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# Barriers and Facilitators to Breast Cancer Screening Among Migrant Women Within Turkey

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## Abstract

**Aim:** The purpose of this study was to examine facilitators and barriers that migrant women in Turkey identified related to breast self-examination, clinical breast examination, and mammography. **Design:** Focus group method was conducted with 39 women. An interview guide based on the Health Belief Model (HBM) and the Health Promotion Model (HPM) was used. **Results:** Three main themes became apparent as a result of data analysis: (a) knowledge and awareness about breast cancer, (b) personal factors, and (c) medical service provider and social environment. **Conclusions:** Focus groups conducted in line with HBM and HPM were effective in explaining barriers and facilitators toward participation of women in screening behaviors. Lack of information, indifference, and cultural factors are the most important barriers of women. **Recommendations for Practice:** The study will shed light on health care professionals working in primary health care organizations for developing the health training programs and consulting strategies in order to increase breast cancer screening practices of migrant women.

## Keywords

migrant women, health belief model, breast cancer screening, Turkish women

Migration contains a broad formation since individuals can migrate from rural area to urban area, neighbor countries, or distant regions. According to the most frequently used grouping within migration classifications, migration is divided into two groups: internal and external. Whereas the term *internal migration* is used to define settlement replacement between certain areas within national boundaries, the term *external migration* defines geographical mobility to neighboring countries or distant regions (Beşer, 2012). The person whose birth place and residential place are different is considered to be a migrant (Özer, 2006).

Internal migration is an important social fact in Turkey. As a result of the rapid industrialization process, important developments regarding the socioeconomic structure in western regions of Turkey have contributed to an increase in internal migration since 1950s. For this reason, migration movements in Turkey are mostly from east to west and from rural to urban (Yıldırım, 2004). The region where the study was conducted is one of the large and developed tourism cities in Southwest Turkey and is densely populated with both internal and external migrants.

Through migration, individuals hope to have better living conditions, job opportunities, education, health care services, and cultural opportunities compared with their previous settlement. However, the fact that migrant individuals tend to have low income levels, economic difficulties, and no health insurance; live traditional lifestyles; and are usually under social and psychological stress adversely affects health conditions of this population; hence, they cannot sufficiently benefit from health care services (Fassaert, Hesselink, & Verhoeff, 2009). Migrant individuals cannot sufficiently benefit from basic health care services, and these services, required to be accessed by everyone in the society in accordance with social equality, cannot be provided to migrant individuals adequately (Hess, 2009).

Breast cancer is the most common cancer type for women living in Turkey and is the second leading cause for deaths caused by cancer (Özmen, 2008). According to data of the Ministry of Health (2013), breast cancer incidences in women have constantly increased, and in 2011, the incidence rate for breast cancer was 45.1 per 100,000 women. Incidences of breast cancer vary in different regions of Turkey due to geographic, economic, social, and cultural factors. Due to education, financial reasons, opportunities for clinical breast examination and mammography, menopause clinics, and priorities of people, breast cancer incidences in the western part of Turkey (40-50/100,000) are more than two times that in the eastern part of Turkey (20/100,000;

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Özmen, 2008). Breast cancer incidences among all women living in a large city in Southwest Turkey, which allows migrants from the eastern and other regions of Turkey, are 34.7 per 100,000 (Ministry of Health, 2010). Tumors with larger diameter and the presence of axillary lymph node involvement increase mortality rates. As a result, early diagnosis and treatment can decrease breast cancer mortality (Akyolcu & Uğraş, 2011; Cavdar et al., 2007).

For early diagnosis of breast cancer, clinical breast examination (CBE) and mammography are recommended, and breast self-examination (BSE) is deemed significant for raising awareness (Akyolcu & Uğraş, 2011; American Cancer Society [ACS], 2012]). The ACS (2012) suggests that BSE is a choice for women from the age of 20 years, and therefore health care personnel should inform women about benefits and limitations of BSE. Recommendations from breast cancer screening programs in Turkey state that women should perform BSEs every month from the age of 20 years. Moreover, women should have CBEs once every 2 to 3 years between the ages of 20 and 39 years and once every year between the ages of 40 and 69 years and a mammography once every 2 years between the ages of 40 and 69 years (Ministry of Health, 2012).

There is no study in the literature that focuses on breast cancer screening behaviors of women migrating internally; however, studies conducted on women migrating to another country concluded that screening behaviors of this group are low (Vermeer & Van den Muijsenbergh, 2010; Wu & Ronis, 2009). Although importance of early screening behaviors on breast cancer mortality is known, it is determined that the rate of BSE is 10.1% to 59.4%, the rate of CBE is 14.1% to 19.8%, and the rate of mammography is between 15.0% and 34.0% in Turkey (Çam & Gümüs, 2009; Gürsoy et al., 2011; Karayurt & Dramali, 2007).

Barriers perceived by migrated women regarding breast cancer screening behaviors include the following: lack of knowledge related to screenings, difference of priorities, nonexistence of breast cancer symptoms, lack of health insurance, fear of being diagnosed with breast cancer, lack of access to health care services, pain, and time constraints (Boxwala, Bridgemohan, Griffith, & Soliman, 2010; Clark & Natipagon-Shah, 2008; Kawar, 2009). It is an undeniable fact that cultural characteristics of women are effective in performing and sustaining early screening behaviors of breast cancer (Ersin & Bahar, 2013). Shame and fatalism among cultural factors are involved in barriers in breast cancer screening behaviors in studies conducted earlier (Clark & Natipagon-Shah, 2008; Kawar, 2009; Ogedegbe et al., 2005). When considering that women are more committed to social values and religion despite ongoing cultural changes in Turkish society, there could be taboos about exhibiting the female body. Some studies (Ersin & Bahar, 2011; Kissal & Beşer, 2011) reveal that some women consider breast and female body as private due to *traditional structure* and *religious beliefs* of Turkish society, and *shame* to be experienced as a result of examination by a male doctor is a barrier for breast cancer screenings. On the other hand, there are women indicating that gender of the doctor, male or female, is not a matter for them in terms of religion (Ersin & Bahar, 2011; Kissal & Beşer, 2011). Fatalism is another cultural factor affecting this behavior (Ersin & Bahar, 2013). Since fatalism, included in religious beliefs of Turkish society, brings in the belief that women cannot control their own health, it can be a barrier to participate in screenings.

As there are many factors affecting breast cancer screening behaviors, these variables should be considered in interventions focusing on increasing breast cancer screenings in different societies.

The Health Belief Model (HBM) is, according to the literature, the most widely used model to explain breast cancer screening behavior. Six concepts of this model interact with breast cancer screenings: sensitivity perception, severity of disease, screening advantages and barriers, cues to action, and self-efficacy (Strecher & Rosenstock, 1996). Perceived barriers are indicated to be the strongest component of the HBM. According to the model, when a barrier is perceived, individuals consider positive and negative consequences of the behavior; as a result, the person decides to take action (Champion & Skinner, 2008; Pender, Murdaugh, & Parsons, 2006). The Health Promotion Model (HPM), developed by Nola Pender, is used to explain health protection and promotion behaviors. According to the HPM, barriers perceived by individuals are important to directly and indirectly sustain health behaviors. Pender et al. (2006) indicated that perceived barriers explain 75% of behavioral change. The HBM and HPM models can be used efficiently in determining barriers for participation in breast cancer screenings. In studies conducted on women based on the HBM, physiological, psychological, educational, social, and cultural factors are effective in decreasing breast screening rates and a tendency toward early screening behavior (Boxwala et al., 2010; Lee, Tripp-Reimer, Miller, Sadler, & Lee, 2007).

Breast cancer early screening behaviors of women residing in Turkey are significantly low, and information regarding its reason is limited (Nahcivan & Secginli, 2007). A study conducted in Turkey revealed that although BSE practice frequency decreases in women having higher scores of perceived barriers, the BSE practice frequency increases in women who have higher scores of perceived sensitivity, perceived seriousness, perceived benefit, self-efficacy, and health motivation (Karayurt & Dramali, 2007). In the study conducted by Dündar et al. (2006), in Turkey, there is a positive relationship between breast cancer information and BSE benefit perception and motivation perception, and BSE practice and mammography benefit perception. Studies conducted demonstrate that knowing belief, attitudes, and knowledge of breast cancer screening will be effective in teaching and adoption of related practices (Avci & Gozum, 2009; Nahcivan & Secginli, 2007). Moreover, several studies have reported that after barriers are determined, screening

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behaviors may be increased with appropriate training (Banning, 2011; Lee et al., 2007).

Although it is important to determine barriers and facilitators in participating in breast cancer screenings, there has not yet been a study in Turkey that investigates breast cancer screening behaviors of migrant women. In this regard, this study is important since the results will reveal internal and external barriers to early detection of breast cancer in migrant women, guide education programs that will decrease screening barriers, and help migrant women benefit from screening programs. In addition, gaining insight into the factors that play a role in breast cancer screenings among migrant women can increase the number of migrant women receiving screenings.

### Purpose of the Study

The purpose of this phenomenological study is to investigate the perceived barriers and facilitators of internal migrant women with regard to BSE, CBE, and mammography within the theoretical framework of the HBM and the HPM. The study questions with regard to BSE, CBE, and mammography were the following: What screening barriers do migrant women perceive? What factors facilitate screenings for migrant women?

## Methodology

### Design and Sample

The sample group of the study consisted of women who were older than 20 years and internally migrated to the region of the Family Health Center (FHC) located in a large metropolitan area of southwestern Turkey and densely populated with migrants. Purposive sampling and snowball sampling were used to provide diversity for sample selection. Five focus groups were conducted. Two of these focus groups were conducted by using purposive sampling in two different public religious teaching courses. For the remaining three focus groups, women were selected by using snowball sampling in the determined region. A total of 39 migrant women participated in focus groups between February 8 and March 8, 2011. All the women who did not have a diagnosis of breast cancer were included in the sample group. Discussions of focus group where minimum 7 or maximum 8 people participated were carried out and recorded via camera and recorder by researcher. Each of focus groups lasted for 60 minutes on an average.

An interview guide based on HBM and HPM was used as a data collection tool. The interview guide had questions related to knowledge of breast cancer screening and barriers and facilitators of breast cancer screening behaviors. Expert opinions and recommendations about the questions were requested from two nurse academicians specialized in qualitative research. Participants were asked the following standard questions; other questions were added during interviews. Some of the questions included the following: "What are the indications of breast cancer which you know? Please explain" and "Who might be possibly under risk for cancer?" To determine knowledge and awareness about breast cancer screening behaviors, the questions included the following: "Can breast cancer be diagnosed early? How?" and "What do you think about how often screenings should be done?" To determine barriers and facilitators of breast cancer screenings, the questions included the following: "Which conditions adversely affect your ability to do your screenings?" and "In which conditions do you decide to have a screening?" Each focus group was conducted during only one session; saturation was determined when no new knowledge was elicited and sessions ended. One research assistant, as an observer, recorded the interactions. Within 1 week after each session, recorded data were transcribed into text.

### Data Analysis

Qualitative content analysis techniques were used in the study. Transcribed data were coded in such a way that it is compatible with predetermined themes and omitted themes in literature and subthemes (Strauss & Corbin, 1990). An interview coding key containing these themes and subthemes was prepared by two different researchers. Interview coding keys were compared by the researchers, issues in conflict were discussed, and a consensus was reached by making necessary modifications. As a result of organization, three main themes and subthemes under these main themes became apparent.

### Research Ethics

To conduct the study, approval and permission were obtained from the Ethics Committee of the University's School of Nursing in western Turkey and a regional health department. Written consent of participants included in the study was obtained.

## Results

### Demographic Characteristics of Participants

A total of 39 migrant women participated in five focus groups. Ages of participants were between 20 and 57 years (average = 36.97, *SD* = 9.77), 87.2% of the participants were married, and the number of children ranged from 0 to 4 (average = 2.12, *SD* = 1.17). Table 1 illustrates the demographic characteristics of the participants.

### Focus Group Themes

As a result of qualitative data analysis, three main themes related to barriers and facilitators of immigrant women and

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**Table 1.** Demographic Characteristics of Participants (*N* = 39).

| Variable | *n* (%) |
|---|---|
| Age in years | |
| 20-29 years | 11 (28.2) |
| 30-39 years | 16 (41.0) |
| >40 years | 12 (30.8) |
| Education level | |
| Literate | 7 (17.9) |
| Primary | 22 (56.5) |
| High school | 5 (12.8) |
| University | 5 (12.8) |
| Marital status | |
| Married | 34 (87.2) |
| Others (single, divorced) | 5 (12.8) |
| Number of children | |
| None | 4 (10.3) |
| 1 | 5 (12.8) |
| 2 | 19 (48.7) |
| ≥3 | 11 (28.2) |
| Insurance status | |
| Yes | 37 (94.9) |
| No | 2 (5.1) |
| Migration pattern | |
| Rural to urban | 15 (38.5) |
| Urban to urban | 24 (61.5) |
| Years of migration | |
| <10 | 19 (48.7) |
| ≥10 years | 20 (51.3) |
| The reason for migration | |
| Business (husband or herself) | 33 (84.6) |
| Climatic conditions | 3 (7.7) |
| Children's education | 3 (7.7) |

breast cancer screening behaviors emerged. The first was knowledge and awareness, the second was personal factors, and the third was medical service provider and social environment (see Figure 1).

### *Barriers in Breast Cancer Screening*

*Theme I: Knowledge and awareness of women related to breast cancer and screening behaviors*. Imperfect knowledge about breast cancer symptoms, risk factors, and breast cancer screening behaviors (BSE, CBE, and mammography) is included under the theme "knowledge and awareness of women related to breast cancer and screenings." In five focus group sessions, some participants reported that they did not participate in screening since they did not have any disease symptom and they felt healthy. One woman said, "I did not go to the doctor since I did not have any pain. If I had, I would have gone. I had no complaints"; another woman said, "I do not go to the doctor because I think I am healthy." Giving birth or breastfeeding women who did not have a family history of breast cancer perceive their risk of breast cancer to be low and therefore deem the screening unnecessary. One participant said, "Those who have a family history of breast cancer should fear, I do not. I have breastfed, I'm very good, I do not see myself as being risky." Few participants perceived their risk to be low because their breasts were small. One participant commented,

> I have not done the screening, anyway my breasts are small, nothing appears, if I have any pain in my armpits, then I will care about it. As I do not have any pain, I do not do any breast screening. If you have small breasts, the possibility of incidence of the disease is lower, right?

The majority of the participants gave different information about when and how BSE is performed. One woman said, "I did self-examination a couple of times, but I could not manage it, I can sense something with my hand but my neighbors told me not to be afraid and that it was probably mammary glands." Another woman expressed, "We do not know whether we should do self-examination before or after menstruation." Many participants made incorrect or different comments about when to conduct CBE and mammography. One woman mentioned, "Breast examination should be done by the doctor twice a year." Another woman said, "If I have pain, I go to the doctor."

*Theme II: Personal factors*. Barriers under the theme "personal factors" are indifference (being young and priorities in life), fear (facing the mass, being diagnosed with cancer, losing one's breast, and radiation), and cultural factors (shame and fatalism).

In all focus group discussions, indifference was determined to be the reason behind why many participants did not participate in screenings. One woman (31 years old) said, "Since I am young, I do not go to the doctor now; as a matter of fact, I should go. When people get to 40-50 years, they learn the value of their health." Another woman said, "Turks do not go to doctor as they are laid-back people." Yet another woman commented, "After I got married and settled here, I cannot find time for myself due to houseworks and children, I always put myself at the end, my priorities are different."

Some women who participated in the focus groups discussed fear as a barrier for participation in screenings. The women indicated fear of being diagnosed with cancer, losing breasts, and radiation. The following are some comments of the women: "We go to the doctor with fear of having any disease"; another woman said,

> Losing your breast is very bad, it will ruin your psychology. If I am diagnosed with cancer, I will be very sorry, my aunt had so, one of her breasts was taken and its appearance is very ugly. When you look at her, it catches your eyes. She uses a bra to cover it but it still appears; it creates sorrow.

Another woman said, "If I have an x-ray and there is a node, radiation will increase it."

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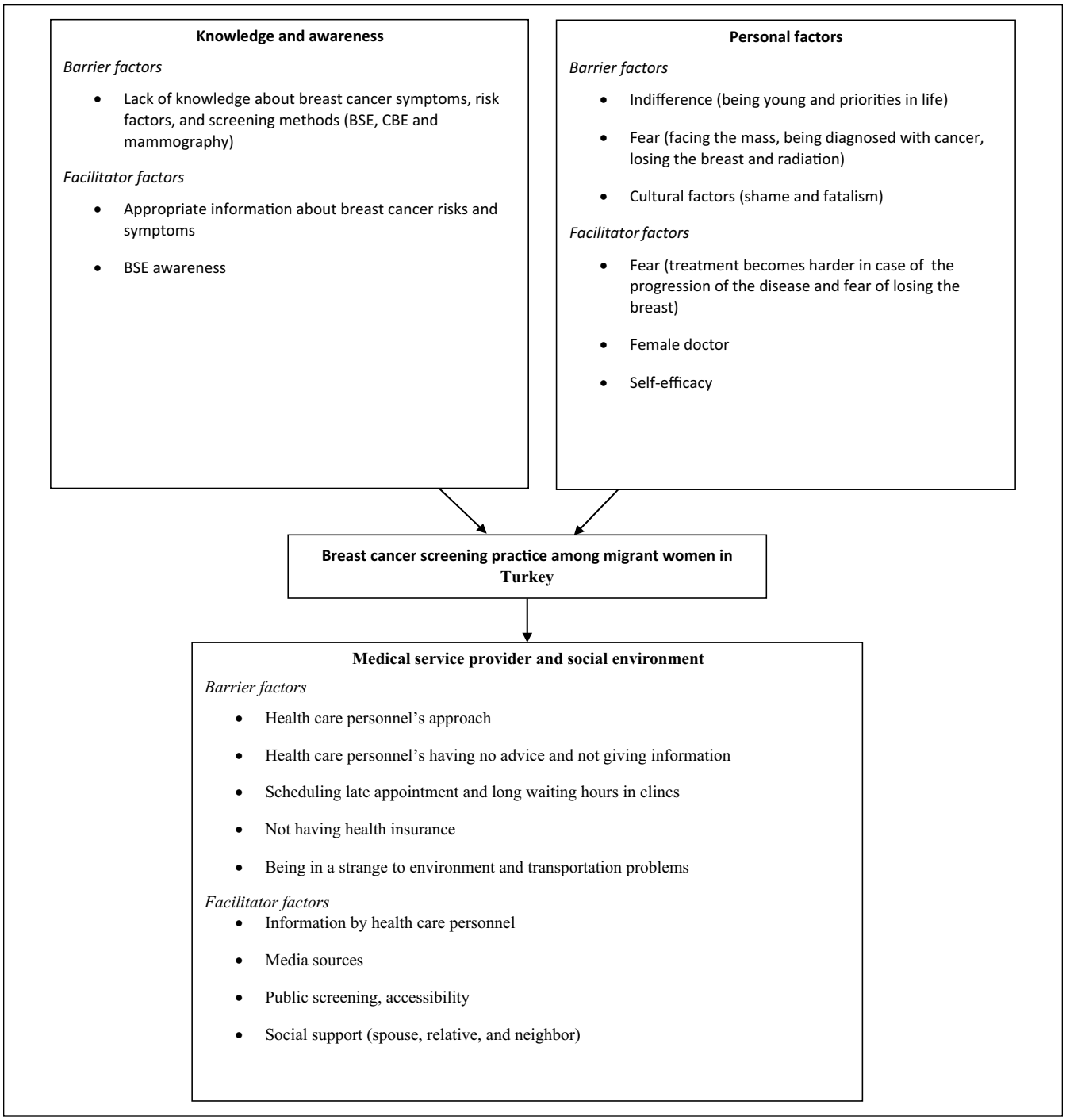



**Figure 1.** Barriers and facilitators to participation in breast cancer screening among women who migrated within Turkey: Themes and subthemes.

Some participants indicated cultural factors (shame and fatalism) as barriers to participation in screenings. They commented that they are ashamed because they perceive breasts and female body as private due to traditional lifestyle and religious belief of Turkish society and male doctors performing the examination in general. One woman said, "It is difficult to do examinations since they are sexual organs; they are not ill-gotten for doctors but it is not easy to overcome, as well. I do not go to have x-rays as I am shy." Only a few participants perceive fatalism as a barrier to screenings. Regarding fatalism, one participant said,

> I do not want to be pessimistic; I really want to think positively. If I have breast cancer, may God protect and cure me. There is

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> nothing to do, there is no vaccine for this. I cannot make my life unbearable for this.

*Theme III: Medical service provider and social environment*. The approach of health care personnel, health care personnel's having no advice about screening methods and giving no information, scheduling late appointment, long waiting hours in clinics, having no health insurance, being in a strange environment, and transportation problems are included under the main theme of medical service provider and social environment.

Within the theme of "medical service provider and social environment," participants indicated their previous experiences with health care personnel as a barrier for participating in screenings. One participant said, "We do not even know if the doctors do examination or not. They blame us of coming to the hospital and of wasting their time because we are not ill, I am ashamed for this reason." Some of the participants indicated health care personnels having no advice as a barrier to screenings. Another participant said, "I did not do screening as the doctor did not request it. I would have done it if doctors had given me the information." Another participant said, "I am living here for a year, nobody knocked on my door in terms of health, nobody informed me about screenings." Only a few participants indicated late appointment dates as a barrier for participating in screenings. One participant said,

> If you go to public hospitals, they will give you an appointment for a mammography for next month, and if you have any disease, it will naturally become worse. Why should I go to hospital if I cannot get the result right away?

Another participant mentioned, "They give you a waiting number, it is hard to wait. It is difficult to reach the doctor." A few participants defined lack of health insurance as a barrier. One woman said, "Examinations are very expensive for me. Not everyone has insurance, examinations are overpriced. I do not have health insurance." Under the theme of medical service provider and social environment, some participants indicated that being a stranger to the environment and having transportation problem are barriers. One participant said,

> I do not know where I am going. I have difficulties in finding the places and I am illiterate, if my kids come with me then there is no problem. But, they cannot come with me every time. If it is something near, I can go by myself and if not, I cannot.

### *Facilitators in Breast Cancer Screenings*

*Theme I: Knowledge and awareness of women related to breast cancer and screening behaviors*. Under the theme "knowledge and awareness related to breast cancer and screening behaviors," appropriate information about breast cancer risks and symptoms and BSE awareness is included. Women who were aware of the risk of the disease and symptoms had a positive approach to screening behaviors. Only a few participants expressed that every woman is at risk for breast cancer (these included breastfeeding women, birth-giving women, and those with a family history). One woman mentioned, "We are always under risk. Those who breastfeed their children less, those with a family history and those under stress can be in the risk group." Another woman said, "Those having the highest risk are women who do not give birth and breastfeed." The expression of another woman (with two children) was, "Since I did not breastfeed my first child, I think of myself as in the risky group."

In all of five focus groups' discussions, some women expressed breast cancer symptoms as a mass in the breast and armpit, stiffness in the breast, and nipple discharge; the women also stated that these symptoms could be identified with BSE. One woman said, "I know that a mass in the armpit, stiffness in the breast, a mass in the breast and nipple discharge are symptoms of breast cancer." Another woman said, "It is a hard and painless mass, if it is floating mass there is no need to be afraid of." One woman said, "As far as what I heard from TV and what I read from brochures distributed, we could feel the mass and masses by moving our hand roundly over our breasts while taking shower."

*Theme II: Personal factors*. Fear being examined by a female doctor and self-efficacy are facilitator factors under the theme of personal factors. Some women discuss fear as a facilitating factor because treatment becomes harder in the case of the progress of the disease and they fear losing their breasts. One woman said,

> Treatment takes a long time. You also go under surgery. I witnessed this in my environment. It is financially and psychologically too much burden for a family, its treatment is complicated, they take your breasts, you go under chemotherapy. Its treatment becomes harder in the case of the progress of the disease and other people behave like you are a half-woman if one of your breasts is taken.

Some participants expressed that having a female doctor is a facilitator to have the screening due to cultural factors and their husbands. One woman expressed, "Female genital organs and breasts are the most necessary organs for a woman, we are shy, a female doctor is necessary for examinations." Another woman said, "We need female doctors, our husbands do not allow us to be examined by male doctors." Some participants expressed "self-efficacy (having confidence in one's ability to carry out screening)" as a facilitator to screenings. One woman said, "If I have self-confidence, I will go to have screening more comfortably."

*Theme III: Medical service provider and social environment*. Under the main theme of medical service provider and social environment, information by health care personnel, media sources, public screenings, accessibility, and social support

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(spouse, relative, and neighbor) are determined to be facilitating factors for participation in screenings.

Many of the participants emphasized that they wanted to be informed by health care personnel regarding breast screenings and that this information should be detailed. They expressed that information given by doctors, nurses, and midwifes working in primary health institutions, especially in places where they reside, could increase rate of participation. Participants commented,

> Women should be comprehensively informed about breast cancer. I will attend if detailed information is given. If damages of breast cancer are told, I will go. Why and for what reason screenings are made should be explained, I will participate if it is explained whether its purpose is experimental subjects or research.

"Family doctor should also guide us. They have to tell us at which age we should have examinations. I think I will go when I come to that age." Moreover, several women expressed a desire to have more information provided by the media: "If nurses and midwifes encourage it, we can go. We are not aware. If health programs are broadcasted in TVs, it will attract women. We can learn it if doctors explain this subject on TV." Some participants defined community screenings and accessibility as a facilitating factor: "Community screenings can be done, they can encourage us. If it is near, this will encourage us since sometimes we cannot even find money for transportation." Another women said, "Transportation is a problem, you have to take taxi, if they arrange a bus from our neighborhood, it will be easier and 5-6 women could go together." A few participants expressed social support (relative, spouse, and neighbor) as facilitator for participation in screenings. One participant said, "Discussions with our neighbors encourage us, I have encouraged many of my friends to participate in screening"; another woman mentioned, "Our husbands should support us."

## Discussion

This study puts forth concepts and theoretical structures that revealed barriers and facilitators affecting participation of migrant women in breast cancer screenings. When studies in the literature related to breast cancer early screening behaviors are reviewed, there is no study investigating breast cancer early screening behaviors of women migrating internally in the world; however, there are many studies related to breast cancer early screening behaviors of external migrant women. Although internal migration and external migration have very different structures and dynamics, they show similarities in terms of experiences of women during migration (İlkkaracan & İlkkaracan, 1998); thus, studies conducted on external migrant individuals are used as a reference point in our study.

In line with information in the literature, the fact that migrant women had imperfect or incorrect information oriented to breast cancer symptoms of migrant women and risk groups caused women not to perceive themselves as being at risk for breast cancer, and thus, they did not practice screening behaviors (Azaiza & Cohen, 2008; Boxwala et al., 2010; Clark & Natipagon-Shah, 2008). Women's knowledge about breast cancer and their family history of breast cancer may also encourage them to conduct breast cancer screening (Lee et al., 2007; Ogedegbe et al., 2005).

Breast cancer screening activities in Turkey have been carried out by CEDSC(Cancer Early Diagnosis and Screening Center) established in 2006 by the Cancer Control Department for the first time. Every woman above the age of 40 years has a right to use screening services from CEDSC free of charge. However, studies conducted reveal that women do not benefit from screening services to the desired level due to low awareness of women about breast cancer and lack of knowledge about CEDSCs (Ersin & Bahar, 2011; Kissal & Beşer, 2011). It was determined that migrant women's having insufficient and incorrect knowledge related to breast cancer screening was a barrier to practice screening behaviors, which was supported in the literature (Clark & Natipagon-Shah, 2008; Kawar, 2009; Ogedegbe et al., 2005). Even though the effect of BSE is questioned, regular and correct BSE practice is important for countries extending National Screening Programs recently, such as Turkey, when considering that women (90%) approach a doctor by determining a mass in breast themselves first (Özmen, 2008). Although BSE awareness was detected as a facilitating factor in this study, another study conducted in Turkey determined that only 5% of women conducted regular BSEs (Nahcivan & Secginli, 2007). Another study conducted in Turkey emphasized that women's knowledge and awareness of breast cancer and BSE must be further developed (Cavdar et al., 2007). Information about correct BSE techniques, CBE, and mammography provided by health professionals through the media and other health education opportunities increases breast cancer screening.

In this study, indifference was the most expressed factor that inhibits screenings. Being young and priorities in life (family and work responsibility) were barriers for screening behaviors; this was compatible with results of other studies (Clark & Natipagon-Shah, 2008; Ogedegbe et al., 2005). In a study conducted with women in Turkey, it was found that feeling healthy and painful mammography caused screening indifference (Kissal & Beşer, 2011).

Consistent with the literature, this study demonstrated that fear of breast cancer was both a facilitator of and barrier to screenings (Clark & Natipagon-Shah, 2008; Ogedegbe et al., 2005). In the study of Kıssal and Beşer (2011), it was explained that although fear became a barrier in screening behaviors because some women thought that they could not cope with the result of the examination, fear became a

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facilitator by providing an increase in perception on severity of disease for some women. Our results highlighted the significance and complexity of the fear, defined as a "double edge sword," which are both motivation and barriers to screening behaviors. Therefore, in future studies conducted on different cultural groups, the effect of the fear on screening behaviors should be carefully investigated.

Shame and thoughts about display of woman body were included in the barrier factors in other studies conducted on migrant women (Azaiza & Cohen, 2008; Clark & Natipagon-Shah, 2008; Ogedegbe et al., 2005). Almost all the women in Turkey are Muslims and they are not willing to go to doctor if the doctor is a man. Therefore, cultural sensitivity in cancer screening programs is important. Fatalism was expressed by participants less frequently in this study. However, in the study conducted by Ersin and Bahar (2011) with more than 40 women in Turkey, fatalism was stated by women less frequently. Since the average age of women included in the sample group of this study (age average 37 years) was low, it could be an indication for women to overcome some cultural barriers related to their own health. Despite the result of the study, since almost all of Turkish society are Muslim, health promotion messages should be made appropriate in parallel with belief of women, and their ages should be also taken into consideration while giving these messages.

It was determined that our finding that "self-efficacy" or "having confidence in one's ability to carry out screening" was in line with the results of other studies (Becker & Foxall, 2006; Ogedegbe et al., 2005). To promote participation of migrant women in screenings, assuring them about their abilities may be encouraging.

Previous experiences with health care personnel, health care personnel having no advice, scheduling late appointments, and long waiting hours in clinics, having no health insurance, and transportation problems were barriers for screening behavior, and again this finding was in line with other studies (Lee et al., 2007; Ogedegbe et al., 2005). In this study, it was determined that recommendations and training given by medical staff in FHC and on TV were encouraging. On other hand, in a study conducted by Banning (2011), it was stated that training given by health personnel was encouraging but recommendations given via different sources (media, magazine, brochure, applied demonstrations, etc.) were temporary. The reason behind why participants in this study wanted to obtain information especially from medical staffs working in FHC is because of the easy accessibility of information and easier contact with the staff working at these centers. Moreover, they recommended that the sharing of information via TV was a good idea, since TV ratings are higher in Turkey and it is deemed to be an easily accessible tool for information sharing.

The fact that the migrant women in this study had a traditional lifestyle and suggestions made by family members have a positive effect on screening behaviors; this was a finding supported by the results of other studies (Kawar, 2009; Ogedegbe et al. 2005). Our study results supported the idea that information obtained from the media, friends, and relatives, which are effective in conducting health behaviors according to HBM and defined as cues to action, are facilitating factors.

## Study Limitations

This study, conducted on migrant women in a particular region of Turkey, can only be generalized for migrant women living in this region. Results cannot be generalized for all women who internally migrated in Turkey. More studies are required to evaluate factors affecting breast cancer early screening behaviors of migrant women in other provinces in Turkey that allow migrants.

## Conclusions and Recommendations

Focus groups conducted as compatible with HBM and HPM were effective in explaining why migrant women did not display screening behaviors. There is a need to plan studies in different regions in order to determine barriers and facilitating factors that migrant women in Turkey perceive regarding breast cancer screening behaviors.

Our study gave an example of a theoretical framework explaining barriers and facilitators of breast cancer screening behavior of migrant women in a large city in Southwest Turkey through themes and subthemes. The structure provided in the study can be used as an example to explain screening behaviors of migrant women. Moreover, healths care professionals (doctor, nurse, and midwife) working in FHCs in regions where the migrant population is dense should benefit from facilitators determined in this study and eliminate barriers as much as possible. Additionally, interventions to increase migrant women's knowledge about participation in breast screening behaviors should be further developed and tested.

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