Perceptions of breast cancer screening programs and breast health among immigrant women

Qualitative study in Alberta

Dalia Eldol MD MPH MSc MCFP

Abstract

Objective To examine how women who have emigrated from the Middle East and North Africa (MENA) region perceive breast cancer risk and screening in Canada and how they approach breast health, and to explore barriers to breast cancer screening in this population.

Design Focused ethnography.

Setting Edmonton, Alta.

Participants Women who were born in MENA countries (eg, Egypt, Iraq, Lebanon, Libya, Saudi Arabia, Somalia, Sudan, and Syria) and had immigrated to Canada less than 5 years prior to study recruitment and lived in Edmonton, Alta.

Methods Six focus groups were conducted over a 6-week period in July and August 2018 with 6 participants in each group (N=36); results were analyzed thematically.

Main findings Three broad themes were identified: knowledge about breast health, cancer risk, and screening services; barriers to maintaining breast health and to screening; and potential solutions for overcoming these barriers. Findings indicated participants have limited knowledge about breast cancer screening practices in Alberta and that multiple barriers to screening remain.

Conclusion This study can help inform the development of culturally appropriate interventions to overcome barriers and to motivate women from MENA countries to use breast cancer screening.

Perceptions des programmes de dépistage du cancer du sein et de la santé des seins chez des immigrantes

Étude qualitative en Alberta

Dalia Eldol MD MPH MSc MCFP

Résumé

Objectif Examiner comment des femmes qui ont émigré du Moyen-Orient et de l'Afrique du Nord (MONA) perçoivent le risque et le dépistage du cancer du sein au Canada, et comment elles abordent la santé des seins, et explorer les obstacles au dépistage du cancer du sein dans cette population.

Type d'étude Une ethnographie ciblée.

Contexte Edmonton (Alberta).

Participantes Des femmes nées dans des pays du MONA (p. ex. Égypte, Iraq, Liban, Lybie, Arabie Saoudite, Somalie, Soudan et Syrie) qui avaient immigré au Canada depuis moins de 5 ans avant le recrutement des sujets de l'étude et qui vivaient à Edmonton (Alberta).

Méthodes Six groupes de discussion se sont réunis sur une période de 6 semaines, en juillet et août 2018, chacun comptant 6 participantes (N=36); les résultats ont été analysés de manière thématique.

Principales constatations Trois grands thèmes se sont dégagés : les connaissances sur la santé des seins, le risque de cancer et les services de dépistage; les obstacles au maintien de la santé des seins et au dépistage; et les solutions possibles pour surmonter ces obstacles. Les constatations ont indiqué que les participantes avaient des connaissances limitées sur les pratiques de dépistage du cancer du sein en Alberta, et que de multiples obstacles au dépistage subsistaient.

Conclusion Cette étude peut aider à éclairer l'élaboration d'interventions culturellement appropriées pour surmonter les obstacles et motiver les femmes des pays du MONA à utiliser le dépistage du cancer du sein.

Breast cancer is a leading cause of morbidity and mortality among women in Canada.[1] Globally, about 2.3 million new cases of female breast cancer were diagnosed in 2020, representing more than 11% of the total cancer incidence burden.[2] In Canada it is estimated that 84 women will be diagnosed with breast cancer every day and 15 women will die of breast cancer daily in 2024.[1]

Data from 2008 indicated more than half (57%) of recent immigrant women aged 50 to 69 had not had mammograms in the previous 2 years compared with 26% of Canadian-born women.[3] Recommendations published in 2023 aimed at prioritizing health care for disadvantaged populations include addressing inequities in cancer screening among immigrants to Canada through specific interventions.[4]

In North America little has been heard from certain ethnic minority populations, including emigrants from Middle East and North Africa (MENA) countries, with respect to breast health and breast cancer risk.[5]

Among female immigrants to Canada originally from MENA countries, few studies have explored their beliefs about and knowledge of breast cancer screening or their experiences with and access to these services.[5,6] Middle Eastern women's perceptions of health, including breast health, tend to be deeply rooted in religion and culture.[6-8] Understanding various factors that shape these women's decisions and actions related to breast health is important to improving their health and providing appropriate preventive health care services.[8] The main objectives of this study were to understand how recent immigrants to Canada originally from the MENA region perceive breast health and breast cancer risk and to explore barriers to breast cancer screening that these women encounter.

Methods

Research paradigm

This study adopted the interpretivism paradigm that considers social and cultural contexts. That is, to understand how women originally from the MENA region perceive and practise breast health and cancer screening in Canada, we need to recognize that their world views have been shaped by their own historic and cultural backgrounds.[9]

Researcher positionality

The researcher (D.E.) is an immigrant to Canada originally from the MENA region who was living in Edmonton, Alta, at the time of the study and identifies as a woman. Her religious, cultural, and social values are similar to those of the participants, and so she identified herself as an insider. The researcher also considered herself an outsider based on differences between her and the study participants, such as education level and professional experience. This unique position helped her understand participants' views and cultural values.

Research design

Focused ethnography was used in this study owing to it being an appropriate research design to understand cultural phenomena among specific groups of people.[9]

Participants and recruitment

Women aged 20 to 69 who were living in Edmonton, had been born in MENA countries (eg, Sudan, Egypt, Lebanon, Somalia, Iraq, Saudi Arabia, Syria, Libya), and had immigrated to Canada no more than 5 years prior to recruitment were eligible for this study. Women with current or past histories of breast cancer and women who had worked as health care professionals in Canada were excluded.

Before participants were recruited, news about the study had been spread in the community using social media (mainly Facebook) and word of mouth in formal and informal women's gatherings. The first 8 participants were purposively obtained. Snowball sampling was used to recruit additional participants.

Data collection

Data were generated by conducting 6 focus groups with 6 participants in each group (N=36), with detailed field notes taken and a researcher's journal kept for each group. Focus groups were conducted over a series of 6 weeks in July and August 2018. Focus groups were selected as an appropriate data collection tool because Arab women tend to enjoy talking in groups and gatherings. Researchers such as Feghali have found that a classic form of communication in focus groups resembles communication styles of some Middle Eastern communities (eg, storytelling).[10]

Various approaches to demonstrate trustworthiness were used in this study. Four criteria from Guba and Lincoln's ideas on trustworthiness were used, including credibility, transferability, dependability, and confirmability.[11] In addition, verification strategies suggested by Morse et al to establish trustworthiness were used.[12] This project was reviewed and approved by the Research Ethics Board at the University of Alberta in Edmonton.

Data analysis

Manual thematic analysis with line-by-line coding was used. Inductive analysis was used to find meaning deeply rooted in the data and not shaped by any researcher prejudice.[9,11]

The analysis process was conducted in Arabic, the original language of focus group participants. A bilingual assistant was recruited to review transcriptions and verify the translation. The author and the language assistant translated only the final outcomes and some of the quotes from the transcripts into English. To ensure

study rigour, final findings were translated back into Arabic to make concept equivalence certain.

Results

Three main themes emerged from the analysis: knowledge about breast health and cancer screening services; barriers to maintaining breast health and to screening; and potential solutions for overcoming barriers.

Knowledge about breast health and cancer screening services

Participants' knowledge about screening practices in Alberta was limited. Nearly half of the participants had no knowledge about mammograms. Twenty-five participants (69%) demonstrated knowledge about signs and symptoms of breast cancer, 18 (50%) had heard of breast screening, and only 9 (25%) had had a mammogram. "What is mammography?! I [have] never heard of it" (Participant 1, focus group 4).

Participants based overall indicators of breast health mainly on an absence of physical illness.

Barriers to maintaining breast health and to screening

Language barriers. Twenty-one participants (58%) identified language as the main barrier to screening. Women who had lived in Canada for less than 3 years or had limited English or French language skills explained that they could not fully describe their worries and health concerns in English or French.

> I really don't understand well when they talk to me in English. That is why I switched to a family doctor that speaks Arabic. (Participant 5, focus group 1)

Health care provider (sex and attitude). Twenty-seven participants (75%) said their health care provider's sex would influence their decision about whether to seek screening. For modesty reasons they would prefer to be seen by female practitioners. Two women highlighted unpleasant experiences with health care providers whom they described as being culturally insensitive. They pointed out that staff can be impatient or impolite with women whose first language is not English. These negative experiences caused participants to avoid seeking health care services unless absolutely necessary.

> A male practitioner approached me and wanted to check me. I felt very uncomfortable and I asked him for a female nurse. (Participant 3, focus group 2)

> Some people don't respect where we come from. The nurse asked me about my medication. I mentioned *karkadiah* [herbal medicine]. She rolled her eyes. I never went back to that clinic again. (Participant 4, focus group 5)

Lack of empowerment. Twenty-five participants (69%) reported having limited knowledge for making informed decisions about mammograms. One example they provided was an insufficiency of information due to either poor English or French language proficiency or inadequate promotion of breast cancer screening.

> Where do you hear about these services? I always watch TV and read newspapers. I don't really see news about breast cancer campaigns. (Participant 2, focus group 5)

Fear. Nine women (25%) expressed fear about adverse screening outcomes that caused them to avoid screening, especially those who had observed close family members or friends dying of or suffering from breast cancer. "No need to open the closed door" (Participant 2, focus group 5) was a common sentiment.

> I'm scared to death to find that I have this bad disease in my breast. Who is going to take care of my family if I die? (Participant 1, focus group 6)

Potential solutions for overcoming barriers

Female participants discussed several ways to improve how breast cancer prevention services are provided to their community. These culturally sensitive methods could potentially be incorporated into existing breast cancer screening programs and guide future interventions. Twenty-five participants (69%) stressed that preventive care services should be available in both English and Arabic. Other participants suggested that women from similar cultural and social backgrounds could be trained to educate women from the MENA community. Nine participants (25%) also brought up the idea of outreach programs. They proposed having events such as seminars organized in their community and guided by Arabic-speaking or bilingual health care workers. Other suggested approaches included online forums and smartphone applications with Arab and Islamic materials and symbols (eg, women wearing hijabs).

> I would like to see information available in Arabic. (Participant 1, focus group 2)

> Instead of going to these services, why not have these services come to us? (Participant 6, focus group 6)

> It would be great if they [were to] create an app, like the SchoolZone [app for public schools in Alberta]. I [would] hope there [would] be pictures of women like us, [with] dark skin, curly hair. (Participant 3, focus group 1)

Discussion

Theoretical framework: the Health Action Model

The Health Action Model (HAM) provides an inclusive framework of key predictors (belief, motivation, and normative systems) of choice and intention of healthy behaviour that can be applied to breast cancer screening among women from the MENA region. However, facilitating factors are needed for action to occur. The HAM suggests you cannot separate the design of targeted effective health promotion programs from the historic and cultural contexts of the participants for whom they are intended.[13] This inclusiveness of the HAM results in understanding key sociocultural and ecological determinants of health-related actions beyond the level of individual health.[13]

Lack of a holistic approach to health

Participants in this study were generally lacking a holistic approach to health. They articulated that the absence of physical illness means to them that they are healthy and free of serious disease.

Multiple factors play a role in this limited understanding of health. Gender disparities are embodied in social norms, and single women who pursue sexual or reproductive health services are met with shame and stigma.[7,14] Islam forbids any sexual activities or conceiving of children outside of marriage, and in Middle Eastern cultures, for example, breasts are mainly seen as symbols of sex and breastfeeding; hence single women are not expected to adopt breast health measures in traditional Arab Muslim society.

Lack of screening knowledge

Poor knowledge of screening practices was a common finding in this study. Mammography is still unknown to most participants. The few participants who recognized mammograms as a breast cancer screening tool had a debate on mammography risks given that it has advantages and disadvantages. Therefore, women are encouraged to learn about breast health and screening strategies to make informed decisions.

Barriers to screening

Language barriers. Similar to findings from previous cross-cultural research, language difficulties were reported as a main challenge in accessing health care.[5,7,14,15] Failure to remove these barriers hinders an individual's ability to transform their intentions into actions.[13,16] Bilingual services and events could increase knowledge of Canadian culture, connect newcomers to settlement services to help bridge gaps, and assist with adjustment.[5,7,8] While relevant literature describes the role of the individual as vital to health literacy, others argue about the significant impact health care providers can have on the health literacy of service seekers.[6,8] Institutional elements including health care services, programs, and providers were recognized as affecting newcomers' health decisions and actions.[6,7,17]

Education, empowerment, and implications for health literacy. In this study, female participants were highly motivated to improve their health. Receiving education and direction on breast cancer screening practices were common goals. Participants indicated that their empowerment would enable them to go beyond fear and take control over their breast health. One participant stated: "The more I know, the less fear [I have] inside me." Scholars have pointed out that having a high education level does not necessarily guarantee an individual access to health care and better health outcomes.[18]

The concept of critical health literacy, which involves the ability to engage with knowledge critically and to take action to improve health, has received wide interest.[19] Critical health literacy can be obtained by both the educator and the learner working in a collaborative environment and benefiting from each other's skills and resources.[6,19] Context is a key factor that shapes how women from MENA countries perceive and practise breast health. Bridging the voices of women from MENA countries with those of decision makers could result in greater uptake of breast cancer screening services.[15,20]

Health care providers. The sex of health care providers was a critical factor in these participants' willingness to take part in breast cancer screening. Most participants in this study stressed the need to respect their modesty in a clinical care setting and to offer a female health care provider. Institutional issues related to the modesty and privacy needs of Muslim women have been found to be sources of distress and reasons for not using health care services.[5,14]

Participants in this study also revealed negative experiences in health care settings that had discouraged them from using the services. This emphasizes the need to eradicate discrimination and stereotyping in health care settings and to provide cultural competency training. Disrespecting alternative medicine or asking young single Arab Muslim women about sexuality, for example, would be considered offensive and may cause extreme embarrassment for families from MENA countries.[14] However, this is a good example of a topic on which health care providers could be trained to help them offer culturally appropriate health care to Arab Muslim populations.

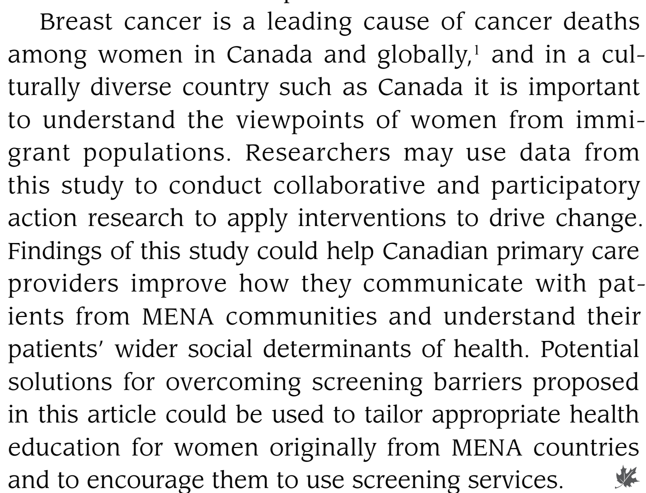
Social influences and Islamic values. Important factors that hinder an individual's decision to seek health care services are their perceptions of the health condition and expected social reactions to it.[13] Social pressures on individuals can result in feelings of shame and stigma.[13] The fact that the breast is attached to reproductive and sexual functions may create social stigma surrounding breast cancer in MENA communities.[21] Fear

of disgrace and social stigma could also be reasons for worries about adverse screening outcomes. In Arab cultures diseases such as cancer are viewed as shameful and something that should be hidden.[14]

Conclusion

Findings of this study show that cultural beliefs strongly influence the views of women originally from MENA countries toward screening and preventive health care. Culturally aware messaging could be carefully integrated into health education programs and services targeting these women to motivate their participation in breast cancer screening.[8,15]

Study participants identified multiple cultural concepts that mesh with their Arab identities and their Islamic perceptions of health. Their perspectives on cultural issues should be integrated into services intended for them. Taking a HAM-based perspective, these customized interventions would generate a strong positive interaction of belief and motivation systems that then translate intentions into practice.[13]



Breast cancer is a leading cause of cancer deaths among women in Canada and globally,[1] and in a culturally diverse country such as Canada it is important to understand the viewpoints of women from immigrant populations. Researchers may use data from this study to conduct collaborative and participatory action research to apply interventions to drive change. Findings of this study could help Canadian primary care providers improve how they communicate with patients from MENA communities and understand their patients' wider social determinants of health. Potential solutions for overcoming screening barriers proposed in this article could be used to tailor appropriate health education for women originally from MENA countries and to encourage them to use screening services.

Dr Dalia Eldol is a family physician in Bridgewater, NS.

Competing interests
None declared

Correspondence
Dr Dalia Eldol; email **daliaeldol@gmail.com**

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