Breast cancer screening existence in India: A nonexisting reality

The increasing toll of breast cancer in developing nations is really a devastating situation. The disease once considered as the problem of affluent nations has now rooted firmly in developing nations like India. The figure ranges from 19% to 34% of all cancer cases among women in India.[1] The latest statistics suggest that in the near future the disease will go on to surpass cervical cancer, the most common gynecological cancer among women in India.[1] There is a notion that if we have to solve a problem we need first to search out the problem. The existence of this problem is such that it exists but does not have an expressed reality. The story of breast cancer screening in India is also a nonexisting reality. Our women are living in the world with the largest number of health problems and with the least number of solutions. In this prospect, several questions arise:

1. Why the disease incidence is rising?
2. Is there any screening program?
3. If yes, then why are we failing to achieve the desired goal?
4. Do the beneficiaries availing the existing screening facility?
5. And last but not least, if all the above situations prevail as a culprit for the rising toll of the disease, what we can do to tackle the menace.

This article lime lights the situation with the explanatory notion in accord to Indian scenario.

Indian women are less likely to develop breast cancer as compared to their western counter part. Early breast cancer constitutes only 30% of the breast cancer cases reported from various parts of India in contrast to 60-70% of cases in developed world.[1] Over 70% of the women present in advance stage[1] which is the major factor behind the high rate of mortality among these patients.[2,3] The whole scenario of the advanced stage presentation moves around the two major factors, nonexistent of breast cancer screening program, and nonparticipation of women if any such program do exist. This is due to unawareness, lack of access to healthcare facilities, and social-cultural attitudes.[1,4] A high level screening program requires certain elements such as high quality screening, high coverage, high rate of participation, and effective referral system for diagnosis and treatment. The problem is more devastating than the cervical cancer screening program. In India, there is no organized cervical cancer screening program but there is some level of opportunistic screening. When women approach healthcare facilities for availing the reproductive healthcare facilities or regarding their gynecological issues, their gynecological problem rings a bell in the physician's minds to look for the cervical cancer and orders Papanicolaou test leading to opportunistic cervical cancer screening. However, there are no such national organized or opportunistic screening programs for breast cancer in India.[1,2]

The opportunistic screening program for breast cancer lies in a cold packet owing to the nature of occurrence of the disease in comparison to cervical cancer. Most of the time disease is totally asymptomatic in the earlier stage with a painless lump. Women from low socioeconomic strata, having low-income, and less education may not seek care upon feeling a breast lump. This may be attributed to their unawareness that what the lump represent, stigma of being rejected by the community and partner, potential fear of loss of the breast, and the major obstacle being the prevailing taboo of not discussing breast cancer topic openly, and disbelief of existence of any effective therapy for the disease.[5] Studies have found the fatalistic attitude as major barrier toward breast cancer screening uptake. Women's disbelief that events are governed by the doctrine of fate and no one could change the course of the events.[6] These fatalistic attitudes could be overcome by Health Belief Model where the individuals are engaged in preventive health behavior through perceived susceptibility to a disease, perceived severity leading to a serious consequence, and perceived benefit of positive outcome through a course of action.[6]

A high level screening uptake has been reported in UK and US, but it is almost nil in India.[7] Organized breast cancer screening services have showed a decrease in mortality in the Western world. Today, the most widely used tools globally for breast cancer examination are mammography, clinical breast examination (CBE), and breast self-examination (BSE).[3] Mammography and regular CBE can result in decreasing the toll of mortality through down-staging of breast cancer of asymptomatic women[2] but its expensiveness and cumbersomeness disbar its use in countries like India.[1,3] So in the developing countries symptomatic findings can be used for early diagnosis and prevention of late stage presentation of disease. BSE has been found to be the most reasonable and feasible approach in early detection and reduction of breast cancer mortality in India and other developing countries.[1,3,7] Studies from India suggested BSE can be used as a tool of creating breast health awareness among women and trained female health workers can play a promising role in disseminating this knowledge among women to carry out BSE.[1,7]

Though BSE is considered as a most feasible tool in early detection of breast cancer, multiple barriers have been identified ranging from unawareness about the procedure to

poor access to the healthcare facilities.[3] Studies regarding the health seeking attitude of the women in London and Canada suggested that Indians majorly reported emotional rather than logistic or practical barrier to seeking medical help.[7] These findings suggest that health seeking behavior among Indian women are majorly governed by emotional status and may not be influenced by their health related knowledge. If women from such affluent society facing such a problem in regard of the disease screening then we cannot expect much from the women living in the rural setup with remote access to even primary healthcare facilities and other priorities over there health issues. So along with increasing the knowledge of these women we have to strengthen their emotional status and could be only done by the community outreach awareness program. This demands a shift of our screening program from mammography to BSE and from tertiary care facilities to primary healthcare facilities and even at the door step of the beneficiaries. As a healthcare provider, it is our responsibility to tackle the situation at all level either at the community or the primary healthcare facilities. The whole scenario demands depolarization of our resources toward the community, mainly women living in villages, as for catching big fish one have to go far in the sea instead of betting at the shore.

Healthcare professionals have been found to be an important source of dissemination of breast cancer knowledge to the women. But the limited availability of trained healthcare professionals like doctors is a severe constraint on reaching the rural and disadvantaged population, demanding new measures to reach this population.[8,9] Although studies from the Western world have shown better compliance for physician conducted awareness programs but studies from India showed high acceptance of healthcare workers as educators.[9] This is the targeting place in our policy, for utilizing the services of our existing primary healthcare infrastructure and its facilities like trained nonmedical personnel's such as Accredited Social Health Activist (ASHA), which would be trained for providing BSE training to women at their door step. If their arise suspicion of the disease they can contact the healthcare unit in the hierarchy upstairs. This could act as a mile stone in hunt of the culprit in remote areas. Since ASHA are female from the same or nearby community, they can easily establish a rapport with the beneficiaries reported in other studies.[9] The policy of involving ASHA in breast cancer screening program could overcome a number of obstacles majorly faced by women from the remote areas of the country. They could overcome the feeling of shyness during examination by a male doctor, need of male to escort them to the healthcare facilities as the service would be available at the door step. ASHA could easily overcome the purdah system, cultural beliefs, and custom barriers debarring these women from accessing the screening facility.

Studies have shown that involvement of trained community healthcare workers has increased compliance toward cervical cancer and breast cancer screening among asymptomatic women in low-income rural communities.[10-12] The next pathway which we could utilize is the role of opportunistic screening in generating the awareness for organized screening at the primary healthcare level and training women for BSE. World Health Organization also stresses on promoting community awareness and encouraging early diagnosis for women attending primary healthcare centers for other reasons.[1] The whole process of training the women through trained community health workers would be like a nuclear chain reaction leading to the generation of home to home trained personals without any extra financial burden on our health system. This might be a simple approach, could save a lot of precious life which we are losing owing to this menace. We all know that it will not uproot the disease completely but could be a promising way to reduce the burden of the disease to a significant extent.

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