



PUBLIC HEALTH RESEARCH PROPOSAL

Awareness of Breast Cancer Screening Among Asian, Black and White Women in England

A public health research proposal focused on ethnic differences in screening awareness, access and participation

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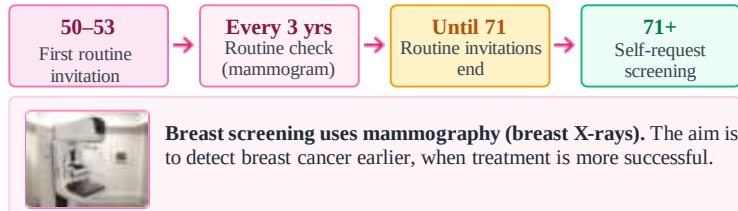
Figure A. Authentic NHS mobile breast screening unit in England.

(Source: NHS England Community Screening Services, 2026)

1. Prevalence and screening context

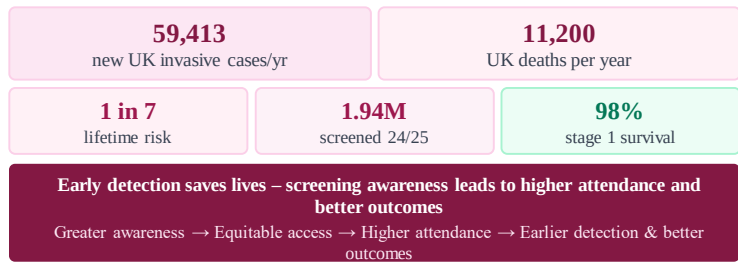
Breast cancer is the most common cancer in the UK, with 59,413 new invasive cases each year and 11,200 deaths in 2022–24. Around one in seven women develop breast cancer during their lifetime. In England, women aged 50 to <71 are invited every three years; 2024/25 uptake was 70.6%, with 1.94 million women screened and 19,291 cancers detected. Early diagnosis matters: 98% of women diagnosed at an early stage survive at least five years. (Cancer Research UK, 2026; NHS England, 2026; GOV.UK, 2026)

Figure 1. NHS breast screening pathway in England.



(Source: <https://www.nhs.uk/tests-and-treatments/breast-screening-mammogram/who-breast-screening-is-for/>)

Figure 2. Breast cancer burden and early-diagnosis message.



(Source: Cancer Research UK statistics; NHS England uptake review)

2. Ethnic differences: what the evidence shows

Ethnic differences should be interpreted carefully. Gathani et al. (2026) reported age-standardised invasive breast cancer incidence of 199.6 per 100,000 in White women, versus 134.7 Indian, 137.3 Pakistani, 146.0 Black Caribbean and 118.2 Black African women in England (2011–2019). However, ethnic minority women, especially Black women, were more likely to have less favourable tumour characteristics in a national study (Gathani et al., 2021). This shows why incidence alone cannot describe equity in early detection.

Figure 3. Age-standardised invasive breast cancer incidence by ethnicity.

Figure data: invasive breast cancer incidence, England, 2011–2019 (per 100,000)

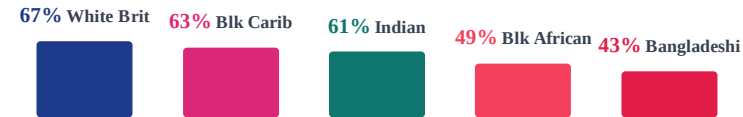


Note: Lower incidence in some minority ethnic groups does not remove the need to address inequalities in early detection.

(Source: <https://doi.org/10.1016/j.ejso.2025.109585>)

Historical London evidence also showed marked variation in first-invitation uptake: 67% White British, 61% Indian, 43% Bangladeshi, 63% Black Caribbean and 49% Black African women (Jack et al., 2014). These are not current national estimates. NHS England also notes limited national data for quantifying the contribution of ethnicity and language to inequalities (NHS England, 2026).

Figure 4. Historical first-invitation screening uptake in London.



Women aged 50–52; 2006–2009 London cohort; adjusted for age, deprivation and screening area.

(Source: <https://doi.org/10.1136/bmjopen-2014-005586>)

3. Awareness, barriers and research need

Reviews identify knowledge/awareness, access, cultural/language, emotional and family factors (Baird et al., 2021; Bolarinwa and Holt, 2023). Pakistani women report body/cancer taboos and value GP/community networks (Khattak et al., 2023). Black women report knowledge gaps, fear, stigma/mistrust, social influences and access barriers (Aliu et al., 2025; Aliu et al., 2026). Lancashire evidence links awareness to ethnicity, faith and location (Lee et al., 2025).

Figure 5. Evidence synthesis of barriers and facilitators across the three groups.

ASIAN WOMEN	BLACK WOMEN	WHITE WOMEN
- Lower screening awareness vs White women - Language & communication barriers - Cultural beliefs and stigma - Lower perceived personal risk - Practical barriers (transport, time)	- Generally lower uptake than White women - Higher risk at younger age - Lower programme awareness - Mistrust in healthcare systems - Socioeconomic & practical barriers	- Generally higher screening uptake - Greater awareness of programme - More positive attitudes - Fewer cultural/language barriers - Challenges remain (fear, anxiety)

(Source: Baird et al. 2021, DOI; Bolarinwa & Holt 2023, DOI; Khattak et al. 2023, DOI; Aliu et al. 2025, DOI; Aliu et al. 2026, DOI)

Rationale: Evidence is fragmented, geographically variable and partly historical. A current comparison can identify modifiable awareness gaps and support equitable, culturally responsive screening communication.

Research question: How does breast cancer screening awareness differ among Asian, Black and White women in England, and what factors may explain the differences?

Aim: To compare breast screening awareness among Asian, Black and White women in England and identify factors associated with unequal awareness.

Objectives:

- Assess screening awareness and knowledge across the three groups.
- Compare barriers and facilitators linked to awareness and attendance.
- Develop evidence-based recommendations to improve equitable awareness and participation.

Research impact: Findings could support targeted communication, stronger GP/community partnerships, flexible appointments and better ethnicity-sensitive data, contributing to earlier diagnosis and reduced health inequalities.

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