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Barriers to Breast Cancer Screening Engagement and Early Intervention Among Black African Women in the United Kingdom

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ABSTRACT

Background: Black African women in the UK have one of the lowest breast cancer screening uptake rates of any ethnic group and are disproportionately diagnosed with late-stage disease. Identifying barriers to screening engagement is essential for developing equitable public health interventions.

Methods: A rapid literature review was conducted across PubMed/MEDLINE, EBSCO, Scopus, and Google Scholar, supplemented by CrossRef and institutional repositories, covering 2015 to 2025. Inductive thematic synthesis was employed to identify barriers, evaluate theoretical frameworks, and appraise intervention strategies. PRISMA was adapted for the rapid review, which was conducted by a single reviewer; the absence of dual screening is acknowledged as a limitation.

Results: Thirty-one studies and reports met our inclusion criteria. 6 intersecting barriers were identified: limited awareness, cultural and religious beliefs, health care distrust, fear of partner abandonment, cancer stigma, and socioeconomic inequalities. The Health Belief Model and Social Practice Theory were the most applicable frameworks. Available evidence suggests that culturally tailored education, community-based screening, peer support, and patient navigation may improve screening engagement; findings should be interpreted cautiously given the qualitative and observational nature of the evidence base.

Conclusion: The barriers facing black African women are intersectional, requiring multilevel, codesigned community interventions. Comparable barriers are documented among black African diaspora communities in Canada and the US. High-quality primary research specifically targeting black African women as a distinct population is urgently needed.

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INTRODUCTION

Breast cancer is the most prevalent cancer among women globally, reported by the World Health Organization (WHO) as the leading cancer in women across 157 of 185 countries, with approximately 670 000 deaths occurring worldwide in 2022.^{1,2} In the United Kingdom (UK), breast cancer remains the most common cancer in women, with approximately 55 000 new cases diagnosed annually and around 11 500 deaths each year, ie, 1 death every 45

minutes.^{2,3} Survival rates have improved significantly, with 9 of 10 women now surviving 5 or more years following diagnosis, largely due to early detection through the NHS Breast Screening Programme (NHSBSP), which has been operational since 1988.^{2,4} However, these gains have not been shared equally across all populations.

Black African women in the UK experience a persistent and well-documented pattern of inequality in breast cancer outcomes. The overall breast cancer incidence is lower in black African women than in white British women, with an age-standardized incidence rate of 118.2 per 100 000 in black African women compared with 199.6 per 100 000 in white

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women across England between 2011 and 2019.⁵ However, black African and black Caribbean women are up to twice as likely to receive a late-stage, high-grade diagnosis compared with white women.^{6,7} Breast Cancer Now reports that 25% of black African women are diagnosed with late-stage breast cancer in England, compared with only 13% of white women.³ This substantially elevated risk of advanced presentation carries critical implications for treatment intensity, quality of life, and mortality outcomes.^{6,7}

Screening attendance is a central driver of this disparity. Jack *et al.*⁸ reported that only 49% of black African women in London attended their routine NHSBSP recall appointments, compared with 78% of white British women. This screening gap persists despite the NHSBSP being universally available and free at the point of access, indicating that structural provision alone is insufficient to address the barriers black African women face.^{3,8} The UK Government's 2024 guidance on breast screening inequalities further acknowledges this gap and calls for targeted action.⁹

Previous reviews of cancer screening barriers in the UK have largely aggregated data across broad black, Asian, and minority ethnic (BAME) groupings, which risks obscuring the specific barriers faced by black African women as a distinct population with unique cultural, linguistic, religious, and socioeconomic characteristics.^{10,11} A 2025 systematic review by Aliu *et al.*¹⁰ explicitly identified this aggregation as a methodological limitation and called for population-specific research. Bolarinwa and Holt¹¹ similarly noted that BAME aggregation limited population-specific conclusions in their 2023 mixed-methods systematic review. The present rapid literature review directly addresses this gap by focusing exclusively on black African women as a distinct population subgroup, incorporating the most current evidence through 2025—including sources beyond the search windows of both prior reviews—and appraising evidence-based intervention strategies, an area identified as underdeveloped by Aliu *et al.*¹⁰ The aim is to synthesize evidence on barriers to breast cancer screening engagement among black African women in the UK, evaluate applicable theoretical frameworks, and appraise intervention strategies to inform public health practitioners, NHS commissioners, policymakers, and researchers.

METHODS

Study design

A rapid literature review was conducted to synthesize evidence on barriers to breast cancer screening engagement among black African women in the UK. Rapid reviews are a recognized and well-

established method of evidence synthesis that applies systematic search principles while streamlining the full systematic review process; they are particularly appropriate for under-researched population subgroups where the available literature base does not support a comprehensive quantitative meta-analysis.¹² A full systematic review was not conducted for the following reasons: the under-researched and heterogeneous nature of this population subgroup made methodological streamlining appropriate; the need to incorporate gray literature alongside empirical sources to address evidence gaps favored rapid review over a traditional systematic approach. In addition, rapid review methodology enabled timely synthesis of the most current evidence given the recent publication of 2 most recent systematic reviews on this topic.^{10,11} The specific streamlining shortcuts employed in accordance with rapid review methodology included the following: single-reviewer screening without dual independent verification, informal rather than formal risk-of-bias appraisal, and a streamlined rather than exhaustive search strategy. It should be noted that the absence of meta-analysis is not a justification for this design choice, as systematic reviews do not require meta-analysis; the choice of rapid review reflects the methodological considerations described above. The trade-off is that rapid reviews involve streamlined screening and do not routinely apply formal risk-of-bias tools. This is acknowledged as a limitation throughout the study. This review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), adapted for rapid review methodology.¹² Structured searches were conducted in 2024 to 2025.

Search strategy

Structured searches were conducted across PubMed/MEDLINE, EBSCO, Scopus, and Google Scholar, supplemented by CrossRef and institutional repositories including NHS England, Breast Cancer Now, Cancer Research UK, the Joseph Rowntree Foundation, the Race Equality Foundation, and UK Government publications. The following search string was applied and adapted to each database's syntax: ("breast cancer" OR "breast neoplasm") AND ("barriers" OR "obstacles" OR "challenges") AND ("Black African women" OR "Black women" OR "BAME") AND ("United Kingdom" OR "England" OR "UK").

Duplicate records were identified and removed through manual cross-referencing of search results across databases, supported by Zotero reference management software; approximately 428 duplicate records were removed prior to screening. MeSH terms incorporated into the PubMed/MEDLINE search included "Breast Neoplasms," "Mass



Screening," "Healthcare Disparities," "Black or African American," and "United Kingdom," combined with free-text terms to maximize sensitivity. Searches covered primarily 2015 to 2025; pre-2015 studies were included where they

introduced a theoretical framework applied in this review, represented landmark studies on breast cancer screening disparities in black women, or provided methodological justification for approaches used here.¹³ Full search details are provided in Table 1.

Table 1. Databases Searched, Search Strings Applied, and Results Retrieved

Database	Search string applied	Date of search	Results retrieved
PubMed/MEDLINE	("breast cancer" OR "breast neoplasm") AND ("barriers" OR "obstacles" OR "challenges") AND ("Black African women" OR "Black women" OR "BAME") AND ("United Kingdom" OR "England" OR "UK")	2024–2025	312
EBSCO (CINAHL, PsycINFO, Academic Search Premier)	("breast cancer" OR "breast neoplasm") AND ("barriers" OR "obstacles" OR "challenges") AND ("Black African women" OR "Black women" OR "BAME") AND ("United Kingdom" OR "England" OR "UK")	2024–2025	287
Scopus	TITLE-ABS-KEY("breast cancer" OR "breast neoplasm") AND ("barriers" OR "obstacles") AND ("Black African women" OR "Black women" OR "BAME") AND ("United Kingdom" OR "England")	2024–2025	198
Google Scholar	"breast cancer screening" AND "barriers" AND ("Black African women" OR "Black women") AND "United Kingdom"	2024–2025	approximately 210 (first 10 pages reviewed)
CrossRef	"breast cancer" AND "barriers" AND "Black women" AND "UK"	2024–2025	94
Institutional repositories (NHS England, Breast Cancer Now, Cancer Research UK, Joseph Rowntree Foundation, Race Equality Foundation, UK Government)	Targeted hand-searches of institutional websites and publication catalogs using keywords: breast cancer screening, ethnicity, Black African women, health inequalities, UK	2024–2025	47
Total records identified			approximately 1148

BAME, black, Asian, and minority ethnic.

Google Scholar results are approximate as the platform does not provide exact result counts. Institutional repository searches were conducted via targeted hand-searching of organizational publication catalogs. Search strings were adapted to each database's syntax where required while maintaining consistent conceptual coverage.

Inclusion and exclusion criteria

Studies and reports were included if they were published in English; addressed breast cancer screening or early detection barriers; involved black African women, black Caribbean women, or BAME populations in the UK; and were published primarily between 2015 and 2025, or were foundational pre-2015 sources. The population scope was informed by the eligibility frameworks used in the 2 most recent systematic reviews on this topic.^{10,11} Where studies included black Caribbean women or broader BAME populations, findings were disaggregated by subgroup where reported; where subgroup data were unavailable, BAME-level findings were interpreted with caution regarding applicability to black African women specifically, consistent with the

recommendation of Aliu *et al.*¹⁰ Studies focused exclusively on non-UK settings were excluded unless foundational to the theoretical or intervention framework applied. Gray literature was included where peer-reviewed evidence was limited, consistent with rapid review methodology.¹² Full criteria and study selection flow are presented in Table 2 and Figure 1.

Data extraction and synthesis

Thematic synthesis, as described by Thomas and Harden¹⁴, was employed following their 3-stage process: (1) free line-by-line inductive coding of findings extracted from the full texts of all included sources (coding was performed on full texts, not solely on abstracts or summaries); (2) organization of



codes into descriptive themes; and (3) generation of analytical themes representing the 6 barrier categories. Data extracted from each source included study design, population characteristics, sample size, setting, identified barriers, theoretical frameworks, and intervention strategies, using a standardized extraction table (see Table 4). Descriptive synthesis was used rather than quantitative meta-analysis, given the predominantly qualitative and narrative evidence base.^{12,14}

Different source types were weighted accordingly: qualitative and mixed-methods studies for lived experience and sociocultural barriers; quantitative studies and systematic reviews for epidemiological and outcomes data; and gray

literature for structural and policy context. Where systematic reviews were included alongside constituent primary studies, systematic reviews served as the primary synthesis source, with primary studies used only to supplement findings not captured within them. Study quality was assessed informally against 4 criteria: population relevance to black African women specifically; methodological rigor; currency of evidence; and source credibility. A formal tool such as the Mixed Methods Appraisal Tool (MMAT) was not applied, and this is acknowledged as a limitation in this study. The findings from lower-rigor sources are interpreted with appropriate caution throughout.

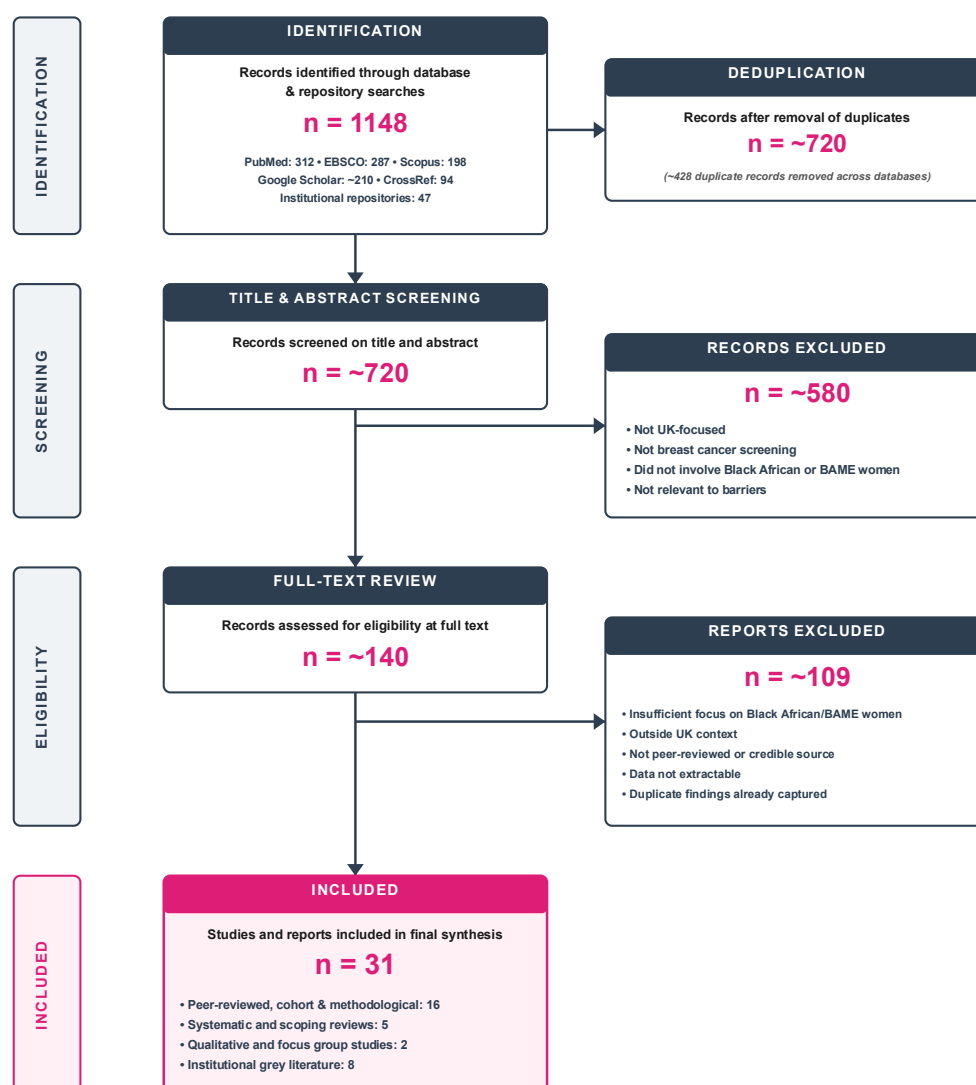


Figure 1. Study selection flow diagram for the rapid literature review

Note: Approximate record counts at each stage reflect the streamlined nature of rapid review methodology. Exact counts varied slightly across iterative search updates conducted between 2024 and 2025. Google Scholar results were screened by reviewing the first 10 pages of the results (approximately 100 records) given the platform's lack of systematic export functionality. The selection process was conducted by the single author; rapid reviews do not typically require dual independent screening (Tricco *et al.*, 2015). Adapted from PRISMA 2020 (Page *et al.*, 2021).

Table 2. Inclusion and Exclusion Criteria Applied During Study Selection



Inclusion criteria	Exclusion criteria
Published in English	Not published in English
Published primarily between 2015 and 2025 (foundational pre-2015 studies included where clearly relevant)	Published before 2015 (unless foundational theoretical or landmark empirical study)
Addresses breast cancer screening, early detection, or mammography uptake	Focused exclusively on treatment, survivorship, or non-breast cancers without reference to screening
Involves black African women, black Caribbean women, or BAME populations in the United Kingdom	Focused exclusively on non-UK settings with no applicability to the UK context
Peer-reviewed articles, systematic reviews, qualitative studies, mixed-methods studies, or gray literature from credible institutional sources	Conference abstracts, editorials, opinion pieces, or student dissertations without peer review
Gray literature from NHS bodies, government health departments, cancer charities, or established research foundations where peer-reviewed evidence is limited	Sources from non-credible or non-verifiable outlets; predatory journal publications

Gray literature was included where peer-reviewed evidence on specific topics was limited, in accordance with rapid review methodology (Tricco et al., 2015). All gray literature sources were assessed for credibility, institutional authority, and relevance before inclusion.

RESULTS

Overview of the included literature

A total of approximately 1148 records were identified through database and repository searches. Following deduplication (approximately 720 unique records), title and abstract screening (approximately 580 excluded), and full-text review (approximately 109 excluded), 31 studies and reports were included in the final synthesis. The full study selection flow is presented in the Appendix (Figure A1). Thirty-one studies and reports met our inclusion criteria, comprising peer-reviewed quantitative, qualitative, and mixed-methods studies; systematic and scoping reviews; focus group studies; and institutional reports. Sources are distinguished throughout as follows: empirical peer-reviewed studies and reviews are cited by author and year; institutional and gray

literature reports are identified by organization and year. The majority were published between 2017 and 2025. Key primary sources included the 2025 systematic review by Aliu *et al.* in *Psychooncology*,¹⁰ which represents the most comprehensive systematic synthesis of barriers to breast cancer screening among women of black African and black Caribbean descent in the UK to date; the 2023 mixed-methods systematic review by Bolarinwa and Holt in *BMC Health Serv Res*,¹¹ and the qualitative focus group study by Marcu *et al.*¹³ Institutional data were drawn from Breast Cancer Now,³ Cancer Research UK,¹⁵ the Joseph Rowntree Foundation,¹⁶ the UK Government's breast screening inequalities guidance,⁹ and the Race Equality Foundation.¹⁹ A summary of all included studies is provided in Table 3.

Table 3. Comprehensive summary of all 31 studies and reports included in the rapid literature review

Author(s) and year	Study design	Population	Setting	Key barriers identified
Aliu <i>et al.</i> (2025)	Systematic review (n = 28 studies)	Black African and Caribbean women	UK	All 6 barriers; intervention strategies; persistent screening gap
Bolarinwa & Holt (2023)	Mixed-methods systematic review	BAME women (UK)	UK	Awareness, distrust, cultural beliefs, socioeconomic barriers
Marcu <i>et al.</i> (2022)	Qualitative focus groups (n = 22)	Black African and Caribbean women	UK	Awareness, stigma, cultural norms; intervention adaptation priorities
Jack <i>et al.</i> (2014)	Population-based cohort study	Women from ethnic groups (London)	London, UK	Screening uptake 49% black African vs 78% white British
Jones <i>et al.</i> (2014)	Systematic review (n = 11 studies)	Black women (UK)	UK	Awareness, partner fear, risk perception, health care distrust
Gathani <i>et al.</i> (2026)	Population-based cohort (n = 329 500+)	Women by ethnicity (England)	England	Incidence rates by ethnicity; lower incidence but later stage in black women
Bamidele <i>et al.</i> (2017)	Qualitative interviews	Black African women (UK)	UK	Awareness deficits; premigration lack of cancer education
El Turabi <i>et al.</i> (2013)	National survey analysis (n = 70 000+)	Cancer patients by ethnicity	England	Poor shared decision-making; health care distrust
Martins <i>et al.</i> (2022)	Population cohort (n = 190 000+)	Cancer patients by ethnicity (UK)	England	Ethnic inequalities in routes to cancer diagnosis; stigma



Estupinán <i>et al.</i> (2023)	Scoping review protocol	Intersectional populations (cancer)	International /UK	Intersectional stigma: race, gender, migrant status, cancer diagnosis HBM-based education improves screening knowledge and uptake
Abu Abed <i>et al.</i> (2025)	Systematic review of HBM interventions	Women (mammography)	International	
Kiemen <i>et al.</i> (2023)	Systematic review (n = 73 studies)	Cancer patients and communities	International	Peer support effective for screening behavior and cancer outcomes 22% uptake among previously non-attending women post community outreach
Onyedum <i>et al.</i> (2025)	Community intervention study	Black African women (non-attenders)	Wolverhampton, UK	
WHO (2024) ²	Institutional report	Global women	International	Breast cancer leading cancer in women globally; 670 000 deaths 2022 25% black African women diagnosed late-stage vs 13% white; 49% vs 78% NHSBSP attendance
Breast Cancer Now (2024) ³	Institutional report/compendium	UK women with breast cancer	UK	
NHS England (2024) ⁴	Institutional guidance	UK women aged 50-70	UK	NHSBSP structure, eligibility, and universal access provisions Black African and Caribbean women up to twice as likely for late-stage diagnosis; ethnicity and risk overview
Breast Cancer UK (2025) ⁶	Institutional report	UK women by ethnicity	UK	
Bower <i>et al.</i> (2001) ⁷	Clinical commentary	Black women (UK)	UK	Advanced breast cancer presentation in black women; foundational evidence of late-stage diagnosis disparity Geographic, transport, linguistic, and structural barriers to breast screening; priority action areas
UK Government (2024) ⁹	Policy/guidance document	UK women	UK	
Tricco <i>et al.</i> (2015) ¹²	Scoping review of methods	Rapid review methodology	International	Rapid review methods justified for under-researched populations; gray literature inclusion appropriate; single-reviewer design acceptable 3-stage thematic synthesis method described: free coding, descriptive themes, analytical themes
Thomas & Harden (2008) ¹⁴	Methodological paper	Qualitative research synthesis	International	
Niksic <i>et al.</i> (2016) ¹⁵	Cross-sectional survey	General population by ethnicity	England	Cancer symptom awareness lowest in black African group (n = 38 492); ethnic minority women twice as likely to lack warning sign knowledge 42% of black African households in UK poverty 2019/20–2021/22; highest poverty rate of any ethnic group
Joseph Rowntree Foundation (2024) ¹⁶	Institutional poverty report	UK households by ethnicity	UK	
Ogedegbe <i>et al.</i> (2005) ¹⁸	Qualitative focus groups	Minority women in community health centers	US (applicable to UK)	Cancer perceived as spiritual punishment; fatalistic beliefs; fear of diagnosis driving screening avoidance Insufficient NHS diversity training; negative cancer care experiences; health care distrust rooted in poor communication
Fazil (2018) ¹⁹	Institutional report	BME communities (UK)	UK	
Vrinten <i>et al.</i> (2019) ²¹	Population-based survey	General population (England)	England	Cancer stigma independently associated with lower screening attendance (n = 1916); more prevalent in ethnic minority individuals Profound discomfort in discussing cancer; community taboos; black African women specifically identified as underserved
Macmillan Cancer Support (2013) ²³	Mixed-methods institutional research	BME people affected by cancer	UK	
Burgard <i>et al.</i> (2009) ²⁵	Longitudinal survey	US workers (applicable)	US	Precarious employment independently associated with lower preventive health care engagement including cancer screening (n = 1774)



Green <i>et al.</i> (2020) ²⁶	Book chapter/encyclopedia	Health behavior theory	International	Health Belief Model 5 constructs: perceived susceptibility, severity, benefits, barriers, cues to action
Abu Abed <i>et al.</i> (2025) ²⁷	Systematic review of HBM interventions	Women (mammography)	International	HBM-based educational interventions associated with improvements in screening knowledge, attitudes, and intentions
Shove <i>et al.</i> (2012) ²⁸	Theoretical book	Social practice theory	International	Social Practice Theory: materials, meanings, competences as structural determinants of health behavior
Lubi <i>et al.</i> (2021) ²⁹	Mixed-methods study	Women (breast cancer screening)	Estonia (applicable)	SPT applied to breast screening non-participation; habitual, practical, and emotional elements determine screening decisions

BAME: Black, Asian and Minority Ethnic. HBM: Health Belief Model. This table presents the most influential primary sources contributing to the thematic synthesis. Institutional grey literature sources (Breast Cancer Now 2024, Cancer Research UK 2023, Joseph Rowntree Foundation 2024, UK Government 2024, Race Equality Foundation 2018) are not included in this table but are cited in the main manuscript where referenced.

Epidemiological context

The epidemiological profile of breast cancer among black African women in the UK is characterized by a paradox: lower overall incidence but substantially worse outcomes at the point of diagnosis. Gathani *et al.*⁵ reported an age-standardized incidence rate of 118.2 per 100 000 in black African women compared with 199.6 per 100 000 in white women across England between 2011 and 2019, based on data from over 329 500 women. Despite this lower incidence, black African women disproportionately present with late-stage, triple-negative, or high-grade tumors that are associated with significantly worse prognoses and reduced treatment options.^{6,7,10} Breast Cancer Now reports that this population is 40% more likely to be diagnosed at stage III or IV compared with white British women.³ Jack *et al.*⁸ found that only 49% of black African women in London attended their routine NHSBSP recall appointments, compared with 78% of white British women. The 2025 systematic review by Aliu *et al.*¹⁰ confirmed that these attendance and outcomes disparities persist nationally and have not meaningfully narrowed over the preceding decade.¹⁰

Barriers to breast cancer screening engagement

Six principal intersecting barriers were identified through thematic synthesis across the 31 included sources. These barriers operate at individual, family, community, and systemic levels and are not mutually exclusive. They interact and reinforce each other to produce a cumulative pattern of screening exclusion.^{10,11} Table 4 provides a summary of each barrier with key supporting evidence and public health implications.

Barrier 1: Limited awareness and risk perception

Limited awareness of breast cancer risk and screening is consistently the most frequently cited barrier across the included literature.^{10,11} Bamidele *et al.*¹⁷ found that most black African women in England reported first becoming aware of breast cancer only after migrating to the UK, having received minimal health education on the topic in their countries of origin. Jones *et al.*¹, in a systematic review of 11 studies, found that black African women consistently reported low perceived personal cancer risk, frequently describing breast cancer as a “white woman's disease.”¹ Marcu *et al.*¹³ confirmed in UK-based focus groups that unawareness and the perception of breast cancer as a disease affecting other populations were among the primary factors associated with lower mammographic screening uptake.¹³ Niksic *et al.*¹⁵, in a large national study of 38 492 people using the Cancer Research UK Cancer Awareness Measure, found that awareness of cancer symptoms was significantly lower in ethnic minority groups than white participants, with black Africans among those with the lowest awareness of cancer warning signs.¹⁵ Bolarinwa and Holt¹¹ confirmed that awareness deficits are compounded by low health literacy and limited access to health information in appropriate languages.¹¹

Barrier 2: Cultural and religious belief systems

Cultural norms and religious beliefs within black African communities substantially and independently shape attitudes toward breast cancer screening.^{10,11,13} Bamidele *et al.*¹⁷ found, in focus groups with black African women in Luton, that cancer was frequently perceived as caused by witchcraft or evil spirits, with women reporting they sought spiritual healing rather than medical intervention, as discussing or treating



cancer through biomedicine was seen as attracting or confirming the condition.¹⁷ Aliu *et al.*¹⁰ further documented that many black African women prioritized faith-based healing over medical intervention, with divine healing culturally positioned above biomedical approaches to health within these communities.¹⁰ Macmillan Cancer Support documented profound and widespread discomfort among black and minority ethnic respondents in

discussing cancer with health care providers, family members, or community peers, reinforcing cultural taboos that prevent help-seeking behavior.²³ The 2025 systematic review by Aliu *et al.*¹⁰ confirmed that religious beliefs and cultural taboos constitute a distinct barrier cluster, and noted that these influences are masked when BAME groups are aggregated in research and policy.¹⁰

Table 4. Summary of Barriers to Breast Cancer Screening Engagement Among Black African Women in the United Kingdom, With Key Evidence and Public Health Implications

Barrier	Key evidence and citations	Public health implication
1. Limited awareness and risk perception	Black African women consistently reported low personal cancer risk perception, describing breast cancer as a “white woman’s disease” ²¹ ; breast cancer perceived as a “Western disease” ^{13,17} ; ethnic minority women nearly twice as likely to lack knowledge of warning signs ¹⁵ ; unawareness as the most prevalent barrier in qualitative studies. ^{10,11}	Culturally sensitive awareness campaigns codesigned with communities; community champions and trusted messengers
2. Cultural and religious belief systems	Faith healing prioritized over medical care ^{10,18} ; cancer perceived as spiritual punishment ¹⁸ ; religious fatalism associated with avoidance of diagnosis ¹⁰ ; taboos around cancer discussion normalized. ^{23,24}	Engage faith leaders and places of worship; incorporate religious sensitivity in all outreach design
3. Distrust of the health care system	39% of black respondents rated cancer care positively vs 57% of white respondents ²⁰ ; poor shared decision-making experiences ²⁰ ; historical and systemic inequities driving institutional mistrust ^{10,11} ; limited diversity in NHS workforce. ¹⁹	Mandatory cultural competency training for NHS providers; improve patient-provider communication and representation
4. Fear of partner abandonment and lack of family support	Unsupportive partners significantly linked to lower screening attendance ^{1,10} ; fear of loss of femininity following diagnosis ¹¹ ; emotional responses including anxiety and relationship concerns as consistent barriers. ¹⁰	Family-inclusive interventions; peer support networks for black African women
5. Cancer-related stigma	Cancer stigma significantly associated with lower screening attendance and more prevalent in ethnic minority communities ²¹ ; black people significantly more likely to be diagnosed through emergency routes, indicating low screening engagement ²² ; profound community taboo around cancer ^{23,24} ; intersectional stigma linked to race, gender, migrant status. ¹⁰	Community-based destigmatization campaigns; open dialogue promoted within black African communities
6. Socioeconomic inequalities and competing priorities	42% of black African households in UK facing poverty between 2019 and 2022 ¹⁶ ; competing employment and household priorities limit appointment flexibility ¹¹ ; precarious employment associated with lower preventive care ²⁵ ; geographic, transport, and linguistic access barriers. ⁹	Free, flexible, geographically accessible community-based screening; structural financial barriers must be addressed

Numbers in superscript correspond to the reference list. NHSBSP: National Health Service Breast Screening Programme.

Barrier 3: Distrust of the health care system

Health care distrust among black African women in the UK is well-documented and rooted in both historical and contemporary experiences of racial inequity within health care systems.^{10,11,20} El Turabi *et al.*²⁰, analyzing data from the National Cancer Patient Experience Survey of over 70 000 cancer patients, found that only 39% of black respondents rated their overall cancer care positively, compared with 57% of white respondents, and that ethnic minority patients had significantly poorer experiences of shared decision-making compared with white patients.²⁰ Bolarinwa and Holt¹¹ confirmed that poor patient-provider communication, a perceived lack of empathy

from health care professionals, and insufficient NHS cultural competency training collectively were consistently identified as factors associated with institutional mistrust among black African women.¹¹ Aliu *et al.*¹⁰ further identified that mistrust is not only interpersonal but also systemic, rooted in structural racism within NHS cancer services, and called for organizational-level intervention.¹⁰

Barrier 4: Fear of partner abandonment and lack of family support

The role of intimate partners and family networks in shaping screening decisions is a distinctive feature of the evidence on black African women in the UK.^{1,10}



Jones *et al.*¹ identified fear of partner abandonment, based on the expectation that a cancer diagnosis would result in relationship dissolution or reduced desirability as a partner, as a notable and specific barrier to early breast cancer presentation among black women in the UK.¹ This fear was associated with avoidance of screening because a diagnosis might be avoided if no test were performed.^{1,10} Aliu *et al.*¹⁰ reported that black women who perceived their partners as unsupportive of cancer screening attendance were less likely to attend mammography appointments, and that emotional responses, including anxiety about the impact of diagnosis on family roles and intimate relationships, were consistent barriers across multiple included studies.¹⁰ Bolarinwa and Holt¹¹ confirmed that low levels of social support from family and community peers further compounded this barrier, particularly among recently arrived black African immigrant women.¹¹

Barrier 5: Cancer-related stigma

Cancer-related stigma operates as both a structural and social barrier to screening engagement among black African women in the UK.^{10,11,24} Vrinten *et al.*²¹, in a population-based survey of 1916 adults in England, found that cancer-related stigma was independently associated with lower cancer screening attendance, and that stigma was more prevalent among individuals from minority ethnic backgrounds, constituting an independent barrier to participation across multiple cancer types.²¹ Martins *et al.*²², in a population-based UK cohort study of over 190 000 patients, confirmed that black people in England are disproportionately more likely to be diagnosed with cancer through emergency routes compared with white people, indicating lower prior engagement with cancer screening pathways, though the causal relationship between stigma and this pattern requires cautious interpretation given the observational study design.²² Macmillan Cancer Support's report on BME cancer experiences documented profound and widespread discomfort among respondents, including black African women, in discussing cancer diagnosis, treatment, or screening with health care providers, family members, or community members.²³ Aliu *et al.*¹⁰ confirmed that black African women face compounded and mutually reinforcing stigmatization arising simultaneously from their race, gender, migrant status, and cancer diagnosis, an intersectional pattern of stigma that operates as a distinct barrier cluster independent of other identified barriers.¹⁰ Aliu *et al.*¹⁰ confirmed stigma as a consistent, cross-cutting barrier across all included studies in their 2025 systematic review.¹⁰

Barrier 6: Socioeconomic inequalities and competing priorities

Socioeconomic deprivation and structural access barriers constitute a pervasive and compounding barrier to breast cancer screening among black African women in the UK.^{10,11,16} The Joseph Rowntree Foundation's UK Poverty report found that 42% of black African households in the UK lived in poverty between 2019/20 and 2021/22, a rate substantially higher than the national average, making black African women among the most economically disadvantaged ethnic groups in the UK.¹⁶ Bolarinwa and Holt¹¹ confirmed that many black and ethnic minority women face competing socioeconomic priorities, including precarious and inflexible employment, childcare responsibilities, and household financial pressures, that severely limit the flexibility required to attend daytime health care appointments.¹¹ Burgard *et al.*²⁵ confirmed that precarious employment status was independently associated with lower rates of preventive health care engagement, including cancer screening.²⁵ The UK Government's 2024 guidance on breast screening inequalities identified geographic distance to screening facilities, long NHS waiting times, transport difficulties, and linguistic barriers within health care settings as additional structural access barriers.⁹ Bolarinwa and Holt¹¹ confirmed that these socioeconomic and structural factors compound other barriers, particularly for recently arrived black African immigrant women with limited English proficiency.¹¹

Theoretical frameworks for intervention design

Two theoretical frameworks are most applicable for understanding and addressing the identified barriers among black African women. The Health Belief Model (HBM), first developed by Rosenstock in the 1950s and refined by Becker and colleagues, proposes that health behavior is governed by 5 core constructs: perceived susceptibility to a condition, perceived severity of a condition, perceived benefits of acting, perceived barriers to action, and cues to action.²⁶ A 2025 systematic review by Abu Abed *et al.*²⁷ specifically examining HBM-based interventions for mammographic screening found that HBM-based educational interventions were associated with improvements in knowledge of, attitudes toward, and intentions to attend breast cancer screening across diverse populations.²⁷ Applied to black African women in the UK, the HBM identifies low perceived susceptibility, the “this doesn't affect me” belief, as the most proximal intervention leverage point, requiring targeted awareness-building before promoting the tangible benefits of screening.^{28,29}



Social Practice Theory (SPT), as conceptualized by Shove *et al.*²⁸, offers a complementary structural lens. SPT examines how health behaviors are embedded within social structures through the integration of 3 elements: materials (physical and structural resources such as screening facilities and transport), meanings (cultural values, symbolic associations, and social norms), and competences (knowledge, skills, and ability to navigate health systems).²⁸ Lubi *et al.*²⁹, in a study explicitly applying Social Practice Theory to breast cancer screening non-participation, confirmed that habitual, practical, and emotional elements of social practice, not merely individual attitudes, determine screening decisions, validating SPT as a structural framework for intervention design in diverse populations.²⁹ Applied to black African women in the UK, SPT draws attention to the simultaneous material, meaning, and competence barriers that must be addressed together, rather than in isolation, for interventions to succeed.^{29,30} Neither the HBM nor SPT is sufficient alone; together they provide complementary individual and structural perspectives for intervention design.^{28–31}

Evidence-based intervention strategies

Culturally tailored education and community outreach

Marcu *et al.*¹³ conducted UK-based focus groups with 22 women of black African and Caribbean descent to identify priorities for adapting existing breast cancer awareness interventions. Participants identified 5 core adaptations: justifying the specific focus on black women; acknowledging that black communities typically do not openly discuss cancer; illustrating how breast cancer symptoms manifest on darker skin tones; involving black community members in designing and delivering the intervention; and addressing the emotional and social consequences of diagnosis.¹³ Aliu *et al.*¹⁰ reported that community health education workshops specifically designed and delivered by and for black women were associated with improvements in both screening knowledge and attendance outcomes.¹⁰ This was the most consistently supported approach across included studies, though the authors noted the evidence base remains largely observational and further intervention trials are needed.¹¹

Community-based and mobile screening

Community-based screening brings mammographic services directly into communities, eliminating transport, appointment flexibility, and cultural access barriers.^{10,11} A 2025 UK-based community intervention in Southeast Wolverhampton demonstrated a 22% screening

uptake among black African women who had previously not attended their NHSBSP recall appointments, following targeted community outreach delivered through trusted community spaces.³⁰ Although this rate remained below the NHS minimum 70% target, it represented a meaningful and statistically significant improvement for a previously non-attending cohort.³⁰ The UK Government's 2024 guidance explicitly supports community-based screening as a priority strategy for reducing screening inequalities.⁹

Peer support and patient navigation programs

Peer support connects individuals with trained community members who share lived experience and can assist with information, emotional support, and practical navigation of health systems.³¹ Kiemen *et al.*³¹, in a systematic review of 609 identified publications (18 randomized controlled trials meeting inclusion criteria), confirmed that peer-to-peer support is associated with improvements in cancer-related health-seeking behavior, knowledge, and psychological outcomes among cancer patients and communities.³¹ Aliu *et al.*¹⁰ specifically identified peer support delivered through trusted community networks as a potentially useful strategy for reaching black African women who are disengaged from NHS breast screening services, though evidence on its effectiveness in this specific population remains limited.¹⁰

Provider cultural competency training

Health care distrust rooted in poor provider communication cannot be addressed through community-level interventions alone; systemic change within NHS institutions is also required.^{10,11,20,21} The Race Equality Foundation documented that insufficient NHS diversity training is a key driver of negative cancer care experiences reported by black African women.¹⁹ Bolarinwa and Holt¹¹ confirmed in their systematic review that poor provider communication, insufficient cultural competency training for NHS staff, and a perceived lack of empathy from health care professionals were the consistently identified barriers, and that systemic improvements in provider training are a critical and evidence-supported recommendation for reducing screening inequalities.¹¹ Aliu *et al.*¹⁰ identified improving clinician communication, representation, and cultural sensitivity as the highest-priority systemic intervention recommendation in their 2025 systematic review.¹⁰

DISCUSSION

This rapid literature review identified 6 intersecting barriers that collectively undermine



breast cancer screening engagement among black African women in the UK. The findings are consistent with, and extend, prior reviews,^{10,11} while providing a more focused analysis of black African women as a distinct population group rather than subsuming them within broader BAME aggregations. The persistent and well-documented association between late-stage breast cancer diagnosis and low screening uptake in this population^{3,5,8,10} suggests that the current NHSBSP design and outreach strategy may be insufficient to reach black African women equitably, though causal conclusions require further primary research.

A central and cross-cutting finding of this review is the deeply intersectional nature of the identified barriers. Black African women simultaneously experience compounded disadvantage arising from their race, gender, migrant status, religious identity, and socioeconomic position.^{10,24} No single barrier operates independently; they are mutually reinforcing conditions that collectively produce a pattern of systemic exclusion from cancer screening services.^{10,11} This intersectional dynamic calls for multilevel interventions that address barriers simultaneously at individual, family, community, and systemic levels, a recommendation consistent with the theoretical frameworks identified in this review.^{28–31}

The 2025 systematic review by Aliu *et al.*¹⁰ represents a pivotal and timely addition to the evidence base, confirming that no intervention has yet been specifically designed, tested, and evaluated exclusively for black African women in the UK. The intervention evidence identified in this review, supporting culturally tailored education, community-based screening, peer support, and provider training, largely derives from studies involving broader BAME populations or non-UK settings, limiting its direct applicability.^{10,11,13,30,31} Rigorous adaptation and evaluation of these approaches specifically for black African women using community-based participatory research methods and codesign principles is a priority research gap.

A critical strength of this review is its global relevance. Similar patterns of low breast cancer screening uptake, late-stage diagnosis, and intersecting sociocultural barriers have been documented among black African diaspora communities in Canada, the US, and other high-income countries.^{1,10,11} These findings may therefore have relevance to North American and broader international public health programming, though direct transferability should be assessed in context given differences in health care systems and population characteristics.

Several limitations must be acknowledged. The evidence base is dominated by studies aggregating black African women within broader BAME categories, limiting the population-specificity of conclusions.^{10,11} Many included studies rely on small or convenience samples from London and other large urban centers, which may not represent the experiences of black African women in more rural or less diverse parts of the UK.^{8,13} As a rapid review, this study did not apply formal critical appraisal tools or PRISMA-compliant systematic review methodology, which limits the formal quality appraisal of included studies.¹² Contemporary primary research specifically focused on black African women in the postpandemic UK health care context also remains scarce.

CONCLUSION

Available evidence suggests these responses should include culturally codesigned awareness campaigns, community-based screening, peer support, NHS provider training, and structural policy action, though the evidence base for each requires strengthening through rigorous primary research.

These findings suggest that age at diagnosis and patient selection criteria are relevant variables when evaluating the prevalence of p.R337H in breast cancer, particularly in the Brazilian context. Whether these findings support changes to current testing practices requires confirmation by larger multicenter studies using standardized methodologies.

ETHICAL CONSIDERATIONS

This study is a rapid literature review synthesizing previously published, publicly available data and reports. It did not involve primary data collection, human participants, personally identifiable data, animal subjects, or biological materials. As such, this study does not constitute research involving human subjects as defined under the Declaration of Helsinki. Institutional review board (IRB) approval was not required, and no informed consent was sought. All sources cited in this review are publicly accessible and have been referenced in accordance with standard academic practice.

DATA AVAILABILITY

This manuscript is a rapid literature review of previously published, publicly available studies and institutional reports. No new primary data were generated or analyzed. All sources cited are accessible online via the URLs or DOIs provided in the reference list.



CONFLICT OF INTERESTS

The author declares no competing financial or non-financial interests in relation to the work described in this article.

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AI DISCLOSURE

In preparing this manuscript, the author used Grammarly for structural formatting, literature organization, and editorial support. The author reviewed, verified, and edited all content and takes full responsibility for the accuracy, integrity, and originality of the final manuscript. All citations were independently verified by the author against original source documents. No AI tool was used to generate data, fabricate citations, or produce figures.

AUTHOR CONTRIBUTION

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