

SOCIO-CULTURAL FACTORS AND LATE BREAST CANCER DETECTION IN ARAB-PALESTINIAN WOMEN

MONA I. A. ALMUHTASEB
FRANCESCA ALBY
SAPIENZA UNIVERSITY OF ROMA

In the Occupied Palestinian Territory (OPT) many breast cancer cases are diagnosed at later stages. This research aims to contribute to the understanding of this late cancer detection rate and to examine breast cancer detection practices among Arab-Palestinian women, as well as factors that contribute to shaping them. A qualitative thematic analysis was applied to 36 semi-structured interviews with women with breast cancer and nine semi-structured interviews with doctors. Results are organized into five sections: 1) breast screening practices, 2) health beliefs toward cancer, 3) doctor's gender, 4) social stigma, 5) misdiagnoses. Results show how health beliefs and socio-cultural norms may be a cause for late breast cancer detection. Arab-Palestinian women with breast cancer face a dilemma. If they prioritize their health and individual needs, they infringe cultural norms, risk their marriage, and question their very social identity of caretakers of traditions and culture. Late cancer detection seems also influenced by inaccurate diagnoses. The OPT healthcare system suffers from the shortage and unavailability of diagnostic devices, but it also needs qualified and skilled specialists. Culturally sensitive educational interventions and guidelines should take into account the unique situation of the OPT, the restrictions to mobility, and the socio-cultural norms and values.

Keywords: Arab-Palestinian women; Oncology; Qualitative research; Occupied Palestinian territory; Breast cancer detection.

*Correspondence concerning this article should be addressed to Francesca Alby, Department of Social and Developmental Psychology, Sapienza University of Roma, Via dei Marsi 78, 00185 Roma (RM), Italy.
Email: francesca.alby@uniroma1.it*

Early detection of breast cancer is very important for effective treatment and saving patients' lives. In the Occupied Palestinian Territory (OPT), many cases are diagnosed at later stages (AlWaheidi et al., 2020; Azaiza et al., 2010; Khleif & Imam, 2013). Although the incidence rate of breast cancer is lower than that in Western countries or in Israel, in the OPT, breast cancer is the second most common cause of death among women (Azaiza et al., 2010; Hussein et al., 2009). One of the factors associated with late cancer detection in the OPT is the low attendance rate in preventive screening (Azaiza et al. 2010; Azaiza & Cohen, 2008; Naba'a & Shelleh, 2018).

Culturally sensitive interventions to support breast cancer screening performance need to be based on studies that take into account the specificities of the context of the OPT. In fact, breast cancer screening behaviors, and mammography in particular, have been found to be associated with specific cultural beliefs and barriers of ethnic groups (Alby, 2019; Alby & Eboli, 2016; Baron-Epel, 2010; Sterponi et al., 2017, 2019; Zuccheromaglio & Alby, 2017).

Several studies examined screening behaviors and attitudes toward cancer among Arab people in the Middle East (Azaiza et al., 2010; Azaiza & Cohen, 2008; Goldblatt et al., 2013; Soskolne et al., 2007). These studies revealed the prevalence of fear, embarrassment, cultural barriers related to modesty and so-

cial stigma, fatalistic beliefs regarding causes and outcomes of cancer (Hammoudeh et al., 2017; Hwang, 2013; Lamyian et al. 2007).

In the study conducted by Azaiza et al. (2010), 400 Arab-Palestinian women were approached, that is, 100 women from each district in the West Bank (Bethlehem, Hebron, Nablus, and Ramallah). The results showed that more than 70% of women had never undergone mammography or CBE (clinical breast examination performed by a doctor), whereas 62% of them performed SBE (self-breast examination). In the study, being more religious was associated with lower access to CBE and mammography and lower SBE performance. Religion is an important coping resource for Arab Palestinian women dealing with cancer but seems to have a negative impact on screening practices by promoting a fatalistic attitude, according to which life and death, as well as the course of a disease, are in God's hands (Almuhtaseb et al., 2020; Azaiza et al., 2010; Rajaram & Rashidi, 1999). Moreover, low consideration has been found to be associated with a lack of knowledge about the need for breast examination (Azaiza et al., 2010; Rajaram & Rashidi, 1999). The results of the study conducted by Soskolne et al. (2007) on a sample of 510 Muslim Arab women indicated that women had limited knowledge about breast cancer and mammography. The rate of mammography screening behavior (at the recommended interval) was only 20%. The women who were significantly more likely to undergo mammography were those who received a recommendation from a health professional or a family member. The significance of a recommendation from family members possibly reflects the importance that these women give to the family regarding decisions about their own health. The importance of the family needs to be emphasized as a culturally relevant factor because in the Palestinian society, the family is often involved in mediating communications between women and healthcare services (Almuhtaseb et al., 2021).

Overall, the Palestinian society is collectivist and traditional (Azaiza et al., 2010). Women play a central role in maintaining cultural values by socializing children to traditional lifestyles. This tendency is strengthened by the long Israeli-Palestinian conflict which promotes an appreciation of identities that are distinctive of a cultural tradition (Terzioğlu & Hammoudeh, 2017).

The persistence of a complex situation of political conflict and economic crisis has heavily influenced Palestinian society. In this context, financial resources and geographical accessibility heavily impact health services access and use (Giacaman, 2018; Majaj et al. 2013). Some of the laboratory tests or devices that assist in the diagnostic process are unavailable at the governmental hospitals or laboratories belonging to the Ministry of Health and, if they are available, women have to wait for a long time for the results (Almuhtaseb, 2017). Alternatively, the patient must turn to private centers, which may be very costly for low-income families and hardly affordable in a society like the OPT, with high levels of poverty and unemployment. In addition, mobility and access to health facilities is limited by the Israeli occupation particularly in West Bank Palestine (Majaj et al., 2013). Every Arab-Palestinian citizen who is willing to go to the occupied Jerusalem or move to the West Bank must go through military checkpoints for inspection. Going through these checkpoints may sometimes take several hours. Under these circumstances, a lot of people do not leave their homes unless in extreme necessity because they feel unsafe and they are forced to wait for a long time at checkpoints (Hammoudeh et al., 2017).

OBJECTIVES

Very few studies have explored women's health-seeking behaviors in the OPT (Azaiza et al. 2010; Majaj et al., 2013). In this qualitative study, we examine breast cancer detection practices among Arab-

Palestinian women, as well as factors that contribute to shaping them. In particular, we aim to contribute to the understanding of the late cancer detection rate registered in this territory. In line with a qualitative approach, we intend to contribute to the situated understanding of these practices within the historical and socio-cultural context of the OPT.

METHOD

The study was conducted in two medical centers: 1) the Oncology Department at Beit Jala Government Hospital in Bethlehem Governorate, the only government hospital in the OPT, which provides many diagnostic and therapeutic services for oncology patients, and 2) Dunya Women's Cancer Centre in Ramallah Governorate, because it is the only non-profit center that provides early diagnostic services for breast cancer and gynaecological services in the OPT.

The study was ethically approved by the Palestinian Ministry of Health. Contact with participants was mediated by the two medical centers. All participants were approached at the centers, informed of the aims of the study, and requested to sign a consent form. Participants were also assured of the anonymity and confidentiality of all the information collected for the purpose of the study. Data collection started on 18 January 2015 and ended on 15 April 2015 due to security and travel restrictions related to the Israeli occupation. We conducted 36 individual semi-structured interviews with Arab-Palestinian women with breast cancer who were selected according to the following inclusion criteria: 1) living in the OPT; 2) diagnosed with breast cancer between one month and three years prior to the interview; 3) having no previous history of mental disorders or other forms of cancer; 4) signing an informed consent form. These women were diagnosed with breast cancer at different stages (from II to IV) and some of them were still undergoing treatment. Their ages ranged between 22 and 67 years. The educational level ranged from total illiteracy to university-level education. Most of the interviewees were housewives ($N = 24$) with children ($N = 30$, ranging from one to nine children). We also collected nine semi-structured interviews with doctors from both centers involved in the study (see Table 1). Their ages ranged from 33 to 59 years, seven of them were males and two females. This disparity between genders is attributed to the lack of female workers and specialists in the oncology field. Six doctors achieved a specialization either in oncology or in surgical oncology, after obtaining, like all of the doctors involved in the study, a bachelor's degree in medicine and general surgery. They graduated from Ukrainian universities, Arab universities such as Algerian and Iraqi, as well as the Al-Quds University in Palestine. We used two different interview guides: one for the women and one for the doctors. In both guides, we addressed the same set of issues but from different perspectives. The interview guide had three sections. The first section explored how the illness was discovered, the second section focused on the communication with doctors and the treatment decision-making process, the third section explored the coping resources used by the participants, specifically the resources of support in facing cancer. This article focuses on the answers given to questions within the first section related to cancer detection and breast screening practices. The interview also covered socio-demographic characteristics and medical information. The interviews — lasting about an hour — were conducted in a private room (in the hospital or at the center) by the first author — an Arab-Palestinian woman, which probably facilitated adherence to the research, in fact nobody refused to participate. She presented herself as a researcher and a doctoral student in social psychology. The participants were informed about the aims of the study and signed a consent form. All interviews were conducted in the Palestinian dialect of Arabic. They were audio-recorded, transcribed in Arabic, and later translated into English. All the interviewees' names have been

changed. The authors adhere to the standards of ethical behavior promulgated by COPE. The consolidated criteria for reporting qualitative studies (COREQ) checklist has been provided with the manuscript to ensure a comprehensive reporting of the interviews (Tong et al., 2007).

TABLE 1
 Participant sociodemographic characteristics (Patients $N = 36$; Doctors $N = 9$)

Patients' characteristics	N (%)
Residents	
Villages	20 (55.6%)
Cities	12 (33.3%)
Camps	4 (11.1%)
Age (years)	
Range	22 – 67 years
Mean	44.5 years
Age Category	
(22-29)	2.8%
(30-39)	36.1%
(40-49)	41.7%
(50-59)	11.1%
(60-69)	8.3%
Marital status	
Married	30 (83.3%)
Unmarried	3 (8.3%)
Separated/Divorced	2 (5.6%)
Widow	1 (2.8%)
Number of children	
Range	0-9
Mean	2.4
Educational level	
Illiterate	1 (2.8%)
Elementary	10 (27.8%)
Middle school	8 (22.2%)
High school	11 (30.5%)
University	6 (16.7%)
Employed	
Yes	32 (88.9%)
No	4 (11.1%)
Cancer stage	
Stage I	5 (13.9%)
Stage 2	9 (25%)
Stage 3	3 (8.3%)
Stage 4	3 (8.3%)
Unknown	16 (44.5%)
Surgery	
Mastectomy	11 (30.6%)
Lumpectomy	22 (61.1%)
None	3 (8.3%)

(Table 1 continues)

Table 1 (continued)

Doctors' characteristics	N (%)
Age (Years)	
Range	33-59
Mean	44
Gender	
Male	7 (77.8%)
Female	2 (22.2%)
Education	
Surgical Oncology	2 (22.2%)
Oncology	4 (44.5%)
Women's health	1 (11.1%)
Radiology	1 (11.1%)
Nursing	1 (11.1%)

The analytical procedures performed on the data corpus included: 1) a verbatim transcription of all the interviews; 2) a qualitative thematic analysis of the interview transcripts. The corpus obtained was analyzed using thematic analysis, which allowed the texts to be examined in terms of their principal contents (Braun & Clarke, 2006; Testoni et al., 2020). We used an inductive process for the construction of coding categories for breast cancer detection practices (Alby, 2019; Alby & Fatigante, 2014; Hsieh & Shannon, 2005). In the first phase, two researchers read the transcripts of the interviews identifying the categories of content to be used for coding. These categories were used to code part of the interviews. The coding was carried out independently by two researchers. Doubtful cases were discussed with a third researcher until an agreement was reached. This comparison helped to revise and specify the categories. In the second phase, the categories were used to carry out the coding of all the interview transcripts. The “saturation” level of the data was a matter for discussion and the data collected was considered sufficient for qualitative exploratory analysis. The verbatim quotations of the interviews selected in the article are representative of the identified categories.

RESULTS

We have organized the presentation of the results in five sections corresponding to the categories that describe breast cancer detection practices in the OPT and factors associated with them. We illustrate the findings using verbatim quotations from the interviews.

Breast Screening Practices and Cancer Detection

In line with the OPT low screening rate, only one out of 36 interviewees discovered that she was ill through screening checks. Most of the women interviewed had gone to see a doctor when they felt a lump or pain in their breast. Some interviewees waited several months, even over a year, after the first symptoms before going to a doctor. Tala, 40 years old, explained that she reached a stage in which she could not endure the pain in her breast before telling her sister who encouraged her to see the doctor:

One year ago, I felt a little pain in my breast, and there was also a blue spot, but I didn't go to the doctor. After the pain increased, I told my sister and she told me that I should see the doctor quickly, so I immediately went to see him.

Tala related an incorrect interpretation of the signs of the disease that delayed her call for help first to her sister and then to a healthcare provider. This is an example of the lack of awareness and knowledge about breast screening and examination observed in the interviews.

Another interviewee, Zena, 42 years old, consulted the doctor seven months after the first symptoms: I felt a lump in my breast, but I didn't go and see the doctor. Usually, when there were TV programs on cancer, I would turn the TV off immediately as I didn't want to hear anything related to cancer, I have always been scared of this disease, I don't know why! Even when people talked about this disease in front of me, I was scared. When I went to the medical clinic of the Ministry of Health, they were talking about the importance of doing periodic breast tests, so I felt afraid and refused to do them. Seven months later, I went to my doctor.

The woman reports how scared she was of a possible cancer diagnosis. Her reaction was to postpone a medical checkup for too many months. Her words show how women's perceptions and attitudes may be major barriers to screening and a cause for late breast cancer detection.

Health Beliefs Toward Cancer

Many interviewees who had reported fear and resistance to seek healthcare services saw cancer as a death sentence and shared the traditional belief that death is inevitable when cancer is diagnosed and therefore it is useless to consult healthcare providers. Such a belief was reported by Zena (42 years old) initially as something that belonged to her sister-in-law and that prevented her from seeking healthcare:

I advised my sister-in-law to do the test and see the doctor because she had a problem as a yellow liquid dropped from her breast, but she refused to see the doctor. She told me: "If I have a problem I will die, so I prefer to die rather than going to the doctor!"

In addition, Zena explained:

Every woman should do the test, but our problem is fear. My total problem was fear; when I was breastfeeding my son, I felt something in my breast, and when I decided to go to the doctor, and I actually did, when I got closer to his clinic I ran away! I was afraid of confronting him and of being told that I had cancer!

Breast cancer detection is known to be influenced by cultural factors and health beliefs. In an interview, a doctor, Amjad, pointed out, in particular, the common belief that treatments are not effective: "Some patients suffer from a lack of awareness but if they know that they can recover from cancer through treatment, particularly in the first stages, they will do tests and treatment immediately."

Another doctor, Lama, connected this attitude toward cancer to avoidance of health-seeking behaviors because of fear: "I encourage women to have an early checkup and diagnosis, but most of them refuse to do the examination fearing that they may have the illness! Its name is scary and everybody is afraid of it."

This attitude toward cancer has been defined as cancer fatalism — the belief that death is inevitable when cancer is diagnosed — and has been observed in traditional societies (Azaiza et al., 2010).

The Doctor's Gender

Breast cancer detection practices are also affected by gendered socio-cultural roles. In particular, interviewees related hesitating to see the doctor for breast examination if the doctor was male. Women clearly stated that they prefer to be examined by a female doctor. Tala (40 years old) reported that the doctor's gender was the reason for waiting a year before performing the test despite the pain she felt: "I didn't have tests for approximately a year when I felt pain in my breast, because I don't want to be examined by a male doctor, I'd rather be examined by a female doctor."

Amal (48 years old) remarked that she actually feels more comfortable when she is examined by a female doctor: "When I did an ultrasound test with a male doctor, I was annoyed."

Sana' (46 years old) commented that the problem is also related to women's husbands who prevent them from going to a male doctor: "For me, there is no problem, as I went to a female gynecologist. Generally, women prefer dealing with female doctors, also, there are women whose husbands refuse to let them see a male doctor."

This problem is also mentioned in interviews with doctors. One of them, Ruba, stated: "Women who do not visit the center have a shyness burden as they are ashamed to be examined by male doctors, whether they are Muslims or Christians."

These behaviors are influenced by cultural factors and ways of considering women's social identity and body. The woman's body in Middle Eastern culture is to be kept private. Thus, Arab-Palestinian girls are raised from an early age to cover their bodies in front of men, to respect and embrace customs and traditions, to value modesty and shyness. Even if the Islamic religion does not prevent women from going to male doctors, more general cultural norms promote the concealment of women's bodies, especially such intimate area as the breast. Therefore, for women, undergoing a medical examination becomes a situation in which they expose themselves to a cultural discontinuity with traditional values and with their own social identity. However, some women do not prioritize traditional customs over their health, as in the case of Ruba (56 years old) who said that, although she prefers female doctors, this did not prevent her from going to see a male doctor: "As for the doctor's gender, there is an idiom that says: 'necessity knows no law' if there is only a male doctor in the neighborhood the woman has to do a checkup with him because treatment is more important."

The maxim that the interviewee quoted highlights how such a restriction to a health-seeking behavior (avoiding a male doctor), has a normative status that can be opposed only through another traditional norm about cases of extreme necessity. However, a tension between different cultural norms and expected behaviors is evident. In this context, women find themselves in the difficult position of reconciling contrasting attitudes and choosing between their health and their social identity and adherence to traditional roles and values.

Social Stigma

Interviewees reported avoiding doing the test or requesting medical assistance in case of symptoms because they were afraid of other people's reactions. They think that people distance themselves from cancer patients through beliefs that depict them as weak and unable to perform their roles in society. In particular, a woman with breast cancer is considered weak and unable to perform her marital duties properly due to her disease, as a doctor, Ahmad, commented:

Some patients refuse to do tests to avoid discovering that they have cancer or because they fear that their husbands may marry again; and if a young woman is about to get married, then her family will feel afraid to tell people that their daughter has cancer.

Another interviewee, Maria (38 years old), connects this belief to her difficulty having preventive tests and to her desire for privacy and secrecy with respect to health conditions:

Regular self-examination may be enough for the woman and so it is not necessary to visit health centers to do tests periodically as this is a very sensitive issue. When I went to the association and told them about my case, I asked them to keep my case private and secret especially in my village, because if the people in my village know about my health condition, they will look at me with sympathy and think that I will never recover from this disease and I will die at the end.

The social stigma is even more of a problem if the woman is still looking for a husband, as a doctor, Ahmad, said recalling the story of one of his patients:

Social matters are largely intertwined with medical issues. For example, 4 years ago, I treated a young woman for breast cancer and she recovered from this disease. However, one day, I was surprised when a family came to ask me if that patient had really recovered from cancer; because their son loved this young lady and wanted to marry her, but this family wanted to make sure that the patient was totally recovered and would be able to give birth in the future.

The shared concern is that a woman who has cancer will not be able to have children and take care of the family. A doctor, Ahmad, provided another quite extreme example of such a belief, in which getting married is prioritized over a woman's health:

In one case I dealt with, I discovered that a 19-year-old woman had breast cancer, and her father refused to give her treatment because she was engaged and about to get married and her father did not want her fiancé and his family to know about her illness.

In this example reported by a doctor, the cancer patient suffered the effects of a decision made by others (the father); however, several women interviewed shared this same attitude that prioritizes being a potential wife and mother over their own health.

Young women do not take tests and do not go to medical examinations because they fear that this may adversely affect their reputation and the possibility of getting married, especially in small villages. Negative beliefs concern the possibility of genetic factors that can be passed on to children, but also the woman's ability to take care of the family and to be beautiful and attractive after hair loss and breast surgery (cf. also Zucchermaglio & Alby, 2016; Zucchermaglio et al., 2016). In Palestinian society, having a family seems more important than a woman's life, as testified in the words of Maysoon, who put her commitments as a mother before her health:

Honestly, every year I was giving birth to one child! I didn't have time to do tests and follow-up with the doctor. I am not educated, but I understand everything. I know that a woman should do the test for early diagnosis of breast cancer every 6 months.

The family also comes first in doctor Fatima's story about a woman who would postpone the diagnostic procedures because totally absorbed by issues concerning her children:

We face a problem with the patient herself when she refuses to have some tests or a biopsy and she postpones everything for several months because she feels worried about her sons and daughters and their studies, or because she wants to celebrate her son's wedding before anything else.

Gendered socio-cultural roles and associated moral stances (about what a "good" wife or mother is) seem to work as a barrier to preventive healthcare.

Misdiagnoses

Another reason for the late cancer detection rate registered in the OPT is related to mistakes in the diagnostic process and therefore to the quality of the healthcare system. The interviews report that several women were misdiagnosed when they requested medical assistance once a symptom of breast cancer appeared. Some interviewees indicated that they consulted a doctor and the first diagnosis was that they did not have the disease, but only an inflammation or sebaceous cyst. Then, the doctor advised them to see him again if the symptoms persisted. However, the women did not go back to the doctor, because they thought that it was unnecessary, due to the fact the doctor had reassured them that the symptoms would fade away over time by taking analgesic or anti-inflammatory drugs. They then went to several doctors and hospitals as the symptoms continued, but they very often resorted to doctors who did not have enough experience with breast cancer or who were not specialized in oncology. When these women finally found out that they had cancer the disease was already at an advanced stage. An example of this pattern was provided by Maysoun (46 years old):

I was nine months pregnant and I noticed some blood spots and a yellow liquid on my bra, so I went to see the pediatrician one week after giving birth, and I told him about that, but he told me: it's normal ... no need to feel anxious ... keep breastfeeding your baby even if more blood drops ... After over one year, the pain in my breast increased!

Asma (36 years old) shared a similar dramatic experience:

At the beginning I felt a lump and went to a private doctor after having a mammogram, he wrote in the report that I didn't have anything, but I felt pain and there was something in the breast. I visited five doctors, and none of them knew how to diagnose my case. I reached an extreme stage of the illness, I couldn't move or walk without a wheelchair, I couldn't drive my car or use the bathroom.

This delay in correct diagnosis implies that the stage of the disease is more advanced at the time of diagnosis and that treatment starts later. It is therefore a crucial factor in women's survival.

DISCUSSION

This research is one of the few studies analyzing the relation between Arab-Palestinian women's late cancer detection and the socio-cultural context of the OPT. Overall, this research indicates how cancer detection in OPT is a complex phenomenon, influenced by the interplay of several environmental, social, and cultural factors. Current results show how women's perceptions and attitudes as well as health beliefs and socio-cultural norms and values may be major barriers to screening and a cause for late breast cancer detection. In the OPT, Arab women with breast cancer find themselves in a sociocultural context that stigmatizes cancer, invites to its concealment, and promotes adherence to traditional customs that prioritize having a family over the woman's health and individual needs. This cultural background sheds light on the results of our study that outline a tension between preventive screening behaviors and traditional customs and beliefs in the OPT.

Our study suggests that late cancer detection is also influenced by the quality of healthcare. The problem is not only limited to the shortage and unavailability of diagnostic devices, but it also includes the need for qualified and skilled specialists. Inaccurate diagnoses put women's life at risk and result in more invasive treatments. A partial explanation for these findings may be the lack of adequate training for doctors as well as the lack of educational programs to increase women's awareness and encourage them to use preventive health services.

Given the nature of qualitative research, we do not aim to generalize results, but to contribute to the situated understanding of coping resources within the local context of the OPT, a unique situation of enduring conflict and insufficient healthcare. Further studies using different analytical approaches may verify the extension of these findings to the wider OPT population.

CONCLUSIONS

Arab-Palestinian women with breast cancer face a dilemma. If they prioritize their health and individual needs, they have to infringe cultural norms, risk their (future) marriage, and question their very social identity of caretakers of traditions and culture in the OPT society. The OPT healthcare system suffers from the shortage and unavailability of diagnostic devices, but it also needs qualified and skilled specialists.

Practice Implications

A change in this situation is needed to improve the early detection rate and, thus, increase the survival of women with breast cancer. Educational programs should be constructed to enhance understanding of the value of early detection and knowledge of guidelines, to teach breast awareness. Nevertheless, educational interventions and guidelines should be adapted to the specific circumstances and possibilities, taking into account the unique situation of the OPT, the socio-political restrictions to mobility, and the socio-cultural norms and values, some of which were highlighted in this article.

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