

Adopt-a-Society bears fruit

Board member Auxilia Munodawafa reports on how an American university has supported a Zimbabwean nursing society to become a member of the ISNCC

I faced a tremendous challenge when I was elected to the board of the International Society of Nurses in Cancer Care in 1996. The challenge was to establish an oncology nursing organisation in Zimbabwe.

Major obstacles became apparent right from the beginning. We needed to create enough interest within the nursing fraternity to join such an organisation. Oncology nursing is not a specialty in Zimbabwe and there is limited oncology education among nurses.

The second and probably the decisive obstacle was to come up with an amount of US \$100 in order to become members of ISNCC and to pay annual dues of the same amount.

Although \$100 might seem a reasonable amount to many people, it appears insurmountable in a country with a struggling economy like Zimbabwe, whose currency is down to \$50 Zimbabwean = \$1 US.

The other factor is that most of these nurses already belong to the Zimbabwe National Nurses' Association where they pay annual dues. They are also probably members of a regional nursing organisation such as East, Central Southern African College of Nurses (ECSACON) as well as the International Nursing Council (ICN), where again they pay dues through their national organisation.

To respond to these problems the ISNCC created an Adopt-a-Society programme, to enable societies from developing countries to be formed and supported by well-established societies or institutions.

In 1999 board member Kevin Sowers heard about the Zimbabwe plight and volun-



Board members Kevin Sowers and Auxilia Munodawafa with one of the nurses in the oncology unit at Duke University Medical Centre

teered on behalf of Duke University Medical Center, to adopt the Zimbabwean society if it was formed. Right from the beginning, Kevin made it very clear that this was to be more than just a sponsorship programme, but also a collaborative one, where both sides could learn from each other by engaging in collaborative activities.

My visit to Duke University as the Interim President of the Zimbabwean Society of Nurses in Cancer and Palliative Care marked the beginning of such activities. I was a guest of Duke University Medical Center. Visits were organised to all the oncology units including outpatient facilities such as the Bone Marrow Transplant Ambulatory unit and the oncology clinics.

During the visit I had the chance to deliver papers on palliative care in Zimbabwe and clinical aspects of cancer nursing in Zimbabwe to the Duke University Medical community and to local representatives of the Oncology Society.

It was a fruitful visit and most appreciated was the high level of hospitality from the various heads of departments who

found time in their busy schedules to explain about all the available services in oncology care. Plans are now underway to arrange for exchange visits of nurses from both organisations. For USA nurses to come and mount short educational programmes in cancer care in Zimbabwe, and for nurses from Zimbabwe to go to USA to see the range of services available and, where possible, adapt whatever is feasible for implementation in Zimbabwe.

There are plans in the future to support nurses from Zimbabwe to go to Duke University to study on the masters programme. Further into the future there are plans to establish the course in Zimbabwe collaboratively with Duke University at the University of Zimbabwe within the department of nursing science. It is hoped that as a result of these activities both sides will learn from each other, leading to better care being given to patients and their families.

I want to take this opportunity to thank Kevin Sowers and all those at the Duke University Medical Center for responding to the Zimbabwean plight and adopting the Zimbabwe Society of Nurses in Cancer and Palliative Care.

I do hope The Adopt-a-Society programme will encourage more established associations from developed countries to assist organisations in the same predicament as Zimbabwe to become members of the ISNCC.

*Auxilia Chideme Munodawafa,
Interim President of the Zimbabwean
Society of Nurses in Cancer and
Palliative Care*

Ripple effects from the international conference

A travel scholarship winner to the Israel conference in 1998 looks back on how the experience has affected her nursing practice

As a Chinese oncology nurse, I was fortunate to receive a travel scholarship to attend the 10th International Conference on Cancer Nursing in Israel, 1998.

The international conference on cancer nursing offers a great chance to disseminate knowledge in cancer nursing and facilitate the development of nursing world wide. This is particularly important to nurses in developing countries such as China. It is hard for a Chinese nurse to attend an international conference held abroad without any help.

It has been two years since I attended the conference but the knowledge and inspiration I gained have deeply influenced my way of thinking about oncology nursing.

Oncology nursing has developed rapidly in recent years in China, and cancer patients demand a higher quality of care. As a result, oncology nurses have to be fully prepared and competent for this demanding work.

Attending the conference helped me to gain information in oncology nursing, practice and nursing research. There have been many benefits in understanding current studies of oncology nursing from other countries.

Since I came back from the conference,

I realised that as oncology nurses we have many things to do to improve our nursing practice and research. As a result I have paid much attention to find out a way to resolve some issues in clinical nursing care and have started to carry out nursing research. I decided to undertake a survey among the patients with breast disease in our hospital, which is a large cancer centre and institute.

The purposes of the survey were to:

- discover the rate of patients who do breast self examination (BSE) among the patients with breast disease
- find out how the patients who do not do BSE feel about BSE

The findings of the survey demonstrate that the rate of BSE is very low. To respond to this I have appealed to related organisations to enhance the education of BSE to the public. I have added BSE into the patient education programme which has been implemented in the clinical areas, and co-operated with the screening team to teach BSE to people during screening activities.

In addition together with my colleagues I am working on nursing research entitled

'Nursing Intervention of Fatigue for Cancer Patients'. In this project we have tried to establish a model of nursing intervention for fatigue which includes nursing diagnosis, assessment, and management of fatigue. The hospital has strongly supported me during my research work.

During the two years since the conference we have paid much attention to psychological nursing and applied pain management for cancer patients to improve the patients' quality of life. And I have disseminated the information I have learned from the conference to other nurses whenever I have an opportunity.

We need more information so as to keep up with the current standard of oncology nursing in the world. I hope that Chinese nurses in the future have an opportunity to attend the international conference on cancer nursing and other international events.

*Wang Qi, Head Nurse,
Department of Surgery, Tianjin Medical
University Cancer Hospital, China.*

Travel scholarships to the conference were sponsored by the Oncology Nursing Society, US, and Clinical Insights Inc, New York, US.

Nurses from Australasia and Far East hold first regional meeting

Fifty nurses from the Far East and Australasia met for the first time at the conference in Oslo to discuss ways to promote cancer nursing in the region. Nurses from China, Japan, Thailand, New Zealand and Australia participated in small group discussion of issues confronting cancer nurses in the region.

The aims of the ISNCC in the Far East and Australasia region were discussed. These include: facilitating networking of cancer nurses, facilitating communication between national cancer nursing groups, assisting nurses in the region to establish cancer nursing groups, providing advice and acting as a resource for developing areas, identifying areas requiring policy, and disseminating information about cancer nursing in the region.

Some of the difficulties that limit achieving ISNCC objectives in the region were identified as: different languages used affects communication, cultural differences and values may limit the development of a shared view/approach to cancer nursing, and the low income economies of several countries in the region.

The most common themes emerging from discussion were the need to establish a regional list of contacts to build up a network and to publicise regional activity in International Cancer Nursing News. Other themes identified were the possibility of sharing information/newsletters on the ISNCC website. Those who attended also

discussed the possibility of a regional conference.

After the meeting the contact details of those who attended were circulated within the group. Regional board members plan to meet and discuss the possibility of a regional conference in June 2001.

Participants appeared to enjoy the opportunity to discuss these issues with colleagues from other countries. Due to the enthusiasm of participants in the session, the Far East and Australasia regional meeting will be held again in London in 2002.

Nurses who would like to become part of the Far East and Australasia network should email Laurie Grealish at laurie.grealish@act.gov.au

An invitation to all

Every two years we gather to review the remarkable progress made in cancer nursing and cancer care. The International Conference on Cancer Nursing has provided the ideal stage from which cancer nurses can describe what we do.

For those of you who have not yet attended one of the International Conferences on Cancer Nursing, let me assure you that they are highly rewarding and I urge you to give consideration to participating in the conference in 2002.

Plans are underway by the Scientific Planning Committee to provide another premier event for cancer nurses from around the world. Plenary sessions will be held throughout the week, and nurses have the opportunity to submit abstracts for podium and poster presentation.

Suggested topics related to the theme are included on the announcement of the conference in this newsletter. Please be alert

for the Call for Abstracts, which will be mailed and included on our web site (isncc.org) in the very near future.

Additionally, I ask that members begin thinking about who they would like to nominate for the three prestigious awards presented by our Society: the Robert Tiffany Lectureship, the ISNCC Distinguished Merit Award, and the Past President's Award. The call for nominations will be sent towards the end of this year so you have plenty of time to begin thinking about candidates.

Twenty-three years ago the 1st International Conference on Cancer Nursing, held in London, was a milestone educational event for cancer nurses and provided the framework for future conferences. The progress made since 1978 can be measured by the abstracts for poster and podium presentations being submitted by cancer nurses from around the world.

Many of these presentations relate to nursing research studies, cancer control programmes, and unique ways of providing prevention and early detection. The information these nurses provide clearly reveals that we are 'making a difference' in cancer care no matter what country we are from.

So mark your calendars now for the 12th International Conference on Cancer Nursing to be held from 28th August to 1st September 2002. It is an event you don't want to miss.

From all across the globe cancer nurses will come to London to celebrate our achievements, to strengthen our resolve to meet new challenges, and to discuss how we are making a difference in cancer nursing and the care we provide to cancer patients and their families. It will be an experience you will remember.

Connie Henke Yarbro
President, ISNCC

Recognised posters in Oslo

Over 150 posters were presented at the Oslo conference by nurses from 18 countries. Three posters were recognised by the poster review committee.

The first *Politics, economy and health are irreconcilable in health care* was by Thandeka Victoria Mbatha (South Africa). She describes the lack of resources which makes it extremely difficult to offer efficient and effective quality care and raises the issue of how, in such circumstances, nurses can address the question of what is quality.

The second poster recognised was *Voices from women on the decision to seek care after an abnormal mammogram* by Alexis Brown Bakos, USA. An estimated

60% of women who have an abnormal mammogram do not return for follow-up. The purpose of the study presented in this poster was to identify the factors involved in order to develop a culturally sensitive protocol which would increase adherence to diagnostic evaluation.

A sample of 202 women from urban hospitals were invited to take part, 121 of whom had not returned for diagnostic evaluation after an abnormal mammogram.

Telephone interviews are being carried out to provide anonymity as each woman is asked why she decided to return or not to return for follow up.

This study recognises the importance of a variety of factors including culture,

resources and beliefs that influence patient's decision making.

The third poster recognised for its contribution was *Management of breathlessness in lung cancer care: A multiprofessional approach* by Jane Thompson-Hill, UK.

Change of address

Management of the ISNCC Secretariat is now being dealt with by Mediate Health Consulting Ltd. Please address all enquiries to Christine Armstrong, Mediate Health Consulting Ltd, P.O. Box 297, Macclesfield, Cheshire SK11 7FZ, United Kingdom.

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Making a position statement

In August 1999 the board of the International Society of Nurses in Cancer Care proposed that a position statement be developed on cervical cancer screening.

This was to be undertaken along the lines of the position statements already developed by the society on tobacco use and on cancer pain.

A working party consisting of nurses with expertise in the areas of screening, policy development and cervical cancer was convened and chaired by Letitia Lancaster from Australia.

Other committee members were Midori Kazamato from Japan, Linda White Hilton from the USA, Myrna McLaughlin Anderson from Panama, Carol Tishelman from Sweden and Laurie Grealish from Australia.

A unique aspect of the working party was that none of the members ever met face to face. All communication was undertaken by either email or fax; a sign that we really have embraced the technology offered in the 21st century.

The first draft was completed on Christmas Eve 1999 and distributed for comment to members of the working party, honorary officers of the society and nominated critical readers in Brazil, Panama, United Kingdom, USA, Australia, Thailand and China.

Comments were then incorporated into the document and the second draft was distributed at the end of January, seeking feedback on the content and clarity of the document, and for review with the explicit

understanding that the end product was to be utilised in both developed and developing countries.

The final draft was distributed for comment to the board members of the ISNCC in April 2000. Once their comments were incorporated, the two Australian members of the original working party set about the onerous task of reducing the paper from a five page document with 34 references to the two page position statement published opposite.

Nurses in all countries are in a key position to promote cervical cancer screening and it is hoped that the position paper will be distributed widely and actively promoted.

*Letitia Lancaster,
Australia*

EDUCATION COLUMN

Uncovering assumptions in nursing

Nurses working in cancer care, like other nurses, make assumptions about practice situations. These assumptions provide a guide for assessment and sometimes planning. Assumptions are usually based on the nurse's beliefs and values. Assumptions derived from beliefs are also known as 'descriptive assumptions'.

Descriptive assumptions are made when the nurse deems what the world is, was, or will be like (Browne and Keeley 1994). Assumptions derived from the nurse's values are known as 'value assumptions' and reflect the ideals the nurse strives for, what the world *should* be like (Browne and Keeley 1994).

Nurses, like other people, develop professional beliefs and values through their education, family, and culture amongst other variables. Nursing education is a major influence in the development of beliefs and values for nurses at the pre-service and post-graduate levels. The challenge for cancer nurse educators is helping their students to recognise the way that their beliefs and values influence their practice.

Recognising when one is making descriptive or value assumptions is important for nurses for two reasons. First, nurses who are clear about their personal assumptions, and how these influence their views, are able to recognise when others are using assumptions to support weak arguments.

Secondly, nurses who recognise their assumptions, and when these assumptions may conflict with institutional assumptions, are able to defend their position by developing arguments using logically

derived reasons to support their views or conclusions. Nurses who are unable to ratify their beliefs and values with those of the institution may suffer from moral distress. Over time moral distress can escalate to feelings of depression, anguish, and moral outrage (Hamric 2000).

Nurse educators have a responsibility to assist cancer nurses to develop the critical thinking skills required for them to identify descriptive and value assumptions. Four strategies, suggested by Browne and Keeley (1994), may be helpful:

- 1 Keep thinking about the gap between the decision and the reasons provided. Get students to ask 'How do you get from the reason to the decision?' 'If the reason is true, what else must be true for the decision to follow?' In the gap the student may find the assumption(s).
- 2 Look for ideas that support reasons. For example, some one may argue 'We need to increase the money spent on nursing education'. The reason would be that: 'If we do so, we will greatly improve the care of patients with cancer.' The assumptions or ideas that would support this reason include: (a) the money will be spent in an effective manner and (b) nurses will be willing and able to respond to the educational message. Both (a) and (b) must be assumed for the reason to be acceptable. The nurse must then verify the 'truth' of (a) and (b), usually with evidence to present a strong argument.
- 3 Identify with the other person. Try to

play the role of the person you are talking with and plan in your mind what he or she is thinking. How ambiguous words are defined will be influenced by the person's assumptions. When a nurse says: 'it's time for your bath now', she may be planning a sponge bath. The patient may be preparing for a tub bath and be disappointed when she does not get the tub bath. Think about what 'bath' may mean for the other person who bathes at home.

- 4 Identify with the opposition. Reverse roles. Ask yourself why someone might disagree with your decision. When you play the role of a person who would not make a similar decision, you can more readily see the assumptions in the original decision process. This is also known as 'playing the devil's advocate'.

In conclusion, nurse educators have an important role in helping cancer nurses to develop critical thinking skills that reveal the assumptions that exist in everyday situations. The essential first step for educators is to identify the descriptive and value assumptions inherent in the philosophy underpinning cancer curricula and make these explicit to students.

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of Canberra in Canberra, Australia*

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Cervical screening

Position statement

Premise

Cervical cancer is both a preventable and curable disease.

Background

Cervical cancer is the second most common cancer in women worldwide. The World Health Organization estimates that each year 450,000 women are newly diagnosed with cervical cancer and that 240,000 women die of the disease.

It is of significance that 80% of cervical cancers are diagnosed in developing countries. Women at greatest risk for the development of cervical cancer are those of low socio-economic status, who are over the age of 50 years, and illiterate.

In developed countries, migrant and indigenous women are also identified as high risk groups.

The introduction of organised screening programs for cancer of the cervix has led to a dramatic decline in incidence and prevalence. An effective screening program includes recruitment, a screening tool, recall for abnormal results, and referral for treatment where appropriate.

Programs introduced in an opportunistic way with little attention paid to infrastructure support, quality measures, uniform policies and call/recall mechanisms, result in less than optimal declines in incidence and mortality.

Screening for the detection of precursors of cervical cancer is one of the most successful public health measures in the prevention of cancer. Most of the women who die of cervical cancer have never been screened.

The Pap smear is an effective screening tool. Methods for early detection of cervical cancer, other than the Pap smear, are being investigated for use in developing countries.

The major determinants of the incidence of cervical cancer should be considered in program development:

- limited access to or an absence of screening programs,
- a lack of personnel in developing countries that are trained to interpret cytological findings, and low participation by indigenous and migrant women in screening programs in developed countries.

Socio-economic differences in screening practices tend to decrease when participa-

tion is promoted, accessibility is increased, cultural and economic barriers are removed and social support is offered.

Screening for cervical cancer should be part of a broader health promotion program

Position

The International Society of Nurses in Cancer Care is committed to supporting strategies that will reduce the incidence, morbidity, and mortality of cervical cancer. The Society supports strategies that promote equity of access and ensure ethical considerations are intrinsic in all screening/prevention endeavours. Nurses are in a key position to promote cervical screening to all women.

ISNCC recommends that:

- All nurses enact their responsibility as consumer advocates to lobby governments and healthcare organisations for the establishment of long-term policies, financial infrastructure, legislation, trained health professionals and quality assurance systems to support cervical screening programs that ensure equity of access to all women.
- Cervical screening services that are provided by appropriately trained health professionals and workers may increase the acceptability and accessibility of cervical cancer screening.
- All nurses assume the responsibility for ensuring that cervical screening is undertaken within a broader health framework relevant to the local context, which promotes women's health (and the health of their families); this may include nutrition, smoking prevention and cessation, sexual practices, and sexually transmitted diseases.
- Health education is offered to improve the awareness of both the public and health professionals of the benefits and limitations of cervical screening programs.
- Health education programs regarding cancer screening must be clear, brief and respectful of local culture, and use a variety of media.
- Recruitment strategies for cervical screening programs must be culturally sensitive and specific, aim for whole populations and promote screening in previously underscreened women.

- Nurses work to decrease the barriers within healthcare and social systems that discourage or prevent women from attending cervical screening programs.

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Cancer prevention and control in Belize

This study looks at what the inhabitants of Belize know about cancer, its prevention and treatment, their attitudes and practices

The lack of a cancer registry in Belize means that it is difficult to make strategic or systematic plans for relevant education. The results of this study presented at the Oslo conference has provided valuable and essential information.

Belize is a developing country in Central America with an estimated population of 222,000 with almost a quarter of the population living in Belize City.

There are diverse ethnic groups that include the Mestizo, the Creole, and other groups, which include the Maya, East Indian and Asian immigrants.

Health care facilities include one referral hospital, six district hospitals, 40 health centres and 35 health posts, as well as other small private hospitals and clinics.

The Belize Cancer Society was formed in 1996 and is the only organisation that is working towards establishing and promoting the awareness and treatment of all types of cancer, and supporting those affected by cancer and their families.

Cancer awareness activities have been designed to empower Belizeans to become actively involved in learning about healthy lifestyle practices. Education on lifestyle practices that help in cancer prevention and control has been done largely by nurses who are active members of the Belize Cancer Society.

One other organisation, the Belize Family Life Association (BFLA) has been involved in countrywide promotion of Pap smears and cervical cancer awareness. However there is no national cancer prevention and control programme within the Ministry of Health. Because of this, Belizeans do not have access to screening programmes. If diagnosed with cancer, citizens of Belize have to seek oncology services in the neighbouring countries of Guatemala and Mexico or the United States.

As a result of this, important data on the

incidence and prevalence of cancer is lost and Belizeans are burdened with the overwhelming cost of seeking expensive oncology services abroad.

The study

The purpose of the study was to determine the knowledge, attitudes and practices of the Belizean community regarding cancer prevention and control. The results could be used to plan future educational programmes.

A questionnaire was developed with 42 items on cancer knowledge, attitude and practices and five items on demographic information.

Nine hundred and seventy-seven (977) individuals were interviewed for the study of which 72% were females and 28% were males. The respondents' age ranged between 18 and 91 years with an average of 39 years. Ethnicity and religious affiliation reflected that of the population.

Physical examination

The study found that 36% of those who responded have an annual physical examination. Of these 37% said they get an examination to ensure that all is well, 33% said they do so to get regular checks because of illness, and 26% for early detection of cancer and sickness.

The results also showed that those who had someone in their family who died from cancer are more likely to go for physical examination than those who did not have someone in their family with cancer.

What is cancer?

Nearly two thirds of the respondents indicated that they know what cancer is. Most who said they know what cancer is mentioned that it spreads through the body. But 7% of the 619 respondents who said they know what cancer is, said it is contagious while 64% of the respondents said cancer

can be passed on in families.

Early warning signs

A third of the respondents said pain is an early warning sign of cancer. More of the respondents who had a family member with cancer mentioned pain than those who did not have experience of cancer. The other most common warning signs included a lump, bleeding and weight loss.

Prevention

Almost a half of the respondents were found to exercise on a daily basis. Of the 458 respondents who exercise daily, 79% did not smoke which parallels the entire population with 73% of non-smokers. The most common forms of exercise reported were walking, jogging, and aerobics. Sixty-one percent of those who exercise daily do so by walking.

The respondents were asked if they believe nutrition plays an important role in cancer prevention for which 54% said yes, 27% said no, and 16% said they did not know. Of those who said yes, 54% said that some foods can prevent cancer and 21% believed that some foods cause cancer. The others who said yes (25%) did not offer any specific reason.

Of those surveyed, approximately half said they drank alcohol. The majority of those who drank (two thirds) did so occasionally, 24% weekly, and 5% daily.

Self-examination

The respondents were asked if they practiced breast self-examination, 37% said they did. Twenty-two of these respondents were males which is 8% of all the males and 236 were females which is 48% of all the females surveyed.

Half of the females said they do not practice breast self-examination which is a significant proportion. Fifty-two percent of the males said they don't and 40% of them did not respond to this item. This has strong implications for education.

Fifty percent of those who said they have someone with cancer in their families, practice breast self-examination and approximately the same percentage who had someone in their family with breast cancer also practice breast self-examination. On the other hand, if the respondents did not have someone who had cancer, the

Statement	Yes	No	Don't know
Cancer is a punishment from God for wrong doing	12.3	80.5	6.4
Cancer is a shameful disease	10.9	87.0	1.6
Is it possible you can get cancer?	83.0	8.9	1.6
Are you scared of getting cancer?	58.7	38.6	2.1

Table 1: Percentage distribution of responses to statements relevant to attitudes/beliefs

probability of practising breast self-examination was 0.34.

Of the respondents who practised breast self-examination 43% did so monthly and 22% did so weekly. Of the 50% who did not, 22% did not do so because they did not know how, 8% had never heard of it, and 7% said they did not have the time.

Pap smears

Of the 698 female respondents, 84% said they have heard of a Pap smear. When asked what is the purpose of a Pap smear, 82% of those who have heard of it said its purpose is to detect cancer while 12% did not know the purpose of a Pap smear. Interestingly, no one said a Pap smear is done to prevent cancer.

Just over half of the female respondents said they had a Pap smear with 56% having had one done a year ago or less. Of those who had a pap smear 58% had it for health reasons and 21% for screening purposes.

Prostate antigen

Most people (96%) did not know what the Prostate Specific Antigen (PSA) test is, probably because it is new to Belize and it is costly since the test has to be sent abroad for analysis.

Those who did state that they knew what PSA is, said it was to detect prostate cancer and check for infection.

Of those surveyed 16% of the men and 4% of the women said they knew how a prostate test is done. Two-thirds who said they knew, mentioned that a PSA is done by rectal examination and 21% stated it is done by blood test.

Attitudes to cancer

The overall attitude of the respondents to cancer is positive even though 59% were afraid of getting cancer. There was significant difference ($p < 0.005$) between males and females in their response to being

scared of getting cancer. However, there was no significant difference between male and female responses to the remaining three attitudinal items (see Table 1). Approximately 37% of those who said it was possible that they could get cancer indicated that they were not scared of getting it.

Risk factors

The general knowledge pertinent to cancer risk factors is assessed through 13 items. The percentage distributions of responses to these items are presented in Table 2. In general, the results revealed that there is a need for knowledge regarding the relationship of certain cancers to some risk factors. A quarter of the respondents did not know or gave the wrong response (23%) to whether 'some sexually transmitted diseases can cause cancer'.

Similarly, a quarter of the respondents did not know and 35.2% gave the wrong response to whether 'obesity is a factor that is said to increase the risk of cancer'.

Another statement respondents had limited knowledge of was whether women who have their first child at 30 years and over are at risk for cancer for which 34% did not know and 30% said no.

The percentage of correct responses to the other three risk factor questions range between 60% and 71% which is acceptable given that there is no formal cancer education programme in the health system.

The responses to the two items on cancer pain management show that there is a need for education in this aspect of cancer. Forty-two percent of the respondents said that men can get breast cancer. This level of affirmative response is interesting given the limited information on breast cancer in men and the rare occurrence of breast cancer in males in Belize.

Conclusions

The researchers conclude that respondents

had some knowledge of cancer but at an unacceptable level. The majority of the respondents did not know what cancer is and how it is acquired; however, they knew the parts of the body that are most affected by cancer. The parts they identified concur with the responses to other questions in the questionnaire and regional and international statistics. They also knew that cancer is hereditary and most of the early warning signs of cancer.

The respondents showed limited knowledge in cancer prevention. As a group they did not know what a Pap smear is and its purpose and more so they did not know what a PSA is and its use.

The attitude of the respondents towards cancer was found to be positive. Most respondents would attend a class on how to reduce their chances of getting cancer, did not think cancer is a shameful disease and that it is not a punishment from God. They also thought they can get cancer and were scared of doing so.

The conclusion in regard to practice is that both females and males are not doing enough to prevent and control cancer. Not enough women are having Pap smears and not enough men having a PSA. Only under half of those surveyed were practicing breast self-examination.

Respondents reported some practices that were not directly linked to cancer prevention and control but contribute to it. These included exercising which was done at an acceptable level. The proportions of people who smoke, drink alcohol, did not go for an annual physical examination, were significantly high, which is hazardous to health.

In general, the researchers conclude that given the knowledge, attitude and practices of the Belizean populace, as determined by this research, there is a need for more education in cancer prevention and control.

The responses and the data available show that the levels of the different types of cancers in Belize is not more that what exist in the Caribbean and the world. More educational programmes in the health system would help to maintain and even reduce these levels because they would positively impact attitude and practices of cancer prevention and control.

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References

Theodore-Gandi, B. (1997). Health of the Adult. Pan American Health Organisation. Pan American Health Organisation Health Conditions in the Caribbean. Scientific Publication No. 561. Washington, USA. 236-250.

Statement	Yes	No	Don't know
Too much sun can cause cancer	65.3	20.9	13.5
Some cancers are related to alcohol use	60.0	20.9	18.8
Some sexually transmitted diseases can cause cancer	51.0	23.3	25.4
Are all cancers fatal?	46.1	49.9	7.7
Some cancers can be cured	72.2	18.7	8.3
Obesity is a factor that is said to increase risk of cancer	38.1	35.2	25.8
Can men get breast cancer?	41.5	34.3	23.6
Some cancers can be cured if detected early	87.1	7.9	4.3
Cancer can only be detected during the late stages	16.7	74.6	8.1
Some things in the environment can cause cancer	79.8	11.4	8.0
Women who have their first child at 30 years and over are at risk for cancer	35.7	29.9	33.9
There is no relief from cancer pain	52.2	33.3	13.6
Cancer patients with pain become addicted to pain medication	70.5	14.0	14.3

Table 2: Percentage distribution of responses to statements relevant to knowledge

Research design: matching method and purpose

To be consumers of research and base their practice decisions on scientific evidence, nurses must understand the design of a research project. How a researcher designs, structures or implements an investigation affects the results of a research project and whether or not those results will be useful in practice.

The word 'design' implies the organisation of elements into a masterful work of art. When an architect designs a house, the plans are made for each room, hallway and doorway so that a desired effect is achieved and a specific purpose is served. The resulting blueprint for the house is individualised or tailored for the specific house and its inhabitants.

In a similar fashion, the design of a research project must be specific to the study and its purposes. The research design is a blueprint for conducting a study that maximises control over factors that could interfere with the validity or truthfulness of the findings. It provides a scheme for answering the research question.

The research design includes all the procedures and techniques that will be applied in a study: who will participate, where the study will be conducted, what data will be gathered, how the data will be gathered, and how the analysis will occur.

A wide variety of research study designs are used in nursing research. However, the various designs fall basically into two categories: quantitative and qualitative. Each type facilitates the development of different kinds of knowledge. Depending upon the type of research question that is posed for a study, the investigator will select quantitative or qualitative approaches.

Quantitative approaches

Quantitative approaches emphasise objectivity. They proceed through a deductive process that starts with a hypothesis derived from the existing literature. The

data collection and analysis proceeds through specific standardised steps. Variables are defined and measured; hypotheses are tested and confirmed or refuted. The focus of the data is on numbers and measurement or quantification of phenomenon. One would expect if the study were to be repeated under the same conditions that the same results would be evident.

Examples of questions that would be investigated using quantitative methods include:

- what is the effect of benign breast biopsy on the frequency of subsequent breast self-examination (BSE) mammograms, and clinical examinations?
- what is the quality of life of bowel cancer survivors?
- how effective is a bereavement programme that offers both education and support?
- what is the relationship between quality of life and coping for women with gynaecological cancer and their spouses?
- what factors influence patients' decisions to participate in a clinical trial?
- what are the correlates of fatigue following adjuvant chemotherapy?

Qualitative approaches

Qualitative methods facilitate holistic approaches to questions about human experience. They turn toward subjectiveness of people's realities. The approaches start from an inductive process and focus on discovery, understanding and gaining insight about people's lived experience of an event. The researcher tries to comprehend the participant's world through observation and interview. The researcher becomes, in part, the data gathering tool as he or she interacts with the participants.

Analysis focuses on finding patterns in the word data.

Examples of questions that would be investigated using qualitative approaches include:

- what are children's perspectives regarding the experience of completing cancer treatment?
- what are oncology nurses' experiences with requests for assisted dying from terminally ill persons with cancer?
- what are patients' experiences receiving Iodine-131 therapy for thyroid cancer?
- what are cancer patients' experiences seeking information about alternative therapies?
- what are parental decision-making processes regarding treatment options for children with cancer?
- what are women's experiences attending peer-led support groups?

As a research study is planned, it is important to match the appropriate method or design with the proposed research question or purpose.

If the purpose is to test hypotheses, establish causal relationships, summarise numerical patterns, or demonstrate statistical significance according to laws of probability, then quantitative methods are required. If the study purpose is to understand people's experiences in natural settings and the processes inherent in their experiences, then qualitative methods are required.

Both methods or designs have their appropriate place and can provide evidence that can inform nursing practice.

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CALENDAR OF EVENTS

The Oncology Nursing Society

26th Annual Congress will take place in San Diego, USA, 17-20 May 2001. *For information contact:* ONS, 501 Holiday Drive, Pittsburgh, PA 15220, USA. tel: 412-921-7373 email: customerservice@ons.org

The European Cancer Conference

will take place in Lisbon, Portugal, 21-25 October 2001. *For information contact:* ECCO 11, FECS Conference Unit, Avenue E Mounier 83,

B-1200 Brussels, Belgium. fax 32 2 775 0200; e-mail: EBCC-2@fecs.be

The 16th Asia-Pacific Cancer

Conference will take place in Manila, Philippines, 18-21 November 2001. *For information contact:* Congress Secretariat, 16th APCC, Phillipine Cancer Society, Manila, Philippines. fax 63 2 734 21 28; email: pcsi@uplink.com.ph

The 18th UICC Cancer Congress

will take place in Oslo, Norway, 30 June-5 July 2002. *For information contact:* email: congrex@congrex.ch.

The 12th International Conference on Cancer Nursing

will take place in London, UK, 28 August-1 September 2002. *For information contact:* Emap Healthcare Events, Greater London House, Hampstead, London NW1 7EJ, UK. email: conference.healthcare@emap.com