthcare services. This will require a committed multidisciplinary and interdisciplinary approach in the matter of “Black Lives.” Specific to mammography screening guidelines and breast cancer outcomes among African American women, it is important to recognize the impact that screening recommendations have on the lives of African American women.

### **Dissertation Summary**

In sharing their stories, study participants frequently mentioned strategies that could involve the church, the media, and the health community to motivate, educate, and promote increase awareness and behavioral change among the African American community. However, the level of awareness regarding breast cancer education and prevention has been limited to essentially once a year, in relation to October being designated as National Breast Cancer Awareness month. In my view, this once-a-year campaign is similar to certain holidays that have been set aside to recognize an annual event. The fact is women are dying every day. Promoting breast cancer awareness once a year limits our thinking and the possibility of maintaining ongoing awareness. Equally important, many participants agreed. However, information alone is not enough—modification of attitudes, beliefs, and behavioral skills are needed (Wells et al., 2017).

Taken together, the importance of reducing racial inequities and breast cancer disparities must integrate behavioral change and also systemic and structural changes.

Understanding the core beliefs of health, spirituality, and mammography participation among African American women is pivotal to the health and wellbeing of the individual, her family, and the community at large. In addition, BFT provided a unique way of knowing and gave these women a voice. Many of the women's stories were similar and shared commonalities in terms of culture and resilience. Most importantly, they negated many of the traditional stereotypes. Therefore, using credible sources, such as the African American woman, is vital to her continued presence in society, as well as opportunities to inform research and practice.

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