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Factors Influencing Breast Cancer Screening Practices Among Arabic Women Living in
the State of Qatar: The Health Care Providers' Perspective

by

Jasmine Jihye Hwang

A THESIS

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Abstract

Breast cancer is the most common cancer contributing to morbidity and mortality among Arabic women in Qatar. Arabic women are at risk primarily due to their low participation rates in breast cancer screening practices. Therefore, there must be a strong emphasis on the health care system to increase efforts in early detection of breast cancer. Using critical ethnography, the purpose of this study was to explore, understand, and describe factors influencing Arabic women's breast cancer screening practices. Fifteen health care providers in Qatar were interviewed. An analysis of the data revealed influences of (a) knowledge and awareness and pain perception, (b) culture, (c) gender and power relations, and (d) systemic factors on women's breast cancer screening practices. Study findings suggest that Arabic women's health cannot be understood in isolation from the environment in which they live; therefore, solutions need to address the context and not be limited to the individual.

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List of Symbols, Abbreviations, Nomenclatures

Symbol	Definition
ANP	Advanced Nursing Practice
APN	Advanced Practice Nurse
BCS	Breast Cancer Screening
BSE	Breast Self-Examination
CBE	Clinical Breast Examination
EM	Explanatory Model
GP	General Physician
HMC	Hamad Medical Corporation
HN	Head Nurse
HCP	Health Care Provider
SN	Staff Nurse
WWC	Well-Women Clinic

Chapter One: **Introduction**

My nursing practice background and focus in the Master's Program is community nursing. As a community health nurse, I have worked with diverse populations such as homeless, immigrant, and refugee who are marginalized for various reasons, and people with various ethnocultural backgrounds. My work experiences within these populations highlight for me that health is not solely an individual's responsibility. Rather, it is influenced heavily by environmental factors outside of the individual's control; factors that affect greatly the person's health and well-being. For my master's thesis, these factors led me to ask the following questions: Does the responsibility for health fall to the individual? Are there environmental influences on health? Are there connections to social responsibilities?

I have been awarded the Graduate Student Scholarship by the lead principal investigator, Dr. Tam Truong Donnelly, and given the opportunity to conduct a section of a larger, mixed methods study entitled "Factors Influence [sic] Breast Cancer Screening Practices Amongst Arabic Women Living in the State of Qatar" and funded by the Qatar National Research Fund under the National Priorities Research Program. The overall goal of the research is to explore the development, implementation, and sustainment of an intervention program that will raise awareness about breast cancer and increase women's participation in breast cancer screening (BCS) activities in the state of Qatar. Study one of the research explores BCS practices among Arabic women using a cross-sectional survey. Study two explores contextual factors influencing Arabic women's BCS screening practices from the perspectives of women, men, and health care providers using

a qualitative method. In my section, I explored the factors from the perspective of health care providers including nurses. In chapter 1, I present the background, problem statements, research purpose, and significance and relevance of the study. In chapter 2, I present the literature review and research question. In chapter 3, I describe conceptual frameworks that guided the research, discuss the choice of research method of inquiry in relation to the research question and purpose, and demonstrate how the method of inquiry guided research procedures. In chapter 4, I present findings, major themes and sub-themes that emerged from the qualitative data. In chapter 5, I present discussion, implications for health care, practice, education, and research, limitations of the study, and conclusion.

1.1 Background

The State of Qatar is a sovereign Arab state, an independent emirate, on the west coast of the Peninsular Gulf (Britannica, n.d.). With proven reserves of oil and natural gas, Qatar is one of the world's richest countries with GDP per capita of \$98,329 in 2011 (International Monetary Fund, 2012). The 2010 census (Qatar Statistics Authority [QSA], 2010) recorded the total population at approximately 1.7 million, of whom 24.4% are Qatari citizens. Qatari female citizens represent 36.7% of the total female population of Qatar (QSA, 2010). Qatar has undergone rapid growth and substantial development leading to changing environmental and social conditions that affect people's lifestyles and the prevalence and patterns of disease including cancer (Bener, Aryub, Kakil, & Ibrahim, 2007; Donnelly et al., 2011, 2012; Tarabeia et al., 2007).

Breast cancer is the most common cancer in women worldwide (Health Canada, 2004; World Health Organization [WHO], 2010). Each year, more than 1.5 million women worldwide are diagnosed with this disease, and 502,000 die from it (WHO, 2010). Breast cancer has been the most common cancer in Qatar as well (Al-Hamdan et al., 2009). The incidence rate during the year 2006 was 30 per 100,000 among women in Qatar while other cancer types fell below 9 per 100,000 (Bajassoum, 2005; Bener, Ayub, Kakil, & Ibrahim, 2007). In the Middle East the highest age-adjusted breast cancer incidence rate has been recorded in Bahrain with 49.8/100,000 and Kuwait with 47.7/100,000 (International Agency for Research Cancer [IARC], 2008). Qatar follows closely with an incidence rate of 38.1/100,000 which is high compared to countries such as Saudi Arabia (22.4/100,000) or Yemen (20.8/100,000) during the years 1998 – 2001 (Al-Hamdan et al., 2009; IARC, 2008). WHO (2006) states that the high mortality rates of breast cancer in the Middle Eastern countries are due primarily to delayed diagnosis of the disease. As a result of these findings, there must be a strong emphasis on health care providers and the health care system to increase public health efforts in screening and early detection of breast cancer (Haji Mahmoodi et al., 2002; WHO, 2010).

Evidence suggests that screening and early detection of breast cancer play an important role in reducing cancer morbidity and mortality (Haji Mahmoodi et al., 2002; WHO, 2010). However, Bener and colleagues (2007, 2009) indicated that although the population in Qatar appears to have adequate knowledge about breast cancer and its screening, they seldom utilize available cancer screening services. The consequences of not addressing the problem include: (a) exacerbation and poor prognosis of the cancer by

lengthening the time that the illness remains untreated (WHO, 2006, 2010), (b) adverse effects on health and well-being including social distress, psychological suffering and functioning, reduced role performance, and emotional hardship to the individual and caregivers (Bener et al., 2009; Boyle & Ferlay, 2005), and (c) an increase in medical and health care costs that could be reduced with early detection, care, and treatment (American Cancer Society [ACS], 2009; Okonkwo, Draisma, der Kinderen, Brown, & de Koning, 2008; WHO, 2006).

1.2 Problem Statement

Despite growing attention to the importance of early detection of breast cancer in Qatar, little is known about how the women view, understand, and participate in BCS practices and why they seldom participate in the screening practices (Bener et al., 2007, 2009). Most studies have focused exclusively on individual factors such as age, education level, and knowledge level. The less visible, ecological influence of socioeconomic, cultural, political, and historical factors is explored much less in the literature. More qualitative research that explores contextual factors that influence BCS practices is needed to (a) address barriers to using cancer screening services and to (b) find ways to provide culturally appropriate breast health care, which will, in turn, decrease the severity of breast cancer, unnecessary suffering, and health care costs.

1.3 Research Purpose

The purpose of this qualitative research is to explore, understand, and describe the factors influencing breast cancer screening practices among Arabic women in Qatar from the perspective of health care professionals.

1.4 Research Question

The research question for this study is: What are the factors, from the health care providers' perspective, influencing breast cancer screening practices among Arabic women living in the state of Qatar?

1.5 Significance and Relevance of the Study

The significance of the research relative to health care providers' practice, the population, health care, policy, and research is described in the following section.

1.5.1 Significance to health care professionals and the population

Direct care is an essential component of health care professionals' (HCPs) practice. Answering the research question formulated in this study is of great importance in HCPs' practice with Qatari women as HCPs must recognize, understand, and respond to the challenges encountered by people who need to access BCS services and achieve a higher level of health and well-being. Barriers to Qatari women accessing screening services make it challenging for HCPs to deliver the optimal level of care (Al-Amoudi, Sait, & Abduljabbar, 2010). A deeper understanding of the phenomenon and the context will enhance competence and readiness of HCPs to address the complexity and uniqueness of the Qatari environment and Qatari women living in the environment. Sound research evidence will advance practice professionally, ethically, and holistically (Hamric, Spross, & Hanson, 2009). It will help practitioners address the uncertainties they face in practice and respond to situations within a changing health care environment (Savage, 2006). Ultimately, answering the research question would be the first step to building

partnerships and working more effectively with Qatari women, thereby contributing to their health and well-being.

1.5.2 Significance to health care, policy, and research

Answering the research question is not only beneficial for care and the health of Qatari women, it also has implications for health care, policy, and further research. Firstly, understanding the perspective of a group of people about whom little is known relative to accessing BCS services can assist in the planning of cancer screening interventions that will be efficacious, accepted, attended, and thereby implemented successfully (Borrayo, Buki, & Feigal, 2005). In turn, effective health promotion programs can contribute to health care by increasing utilization of diagnostic services and decreasing morbidity, mortality, and illness complications associated with breast cancer and overall health care costs (WHO, 2006). Secondly, the research evidence generated from this study can benefit health care policy by providing an opportunity to critically analyze current health policy and offering ways to improve policies so that it promotes equal, timely, and appropriate access to health care (Canadian Nurses Association [CNA], 2008a; Hamric et al., 2009). Finally, findings from this research can benefit nursing, public health, and human science research by generating evidence-based knowledge that can inform practice and theory development (Brown, 1998) specific to the context of Qatar.

Chapter Two: **Literature Review**

A literature review was conducted to provide a context for the study and a foundation on which to generate new understanding of the phenomenon of interest. The major findings from the literature review are categorized as: (a) biomedical explanations of breast cancer, (b) individual and environmental factors affecting utilization of screening measures, and (c) cultural beliefs and factors affecting breast cancer screening practices.

2.1 Biomedical Explanations of Breast Cancer

Breast cancer is a heterogeneous disease in both its pathology and clinical manifestations (WHO, 2006). Breast cancer has been theorized to be a localized disease originating and disseminating in a progressive fashion, starting as a benign mass, then gradually progressing to invasive carcinoma, and finally metastasizing systemically (WHO, 2006). As a consequence, radical breast-conserving surgery with adjuvant therapies (such as radiation and chemotherapy) has been the widely accepted treatment modality (WHO, 2006). However, the current understanding is that breast cancer is a highly complex illness in which numerous etiologic and prognostic factors intermingle to determine the prognosis and health outcomes (WHO, 2006).

2.1.1 Etiology

Although the etiology of breast cancer is unknown, a variety of interrelated risk factors such as genetics, hormones, environment, socio-biology, and physiology are known to influence its development (Health Canada, 2004; Robbins, Cotran, & Kumar, 2001; WHO, 2006). The literature has documented the following reasons as potential

risk factors contributing to the rising incidence rate of breast cancer in developing countries: consanguinity (the quality of being descended from the same ancestor as another person), increased life expectancy, urbanization, adoption of western lifestyles including dietary habits, lack of exercise, obesity based on BMI, early menstruation before age of 12 years, delay of age of marriage and first pregnancy, and decrease in the practice of breast feeding, drinking alcohol and smoking tobacco, and taking birth control pills and hormone replacement therapy (Bener et al., 2009; Health Canada, 2004; Saadat, 2008; WHO, 2006, 2010). Qatar has gone through urbanization and adapted to westernized lifestyles including changes in dietary choices, sedentary lifestyles, lack of physical activities, increases in obesity, delay in marriage and first pregnancy, and a low incidence of breast feeding (Al-Hamdan et al., 2009; Bener et al., 2009; WHO, 2006). Although some risk reduction might be achieved with change in lifestyles, diet, and overall physical characteristics related to obesity as well as use of medications such as tamoxifen and other anti-estrogen compounds, reducing the incident rate of breast cancer remains a challenge as it is associated with multiple interrelated risk factors and usually diagnosed in very late stages (WHO, 2006, 2010). Diagnosing breast cancer will not reduce the incidence of the disease; however, at best, it will reduce the amount of and length of treatment, as well as the rate of mortality. As a result, WHO (2006, 2010) has emphasized the importance of a national cancer control approach for its early detection.

2.1.2 Breast cancer screening measures

Breast self-examination (BSE), clinical breast exams, and mammograms are the most frequently used and generally accepted methods of breast cancer screening (Simon,

2006; WHO, 2006). However, the benefits and effectiveness of commonly recommended procedures for breast cancer screening remain controversial in the literature. Some researchers questioned the benefit of mammography and argued that it causes more harm than good by diagnosing many false-positive cases (Newman, 2010), causing economic and psychological distress, anxiety, and physical discomfort and trauma (Kopans, 2010). Furthermore, the role of BSE in detecting breast cancer is controversial. Although BSE instruction may increase women's awareness of breast health and lead to earlier diagnosis of breast cancer (Akhigbe & Omuemu, 2009), there are currently no data that support the argument that BSE increases detection of breast cancer (Baxter, 2001; Rim, Chellman-Jeffers, & Fanning, 2008; Spurgeon, 2001). In contrast, Baxter (2001) suggested that there is good evidence of harm from BSE instruction such as anxiety, unnecessary biopsies, increased number of physician visits for the evaluation of benign breast lesions, and higher rates of benign biopsy results.

Despite the controversies, there is a general consensus in the literature that mortality rates can be reduced significantly through screening programs that detect breast cancer at its earliest possible stages and thereby facilitate early treatment that can destroy the cancer before it becomes fatal and uncontrollable (ACS, 2009; Berry et al., 2005; WHO, 2006). In Canada, it is recommended that women aged 50 years to 74 years be invited to participate in an early detection program (a routine screening mammogram) for breast cancer every two to three years (The Canadian Task Force on Preventive Health Care, 2011). This recommendation applies only to women at average risk of breast cancer without personal or family history of breast cancer. Women aged 30 years to 69

years who are at high risk, with personal and/or family history of breast cancer, are recommended to have annual screening with combined mammogram and breast MRI (Ontario Breast Screening Program, 2011). In Qatar, it is recommended “a monthly BSE starting at age 20 [years], [an annual] CBE for women aged 35 years and above, and an annual mammogram for women aged 40 years to 69 years” as per Qatar National Cancer Society and Hamad Medical Corporation (Donnelly et al., 2012, p. 2).

2.2 Individual and Environmental Factors Affecting Screening Practices

The literature identifies factors that either hinder or facilitate women’s breast health and health care practices. In this review, factors are categorized as individual and environmental.

2.2.1 Individual factors

Although WHO (2006, 2010) has aimed to increase utilization rates of cancer screening measures world-wide, numerous, individual barriers to utilizing screening procedures make the goal a formidable challenge. In several studies with Arabic women, lack of knowledge about benefits of early screening and screening methods, embarrassment, low self-efficacy, inconvenience, fear of positive test results, and health beliefs and perceptions hinder women’s breast health and cancer screening practices (Al-Amoudi, Sait, & Abduljabbar, 2010; Amin, Al Mulhim, & Al Meqihwi, 2009; Azaiza & Cohen, 2008; Cohen, 2006; Saadat, 2008). On the other hand, studies by Bener et al. (2002, 2009) identified facilitating factors that influence breast cancer screening behaviours as: knowledge about breast cancer and screening, perceptions of susceptibility to breast cancer, fear (in some cases), a positive family history, positive perceptions of

breast health, level of education, living in urban area, having medical check-ups when healthy, beliefs about personal responsibility for health, and a supportive social milieu.

2.2.2 Environmental factors

Besides individual factors, various environmental factors serve as barriers to utilizing screening services. Researchers have reported low socioeconomic status or living in low-income countries, cost involved with mammogram or seeing a doctor, and missing work as major barriers to screening (Azaiza, Cohen, Awad, & Daoud, 2010; Donnelly, 2008; Fiscella et al., 2010; O'Malley et al., 2001; Peek & Han, 2004). In Qatar, all medical services are free or heavily subsidized by the government. However, this might not mean that obtaining health care is free of costs for everyone. A study in Canada indicated that women who live in poverty, who move frequently, and have no fixed address and telephone number are challenges for health care providers to reach for a reminder for breast cancer screening (Donnelly, 2008). Furthermore, for women who depend on family members, especially the elderly, seeing a doctor and having a mammography test done depends on the individual's and family's socioeconomic status, (i.e., money, time, and transportation) (Donnelly, 2008). Therefore, socioeconomic status through education, income, and other variables, may determine resource access issues that affect women's breast cancer screening behaviour.

Moreover, several researchers have demonstrated that broader, contextual factors such as cultural perceptions and conceptualizations of health and illness, social network and interactions, and socio-cultural norms and identities shaped by gender, religion, and socioeconomic factors were the most significant factors that either hindered or facilitated

women's decision-making to see a doctor or seek screening tests among Arabic women (Azaiza & Cohen, 2006, 2008; Baron-Epel, Granot, Badarna, & Avrami, 2004; Cohen & Azaiza, 2005). For example, social network experiences such as ineffective physician-patient communication, lack of physician guidance, and hierarchical power relationships between physician and patient are obstacles to breast cancer screening (Black, Frisina, Hack, & Carpio, 2006; Donnelly, 2008; Lamyian, Hydarnia, Ahmadi, Faghigzadeh, & Aguilar-Vafaie, 2007). However, advice, personal knowledge, and information obtained from family members and friends, effective clinician-client health communication, physician support and encouragement for cancer screening can facilitate women's decision to seek screening tests (Bener et al., 2002; Donnelly, 2008; Lamyian et al., 2007; Petro-Nustas, 2001). Aziza et al. (2010) suggested that women in the Middle East region were more likely to undergo screening mammography if they were less religious or Christian. In some traditional societies with strong religiosity, a woman's body is perceived as private and should be viewed by her husband only; this belief can act as a barrier by restricting the woman's access to breast cancer screening services (Azaiza et al., 2010; Donnelly, 2008; Saadat, 2008).

2.3 Cultural Beliefs and Factors Affecting Breast Cancer Screening

The literature review reveals various ethno-cultural beliefs and conceptualizations of breast cancer that differ significantly from biomedical explanations of the illness.

2.3.1 Causes of cancer

Among some cultural groups such as Hispanic/Latina, African American, Asian American/Pacific Islander, Asian Islamic, American Indian/Alaskan Native, and Chinese

American, people who have strong religious and spiritual beliefs regarding karma, God's will, and evil spirit, may view cancer as punishment for not living right and for committing sinful behaviours, or a consequence of their ancestors' conduct (i.e., such as being a butcher) (Borrayo et al., 2005; Burhansstipanov, Lovato, & Krebs, 1999; Facione, Giancarlo, & Chan, 2000; Ho, Ho, Chan, Kwan, & Tsui, 2003; Rajaram & Rashidi, 1999; Wong-Kim, Sun, & DeMattos, 2003; Yeo et al., 2005). On a similar note, some Chinese Americans attribute the cause of cancer to the deities (or spirits) being offended (i.e., the door deity or the monkey deity [monkey is a popular animal in some areas of China]) and the spirit of a loved one seeking reunion in the next incarnation (Yeo et al., 2005). Some cultures may associate physical abuse as a cause of breast cancer. Wardlow and Curry (1996) reported in their qualitative study that the African American participants believed bruises resulting from domestic violence could turn into cancer if they were not given any medical attention. Furthermore, the participants were concerned that breast cancer screening might result in revelations of the existence of an abusive situation that they might not wish to be revealed (Wardlow & Curry, 1996). Similarly, some Arab women in Israel perceived cancer as punishment for improper behaviour, or not living according to the religion's (Muslim) commandments; therefore, cancer was also perceived as a test set by God, testing their patience, religiosity, and belief in God (Azaiza & Cohen, 2008). On the other hand, some Arab women perceived giving birth and breast-feeding as protective factors that reduce risk of breast cancer because of the belief that God blesses women who give birth to many children and breast feed their babies. This belief can reduce the risk of breast cancer but it also can be a barrier to breast cancer screening as

some Arab women may believe that they do not need to be screened because they breastfeed/breastfed their children (Bener et al., 2002).

2.3.2 Treatment and cure

As a consequence of culturally unique beliefs about cancer, some ethno-cultural groups such as African American may believe that only God can cure cancer and thus having faith in God is the only completely benign and powerful treatment available (Gregg & Curry, 1994; Ho et al., 2003; Mitchell, Lanning, Mathews, & Swanson, 2004; Yeo et al., 2005). Furthermore, Gregg and Curry (1994) found that African American women participants believed that the treatment for cancer and its associated mental and physical trauma (i.e., stress, scar, and hair loss) were as bad as or worse than having untreated cancer, thus being dissuaded and refraining from screening practices. For example, the loss of hair might be particularly disturbing for African American women because their hair often represents an important aspect of self and ethnic identity. A similar finding was noted in a study with older Latina women in which participants expressed the belief that physical traits (i.e., breast, hair) define a woman's feminine identity and sexuality (Borrayo et al., 2005). Finally, some Hispanic/Latina women believed that cancer was a death sentence; therefore, they did not value early detection provided by screening (Perez-Stable, Sabogal, Otero-Sabogal, Hiatt, & McPhee, 1992). "If you have it, there's not much cure for it ... It will last until it kills you" (Gregg & Curry, 1994, p. 523). The sense of pessimism and fatalism has been documented in other studies with some Latina and African American women (Borrayo et al., 2005; Gregg & Curry, 1994). Similarly, due to the pervasive belief about cancer as God's will, some

Arab women in Israel and Jordan perceived cancer as a disease with no cure and equivalent to death (Azaiza & Cohen, 2008; Baron-Epel et al., 2004, Petro-Nustas, 2001). Petro-Nustas (2001) suggested that this belief might be a factor for under-utilization of breast cancer screening services in the Middle East region.

2.3.3 Screening practices

The literature review revealed additional cultural beliefs that screening: (a) will not prevent breast cancer, (b) will do more harm than not knowing and living with cancer, and (c) is invasive of a personal, private body.

2.3.3.1 Screening will not prevent breast cancer

Gregg and Curry (1994) reported that the African American women participants displayed pessimism in their belief that screening merely catches the disease after the fact, thus it was not an effective preventive tool. On a similar note, Balslem's (1991) study with African American women indicated that the participants viewed cancer testing as looking for trouble as it cannot stop cancer from occurring. Donnelly, Mckellin, Hislop, & Long (2009) and Ramirez, Villarreal, Suarez, & Flores (1995) identified that the spiritual belief that God's will is what will happen was a barrier to breast cancer screening in some cultures. Furthermore, other researchers have found that it was inappropriate to discuss cancer with some cultural groups, such as Hispanic/Latina, African American, and Chinese, because thoughts were viewed as having the ability to shape reality and affect events; that is, speaking about breast cancer could bring it into being (Carrese & Rhodes, 1995; Pasick, D'Onofrio, & Otera-Sabogal, 1996; Rajaram & Rashidi, 1998). As in other studies, for some Arab women in Qatar, Israel, and

Palestinian authority, the spiritual belief that God's will is what will happen and a view of cancer as a death sentence were barriers to breast cancer screening (Azaiza & Cohen, 2008; Azaiza et al., 2010; Bener et al., 2002; Soskolne, Marie, & Manor, 2007). Unlike other studies, a qualitative study with Arab women in the United Arab Emirates (Bener et al., 2002) reported that some women may believe that God acts through screening and doctors are messengers from God for treatment; therefore, they would be proactive with getting breast cancer screening.

2.3.3.2 Screening will do more harm than not knowing and living with cancer

Within some Hispanic/Latina and African American cultures, women felt that screening procedures such as mammograms only increased the chance for getting the disease by causing trauma to the breast, as a result of pressure put on the breast and radiation from the mammogram (Chavez, Hubbell, McMullin, Martinez, & Mishra, 1995; Rajaram & Rashidi, 1998; Wardlow & Curry, 1996). Similar to findings from these studies, some Arab Israeli women believed that performing mammography brings bad luck (Soskolne et al., 2007). A qualitative study with Arab women in Israel identified the fear of loss of the role of Arab women in society as a result of cancer screening, (i.e., marriage and raising children, as a major barrier to screening) (Baron-Epel et al., 2004). The authors suggested that some Arab Israeli women perceived screening as possibly resulting in a diagnosis of cancer, thus resulting in the inability to fulfill their traditional female roles and responsibilities, loss of status in society, loss of femininity and sexuality, feelings of uselessness, worthlessness, and isolation, neglect and abandonment by family, and change in the relationship with their husbands (Azaiza & Cohen, 2008;

Baron-Epel et al., 2004). Some Arab women expressed fear of gossip, social stigma attached to breast cancer such as loss of femininity, abnormal and fatal, cultural taboo of breast as dirty, wrong, and immoral, and fear of burdening family members (Azaiza & Cohen, 2008; Baron-Epel et al., 2004; Bener et al., 2002). As a result, some Arab women might avoid accessing cancer screening services despite knowledge about breast cancer and its screening.

2.3.3.3 Screening is invasive of a personal, private body

For some Asian cultures such as Vietnamese which is influenced by Confucian teaching (A woman and a man should never touch or be close to each other), a woman's body is conceptualized as a private body, leading to a pervasive feeling of embarrassment, hesitation, and invasion of personal privacy and making clinical breast examinations culturally sensitive and challenging for the women (Donnelly, 2008).

Similarly, for some other cultural groups such as traditional Hispanic/Latina, Cuban, and South American, only a husband or a lover should touch a women's breast; therefore, women may feel uncomfortable with a doctor touching their breasts or require permission to have breast cancer screening done (Bailey, Bennett, Hicks, Kemp, & Warren, 1996; Borrayo et al., 2005; Rajaram & Rashidi, 1998). Similar to other cultural groups, some Arabic women may conceive modesty and concealment of sexuality as virtuous qualities for women. As a result of this quality, women often are silent and secretive about their breasts and breast cancer. They may feel uncomfortable, embarrassed, and guilty about exposing their breasts to doctors and may require spousal permission for breast cancer screening (Azaiza & Cohen, 2008).

2.4 Summary of Literature Review

The literature reveals numerous factors and barriers associated with breast cancer screening practices, suggesting that breast cancer is a complex illness, and experiences of it are unique, individual, social, and cultural. Various cultural beliefs about the origin and treatment of breast cancer and cancer screening differ significantly from the dominant biomedical understanding of the illness. The review reveals several gaps in the literature. Firstly, although there is abundant literature on factors associated with breast cancer screening practices, reasons for under-participation remain unclear. Secondly, most qualitative research inquiring into cultural beliefs about breast cancer was published during the period of 1990-2000, not during the past decade. Thirdly, to the best of my knowledge, there is no qualitative research that honours and explores cultural beliefs, attitudes, knowledge, and other socio-political-historical-discursive contextual factors that affect Qatari women's breast health. Such research is needed to inform health care providers and health care decision makers differently, thereby drawing attention to the need to address the context-bound nature of breast cancer screening.

Chapter Three: **Methodology**

In this section, I describe the theoretical frameworks and the research method of inquiry chosen for the study. Then, I demonstrate why these were the best approaches to answering the research question.

3.1 Theoretical Frameworks

Following the theoretical frameworks of the main research study in Qatar, funded by the Qatar National Research Fund under the National Priorities Research Program (Donnelly et al., 2011, 2012), this qualitative research based its theoretical foundation on an ecological perspective and Kleinman's (1978) explanatory model. By combining the two theoretical frameworks, I not only examined the influence of culture on breast health related decisions and behaviours, but also sought understanding of the human health phenomena within the broadest context.

3.1.1 An ecological perspective

An ecological perspective on health is a conceptual framework that emphasizes both individual and environment as targets of health promotion (Glanz, Lewis, & Rime, 2002; Green, Richard, & Potvin, 1996; McLaren & Hawe, 2005; McLeory, Bibeau, Steckler, & Glanz, 1988). The framework has been used increasingly as a theoretical foundation in public health and health promotion literature, including the Ottawa Charter for Health Promotion (WHO, 1986), the Lalonde Report (1974), the Epp Framework (1986), and Healthy People 2010 (Davis, 1998). Emanating from multiple disciplines, the ecological perspective emerged to critique a victim-blaming ideology of life-style health promotion interventions that neglect the importance of

contextual influences on health and illness (McLeory et al., 1988). An ecological conceptual framework encompasses a broad context to include physical, social, cultural, and historical aspects, as well as characteristics and behaviours of persons within the context (McLaren & Hawe, 2005).

Central to the ecological perspective is the assumption of reciprocal, interdependent, mutual interactions between the individual and the context; that is, human behaviour is viewed as being affected by and effecting multiple levels of environmental influence such as individual, interpersonal, organizational, community, and public policy levels (Barker, 1968; Eng, Hatch, & Callan, 1985; McLeory et al., 1988; Moos, 2002). The philosophical underpinning of the framework is that reality is subject to changes as it is context bound. Therefore, appropriate changes in the environment at multiple levels will lead to changes in the behaviour of individuals with the support of individuals (McLaren & Hawe, 2005; Stokols, 1992). This assumption is central to the research purpose and question addressed in this study. Therefore, in order to answer the research question and identify environmental influences on health care practice behaviours and choices and environment-focused interventions, it is imperative to investigate contextual influences on health and illness at multiple contextual levels.

3.1.2 Kleinman's explanatory model

Prior to discussing the explanatory model, it is necessary to discuss culture, which is the core concept in the model. Kleinman (1978) defined culture as “a system of symbolic meanings that shapes both social reality and personal experience, mediates between the ‘external’ and ‘internal’ parameters of medical systems” (p. 86).

In this definition, culture is conceptualized as a mediator that intervenes and reconciles external (social, political, economic, historical, epidemiological, and technological) and internal (psycho-physiological, behavioural, and communicative) factors through symbolic meanings such as use of language, worldviews, beliefs, ideas, and practices to shape people's decision-making and behaviour (Kleinman, 1978). From this perspective, meanings of health and illness are shaped by culture; that is, culture not only influences people's perceptions, beliefs, and expectations, but also their behaviours and experiences (Angel & Thoits, 1987; Donnelly, 2004). A central assumption underlying this definition is that culture is contextually enacted and socially constructed; hence, it is a relational and dynamic process laden with emotional meanings and values (Browne & Varcoe, 2006; Rajaram & Rashidi, 1998). Therefore, it is imperative to explore the social context in the creation of the system of symbolic meanings (culture) that shape an individual's experiences of health and illness by acquiring subjective narratives of people living in the cultural setting.

Kleinman's (1978) explanatory model (EM) is an attempt to understand the concepts of health, illness, and healing as both social and cultural systems (Kleinman, 1978). An EM for illness is an individual's culturally specific understanding of a particular illness (etiology, nature of symptoms, pathophysiology, diagnosis, treatment, prevention, roles and expectations of the sick individual) and health condition that is socially constructed and shaped by culture and history (Donnelly, 2004; Kleinman, 1978; Shaw, Huebner, Armin, Orzech, & Vivian, 2009; Yeo et al., 2005). This model acknowledges multiple, dynamic, and ever-changing realities and different interpretations

of realities. It offers a unique lens of viewing illness from the perspective of the person living in the culture. As evident in the literature review, breast cancer has been conceived differently among different cultural groups. These cultural belief systems or EMs of women, which are not in accordance with biomedical explanations of illness, have an impact on women's health behaviours and decisions regarding cancer screening tests (Donnelly, 2004; Rajaram & Rashidi, 1998; Yeo et al., 2005). Thus, to understand how Arabic women in Qatar think about and attend to their health, it is essential to have an understanding of their beliefs, values, expectations, practices, and what they consider to be social norms in regard to health care seeking and their relationships with health care providers.

Kleinman (1978) contends that many health care professionals hold an assumption that clients' value systems are irrational and unscientific because they are value-laden and subject to change. In Western society, there is a pervasive preference for objectified knowledge over experiential knowledge (Rodgers, 2005). Biomedical knowledge originated from positivism is taken for granted as credible while other ways of knowing that are essential to understanding human experiences are devalued and disputed (Rodgers, 2005). Kleinman (1978) questions this undue adherence to a philosophy of positivistic science by the professional sector of health care and over-reliance on its guidance for knowledge development and lack of awareness of alternative views. Lack of understanding of women's EMs may result in (a) ineffective health promotion strategies used to enhance breast cancer screening and (b) a breakdown in the communication process between the subculture of biomedicine and the cultural

community. Thus, Kleinman (1978) calls for a broader cross-cultural perspective that would include EMs held by patients (lay, popular culture) and health care providers (biomedical). He suggests that health care providers must be able to elicit and recognize clients' EMs of illnesses and that the client as a partner in care has a right to accept, alter, and reject health information/advice given to them in order to build effective health promotion strategies that enhance quality of health care. At this juncture, it would be necessary to elucidate the (a) EMs of Arabic women (which is another qualitative inquiry of the larger study) and (b) those of health professionals and their understanding of EMs of the women to compare differences and commonalities and generate viable solutions to overcome barriers to utilizing cancer screening services. In this research, I explored the EMs of HCPs and their understanding of EMs of the women.

In conclusion, Kleinman's (1978) theoretical model of health care as a cultural system provided a method for analysis of the impact of culture on an individual's illness and health experiences. Kleinman's conceptual framework was a valuable, guiding tool in uncovering new, unfamiliar, and different cultural beliefs about breast cancer and making sense of contextual factors influencing Qatari women's breast cancer screening practices. Nevertheless, this conceptual framework was limited to addressing health care at a professional-client level. Together with the ecological perspective, however, I was able to examine not only the influence of culture on Arabic women's breast health care behaviour, in particular, breast cancer screening practices, but also the broader, socio-political-historical-discursive ecological influences on the women's decisions for their health.

3.2 Research Method of Inquiry

Critical ethnography was used to explore the phenomenon of interest and answer the research question. Critical ethnography is an inquiry approach that has emerged in consideration of existential issues to describe particular phenomena as embedded in culture or a “local moral world” (Kleinman, 1996, p. 98). It has its roots in the Chicago school of sociology (Smyth & Colin, 2005). It is a branch of ethnography informed by critical social theory (Fontana & Frey, 1994) with “an emancipatory intent aimed at uncovering [issues of injustice and] oppressive ideologies in society” (Jackson, Clare, & Mannix, 2003, p. 215) and changing social conditions in the interests of those who are rendered marginal by the dominant culture (Carspecken, 1996; Jackson et al., 2003). Therefore, critical ethnography accounts for historical, social, and economic situations (Fontana & Frey, 1994). For this inquiry of a qualitative research methodology, a particular reference is made to the work of Phil Carspecken (1996) who developed and provided the most extensive and theoretically sophisticated account of critical ethnography. In this section, the philosophical assumptions underlying the methodology, assumptions embedded in the research question, and the fit of the method to the research question are discussed, and research procedure are described.

3.2.1 Philosophical assumptions

I demonstrate ontological, epistemological, and methodological assumptions underpinning critical ethnography. These philosophical assumptions of the methodology reflect my worldview as a researcher.

3.2.1.1 Ontology

“Ontology refers to claims regarding the nature and structure of being” (Rawnsley, 1998, p. 2). In critical ethnography, reality is distinct from knowledge about reality. Reality refers to more than what is known and constructed as knowledge by members of a cultural group (Georgiou & Carspecken, 2002; Harrowing, Mill, Spiers, Kulig, & Kipp, 2010). Critical ethnography is concerned with construction of reality and what/who controls and organizes the reality formation and how they do this (Savage, 2006). It has strong emphasis on the ontological foundations of seeking reality through understanding the relationship of culture to systemic social structures that influence how people think and act (Georgiou & Carspecken, 2002). Explication of the social structures that might escape people’s awareness is important in critical ethnography because lack of awareness results in repetitive routines of certain actions that contribute to mutual knowledge construction, asymmetric power relations, and the *status of quo* of what is taken for granted as truth (Georgiou & Carspecken, 2002). It is through the critical analysis of systemic power relations that critical qualitative research findings are understood fully and utilized to effect change (Harrowing et al., 2010).

In this sense, the person is viewed as influenced by cultural conditions (ethics, norms, and conduct), social resources, constraints (Harrowing et al., 2010), and cultural power (Georgiou & Carspecken, 2002). There is no one truth or reality as reality is symbolically and intersubjectively mediated and is fallible over time (Georgiou & Carspecken, 2002; Harrowing et al., 2010). Culture is reconstructed through subjective interpretations of phenomena (Georgiou & Carspecken, 2002). Thus, the goal of

ethnography is to capture both a system of symbolic meanings and surrounding systemic social structures, document the existence of alternative realities, and describe a rich and wide-ranging landscape of human interaction in the language of the people studied (Speziale & Carpenter, 2007).

3.2.1.2 Epistemology

Epistemology is “theory of knowledge to encompass philosophical problems concerned with the origin and structure of knowledge ... as the branch of philosophy that struggles with possibilities and limits of human knowing” (Rawnsley, 1998, p. 2). Critical ethnography rejects positivism, or empiricism, which takes objectivity as a paradigm for knowledge because objectivity, in critical ethnography, is conceived as distorted by culturally influenced perceptual processes (Georgiou & Carspecken, 2002; Speziale & Carpenter, 2007). For example, some human phenomena such as fear and suffering are not amenable completely to objectification or hypothesis testing, because of a high degree of complexity or context-dependence of the nature of the phenomena (Letourneau & Allen, 1999; Speziale & Carpenter, 2007). In critical ethnographic traditions, claims to truth are discursively organized and incriminated in social relations of power (Georgiou & Carspecken, 2002; Hardcastle, Usher, & Collin, 2006; Kincheloe & McLaren, 2003). Therefore, critical ethnographers seek understanding of the relationship between power and knowledge through ways of living or patterns of meaningful actions and pragmatics of communication as paradigms for knowledge (Georgiou & Carspecken, 2002). Hence, narratives are a way of speaking issues of power and equity (Pingatelli, 1998). Through “the lens of power, prestige, and authority

in response to an ethical responsibility to address unfairness or injustices” (Harrowing et al., 2010, p. 242), critical ethnographers bear witness to the stories of people rendered marginal and tell their stories in their own words to challenge current ways of knowing, generate critical dialogue about power and equity, and lend more authority to their voice (Kohl, 1994; Savage, 2006).

3.2.1.3 Methodology

Ontological and epistemological assumptions influence the methodology. Critical ethnography is a research method that rests on the assumption that understanding of truth and meaning is found through the interpretation of subjective narratives of the person or the group’s experiences and actions embedded within a context such as culture, history, power relations, practice, and language (Carspecken, 1996; Speziale & Carpenter, 2007). Therefore, it is concerned with cultural reconstruction as closely as possible to an insider’s position of view of a phenomenon with respect to culture in naturally occurring settings (Georgiou & Carspecken, 2002, Savage, 2006). The researcher must strive to capture the way meaning is constituted within the group through interpretive cultural analysis of the insider, with particular attention to discourse and behaviour of participants to create knowledge of the systemic social phenomena (Georgiou & Carspecken, 2002; Harrowing et al., 2010). Therefore, the researcher is the data collection instrument in identifying, interpreting, and analyzing the emic perspective of the culture under study through interviewing, observing, and recording of cultural data (Harrowing et al., 2010; Rubin & Rubin, 2005; Speziale & Carpenter, 2007). In critical ethnography, cultural data means the “internalized grasp of those intersubjective expectations that mediate position

taking between members of a cultural community” (Georgiou & Carspecken, 2002, p. 690).

3.2.2 Assumptions embedded in the researcher’s theoretical stand

The researcher’s first theoretical assumption underpinning this research is that individuals’ health is more than merely the absence of disease; that is, it is a resource for living influenced by physical, intra- and interpersonal, environmental, cultural variables, circumstances, beliefs, and other social determinants of health (Green et al., 1996; Hamilton & Bhatti, 1996; Vollman, Anderson, & McFarlane, 2004; WHO, 1986, 2010). The unitary nature of person-with-environment and the interaction between the two (Drew & Dahlberg, 1995; Munhall, 1989) make it necessary to investigate how environmental factors and other social determinants of health influence the population’s health care practices and the choices that they make.

The second assumption embedded in this research is that knowledge can be derived from various sources, not only the bodily senses (objective, experimental), but also aesthetic, ethical, and personal ways of knowing (Carper, 1978; Monti & Tingen, 1999) to honor the fullness of humanness. Within the constructivist/interpretative paradigm, intersubjectivity rather than objectivity is emphasized in addressing the research question because reality is complex, holistic, multiple, dynamic, and context-dependent (Monti & Tingen, 1999; Weaver & Olson, 2006). Therefore, it is crucial to value and pay attention to subjective narratives of people who have experience with the research topic and bring hidden meanings into consciousness through critical analysis.

3.2.3 Fit of the methodology to the research question

As previously mentioned, the research question that was addressed in this study is: What are the factors, from the health care providers' perspective, influencing breast cancer screening practices among Arabic women living in the state of Qatar? Critical ethnography was the best approach to understanding the phenomenon of interest and answering the research question because the philosophical underpinnings of the methodology are consistent with the researcher's constructivist/interpretive paradigm (Weaver & Olson, 2006) and the assumptions embedded in the researcher's theoretical stand and conceptual frameworks. The use of critical ethnography enabled the researcher to uncover various contextual factors, from the health care providers' perspective, influencing Qatari women's breast cancer screening practices, and revealed how health is both constrained and fostered by health care and social systems which are produced and reproduced in culture (Cook, 2005; Hardcastle et al., 2006; Savage, 2006). Within the qualitative paradigm, ethnography is particularly valuable because of the attention it gives to context and its synthesis of findings from triangulation of different methods such as observation and interview. Critical ethnography proved to be not only applicable, but also a pertinent and effective methodology to approach this research study.

3.2.4 Research process

As part of a larger research study (in progress) funded by the Qatar National Research Fund, this research was conducted in the State of Qatar. Data collection was conducted in three health care facilities that provided women's health care services to Arabic women. In this section, I demonstrate how the chosen method of inquiry was

instrumental in conducting the research procedures including sampling, data collection, and data analysis.

3.2.4.1 Sampling

Sampling is “the process of selecting a portion of the population to represent the entire population so that inferences about the population can be made” (Polit & Beck, 2008, p.339). The steps include identifying eligibility criteria, specifying sample size, sampling plan, and how to gain entry, and finally recruiting the sample (Polit & Beck, 2008).

3.2.4.1.1 Eligibility criteria

Based on the literature reviewed and feasibility of the study, participants’ selection criteria included: (a) health care providers (nurses, physicians, and social workers), (b) who can speak English, and (c) who provide direct health care to Arabic women in Qatar. Health care providers were deemed to be credible sources for data collection as they could share diverse views regarding the Qatari population’s encounter of barriers and contextual factors in breast health care practice.

3.2.4.1.2 Sample size

As in any qualitative studies, data are collected until data-saturation is reached (LoBiondo-Wood & Haber, 2002). Saturation refers to the repetition of discovered information and confirmation of previously collected data at a particular time (Morse, 1994). Due to time constraints, the estimated sample size for the period of four months was restricted to 15. The fifteen health care providers were recruited from three primary health centres in Qatar.

3.2.4.1.3 Sampling plan

Purposive sampling strategy which is the process of deliberately selecting heterogeneous subjects who are considered to be information-rich and typical of the population (Donnelly, 2004; Morse, 1994) and snowball sampling which is a technique for identifying potential participants by asking existing participants to recommend others who also meet the selection criteria (LaBiondo-Wood & Haber, 2002) were used to identify and recruit potential participants in partnership with health care organizations in Qatar. Participants with different health care practice backgrounds were selected from different health care centers to reflect diversity in perspectives and to gain insight from individuals who practice in different levels of health care.

3.2.4.1.4 Gaining entry

The research was conducted in three community-based primary health centers in Qatar. The lead principal investigator and the researchers of the larger study ensured that the sites maximized the potential of the phenomenon to be studied and gained access to the community health centers for recruitment of potential participants (also see Appendices A). In order to build trust and a partnership with them, the researcher had a meeting with administrators and managers to present the study purpose, benefits and potential risks for participation, contributions to society, and how the participants' confidentiality would be protected (Speziale & Carpenter, 2007). Arabic speaking research assistants of the larger study assisted the researcher to gain trust and access to the site.

3.2.4.1.5 Recruitment

The health research ethics committee approval was obtained by the lead principal investigator and researchers of the main study from the Conjoint Health Research Ethics Board at the University of Calgary and the Hamad Medical Corporation. The ethics for this master's thesis was added to the main study as an amendment. After obtaining managerial permissions, eligible participants were identified according to the eligibility criteria by managerial administrators in the institutions. I asked the administrators and managers to provide me with names of only those who gave them permission to give their contact information to me. Face-to-face recruitment was used to recruit potential participants. I went to the community health clinics, approached the eligible participant, provided them with a consent form (See Appendices B) that described the purpose of the study, benefits and risks of participating for the individual, benefits to society, and confidentiality of the data, and asked them to participate in the study (Speziale & Carpenter, 2007). I stressed the voluntary nature of participation, and provided them with opportunity to ask questions or voice concerns. When the participant agreed to participate in the study, I arranged a place and time for an interview that was convenient for both the researcher and the participant. A written, informed consent was obtained after verbal consent.

3.2.4.2 Data Collection

The purpose of the ethnographic data collection is to make explicit what is implicit within a culture by obtaining an emic perspective that reflects the cultural group's language, beliefs, and experiences (Speziale & Carpenter, 2007). The only way

ethnographers can begin to access the emic view is by interviewing group members, observing their behaviour, and collecting cultural artefacts (Speziale & Carpenter, 2007). In this research, data collection and analysis were guided by strategies suggested by Carspecken (1996).

3.2.4.2.1 Observation

Carspecken described this stage as articulating the “background horizon” (Carspecken, 1996, p. 121). The purpose of observation was to: (a) get to know the physical environment (who is involved and routines) and “sharpen one’s awareness of events that may occur routinely” (Carspecken, 1996, p.49) and (b) tease out themes, key issues, and areas that require further exploration during the interview (Hardcastle et al., 2006).

After obtaining verbal consent from every health care professional involved in the observation, I observed health care professionals’ activities and the physical environments of the community health care clinic settings (without patients) because I understood that breast cancer might be a very culturally sensitive issue to Arabic women. In this research, I did not observe any patients or interactions between health care professionals and patients. The focus questions of the observation were: How does screening work? How does it happen in this particular environment? I observed behaviours, activities, routines, social interactions, dialogue, tone of voice, gestures, facial expressions, and postures between health care professionals, examination rooms, medical equipment, and furniture, with a wide-angle view. After observation at each health center, I wrote field notes using thick description, “a rich and thorough description

of the research setting and of observed transactions and processes” (Polit & Beck, 2008, p. 202). The observation was brief, informal, lasting no more than half an hour at any time. “Complete observer” (Creswell, 2003, p. 186) technique was used to minimize reactivity, interruption, and causing an unsafe situation (LoBiondo-Wood & Haber, 2002). I expected that perhaps people who were being observed might act differently with me around. However, as Carspecken (1996) argued, the Hawthorn effect is not damaging to a qualitative study; what is important is acknowledging that the presence of the researcher might influence behaviours of the participants. Observation and analysis of the observational data occurred simultaneously, using a recursive back and forth process (Hardcastle et al., 2006; Speziale & Carpenter, 2007). The results of analysis of the observational data were cultural themes that appeared meaningful during interaction such as interaction patterns, power relations, and roles.

3.2.4.2.2 Semi-structured interview

Carspecken (1996) suggested that the central purpose of the interview is to democratize the research process by “giv[ing] participants a voice in the research process and a chance to challenge material produced by the researcher” (Carspecken, 1996, p. 155). By performing “member checks” (Carspecken, 1996, p.89), a researcher’s initial interpretation of findings are returned to the participants for further discussion, feedback, and exploration of tentative meanings developed during data collection to enhance the integrity, validity, and trustworthiness of study findings (Carspecken, 1996). In critical ethnography, participants are active participants in that they can and should negotiate

findings with the researcher, shape emerging analyses, and determine the application of findings back to their own broader, contextual environments (Cook, 2005).

According to Carspecken (1996), the semi-structured, in-depth interview is an excellent strategy in collecting the dialogical data. Face-to-face interview was effective in establishing trust and rapport with the participants. The length of the interview ranged from 30 to 60 minutes. Carspecken (1996) suggested that interviewing the same subjects repeatedly strengthens the validity of meaning reconstruction. Therefore, as recommended by Carspecken and according to feasibility of the study, seven out of 15 participants were conveniently chosen according to their availability for the second interview and interviewed twice to (a) enhance the trustworthiness of findings of the research and (b) clarify and validate descriptive summary of the first interview and initial interpretation of findings. The first interview was an individual, in-depth, face-to-face interview at the participant's most convenient time and place. The second interview was also an individual, in-depth, face-to-face interview for approximately 30 minutes at the participant's most convenient time and place. Participants were informed that they might be asked to participate in the second interview prior to their participation in the first interview (See Appendices B). The interview was guided by broad, open-ended, and non-directive questions (See Appendices C). In order to answer the research question, the participants were asked questions about personal, cultural, social, political, and historical factors that might affect how Arabic women seek help for breast health issues. However, the role of the researcher was to facilitate but not lead, and to be open to listening actively to unexpected narratives (Smyth & Colin, 2005).

In order to increase the accuracy of data collection and preserve native expressions, all interviews were audio-taped, after receiving permission from the participants about recording the interview conversation, and transcribed verbatim for textual, thematic analysis (Donnelly, 2004; Speziale & Carpenter, 2007). Field notes were completed after each interview in order to locate presuppositions and biases that the researcher holds. Krahn and Putnam (2003) suggested that interviewing is a mutually influencing process; hence, it is important that the interviewers be aware of the influence that they have on the participants' responses. Efforts were made to enable the participants to feel comfortable speaking about their experiences (i.e., establishing rapport, being non-judgmental, arranging a quiet interview setting, and careful framing of an opening question).

3.2.4.2.3 Reflexivity

Carspecken (1996) recommended Giddens' (1984) notion of reflexivity as essential to the research process. Reflexivity is described as "the struggle for objectivity in collecting and analyzing data while being so intimately involved with the group" (Speziale & Carpenter, 2007, p. 202). I acknowledged that as a researcher I might bring certain personal and professional biases, values, and experiences to the research process. With this awareness, I carefully monitored, examined, and articulated my actions and thoughts through peer-debriefing with the principal investigator and constantly challenged myself during the research activities (Hardcastle et al., 2006; Kincheloe & McLaren, 2003; Smyth & Colin, 2005). Nevertheless, it is important to remember that "meaning is not merely investigated, but is constructed by the researcher and informant

through active and reciprocal relationships and the dialectical processes of interaction” (Anderson, 1991, p.116).

3.2.4.3 Data analysis

Data analysis occurred simultaneously with data collection from the interview. In critical ethnography, the purpose of the data analysis is to (a) capture and describe both the cultural conditions of action and system phenomena (Georgiou & Carspecken, 2002) and (b) provide a detailed description and interpretation of “why this is and what can be done about it... [beyond] what is” (Cook, 2005, p. 132).

3.2.4.3.1 Procedure

Data coding, analysis, and interpretation were undertaken using NVivo 9, a qualitative data analysis software, which made it possible to create a tree of themes and sub-themes (See Appendices D). The data analysis steps involved (a) line-by-line, naïve reading of the raw data to acquire a sense of the whole text, (b) being immersed in the data and extracting significant statements or recurrent patterns through interpretive reading, and (c) formulating meanings of each significant statement and identifying recurrent patterns and categorizing them into clusters of cultural themes (Speziale & Carpenter, 2007). Themes were not necessarily selected on the basis of their frequency in the transcripts alone. Other factors noted that added richness to the data included particular quotations, experiential examples, and paradigm cases that highlighted the themes (Speziale & Carpenter, 2007). Emerging concepts and themes were clustered, and shared meanings were confirmed by comparing within and across data set transcripts (Speziale & Carpenter, 2007). An outcome of the analysis was a set of interrelated

concepts, themes, and subordinate themes that appeared to capture most strongly the factors that influence Qatari women's breast cancer screening practices. The categorization of themes and sub-themes was then discussed with the principal investigator of this research project. The analyzed data were then examined for linkages to existing literature that best explained the phenomena and the environment (Cook, 2005; Hardcastle et al., 2006; Smyth & Colin, 2005). In critical ethnography, the research findings are considered valid and credible if they make sense to the participants because truth is defined in terms of consensus or "shared in understandings" (Kincheloe & McLaren, 2003, p. 19). Therefore, I went back to the participants at the end of the preliminary data analysis and confirmed validity of the findings (member checking) by presenting preliminary findings (themes and sub-themes) to seven participants.

3.2.4.3.2 Trustworthiness

Carspecken (1996) suggested that triangulation via the use of multiple recording devices and bodily senses during data collection increases credibility of the research findings. Constant checking and rechecking the information and going back and forth in the data collection and analysis are important in establishing trustworthiness in an ethnographic, qualitative inquiry (Hardcastle et al., 2006). In addition, the rigor, integrity, validity, and sincerity of meaning reconstructions can be strengthened with prolonged engagement in the field, peer-debriefing by colleagues, and member checks (Carspecken, 1996; Hardcastle et al., 2006; Smyth & Colin, 2005). Furthermore, in order to enhance transferability of the findings, data were collected from a variety of participants and recorded in English with utmost care to preserve the meaning intended.

3.2.4.3.3 Ethical considerations

The protection of study participants is important regardless of the research paradigm (Speziale & Carpenter, 2007). I informed participants fully about the matter to which they were consenting, informed them that they could withdraw from the study at any time, for any reason, and refuse to answer questions they felt uncomfortable to answer (Speziale & Carpenter, 2007). There were no foreseeable risks to participants as a result of their participation in the interview. However, if participants found it emotionally upsetting to tell their stories, I would stop the interview and offer them counselling and/or supportive services if they considered that would be helpful. Prior to commencing the interviews, counselling and supportive services were identified in Qatar with the support from the health institutions participating in this research. Great attention was paid to preserve anonymity and protect the privacy and confidentiality of the participants. Participants were identified by pseudonym and transcription code only. All data were in the electronic form and were stored on the researcher's password protected computer accessible only by the researcher. The researcher and the lead principal investigator of this research project had full access to the data. Data collection and analysis process was supervised by the lead principal investigator of the research. After the research is completed, the consent forms will be destroyed. All the field notes, transcribed interview data, and audio recordings will be destroyed seven years after the completion of the main study as per the University of Calgary, Conjoint Health Research Ethics Board guidelines.

Chapter Four: **Results**

An analysis of the qualitative research data revealed demographic characteristics of health care providers who participated in the interviews. Factors that influenced women's breast cancer screening (BCS) practices in Qatar coalesced into four major themes which were: (a) influence of knowledge, awareness, and pain perception on BCS, (b) influence of culture on women's BCS practices, (c) influence of gender and power relations on BCS, and (d) influence of systemic factors on BCS. Through the lens of the ecological perspective and Kleinman's (1978) EM, the findings of the study suggest that Arabic women's health in Qatar cannot be understood in isolation from the environment in which they live. Rather, the health of Arabic women is both constrained and fostered by health care and social systems that are embedded in culture. In the following sections of this chapter, demographic results, the four major themes and their sub-themes are reported. Pseudonyms are used to respect and maintain the participants' confidentiality. In this report, the term 'Arabic women' is used as shorthand for 'Arabic-speaking women'.

4.1 Demographic Results

The demographic data were collected to describe demographic characteristics of participants and to provide a context in which the results of the study can be understood (See Table 1). Participants had a minimum of five years of clinical experience with women's health care, with an average of 13.6 years of clinical experience. Six of the participants were physicians, two were head nurses, six were staff nurses, and one was a social worker. Their countries of origin were Qatar, Egypt, India, Iran, Sudan, Jordan,

and Bulgaria. Of the 15 participants, two were male. These demographic characteristics of participants are not necessarily representative of the demographics of health care providers in Qatar. However, their varied areas of practice, years of experience, genders, and countries of origin made it possible to gain diverse perspectives and insights.

Table 1 Participant demographics

Pseudonym	Gender	Title/Areas of Practice	Years of Experience	Country of Origin
Asha	Female	Staff Nurse	10	Indian
Rani	Female	Staff Nurse	11	Indian
Shani	Female	Staff Nurse	10	Egyptian
Eman	Female	Social Worker	15	Qatari
Fatimah	Female	General Physician	24	Sudanese
Salma	Female	General Physician	20	Egyptian
Aamaal	Female	Head Nurse	25	Qatari
Alima	Female	General Physician	10	Qatari
Bahar	Female	Staff Nurse	8	Iranian
Shanti	Female	Staff Nurse	5	Indian
Rashida	Female	General Physician	7	Egyptian
Zainab	Female	Head Nurse	16	Jordanian
Maya	Female	Staff Nurse	26	Indian
Nayden	Male	Gynecologist	7	Bulgarian
Saeed	Male	Gynecologist	10	Jordanian

4.2 Influence of Knowledge, Awareness, and Pain Perception on Women's Breast Cancer Screening Practices

Analysis of the data revealed knowledge and awareness of breast cancer screening and perception of pain as personal level factors influencing Arabic women's BCS practices in Qatar.

4.2.1 Knowledge and awareness

Participants identified increasing knowledge and awareness and higher literacy level and access to health information as facilitators for women's BCS practices. Conversely, unfamiliarity and unawareness of BCS was identified as a barrier. They spoke about the need to increase knowledge and awareness among women in Qatar.

4.2.1.1 Increasing knowledge and awareness among women

All participants identified knowledge and awareness of breast cancer and its screening as a major factor facilitating women's participation in BCS practices. Alima (general physician [GP]) said, "Women are more aware now. Before, when I [referred them] to [the] well-women clinic, they would [not want to go]. [But] now they come and ask me to give them an appointment to the well-women clinic [for CBE and other assessments]." Saeed (gynecologist) attributed increased knowledge and awareness to: "People are learning more. They read, watch, and listen. They understand. They are more open about [breast cancer screening]." Like Alima and Saeed, most physician participants noted that more women than before are increasingly aware of breast cancer, its screening, and women's health issues. They attend the well-women clinics (WWCs),

want to learn about breast self-examination (BSE), and request clinical breast examination (CBE) and mammograms.

4.2.1.2 Literacy level and access to health information

When talking about what factors contributed to an increase in women's knowledge and awareness of breast cancer and its screening, participants perceived that literacy levels and access to health information were important contributors to an increase in knowledge and awareness. For example, participants said:

[Older ladies who] don't know how to read and write don't know a lot about breast cancer. (Rashida, GP)

Grandmothers are only sitting at home. But now [many women] are going to work and school. ... [They have access] to knowledge on Internet. [Therefore], now the [beliefs about breast cancer] is changing [from traditional one to biomedical one]. ... Some women [who are educated and can read and write] have more access to information than others. They want to know about [the well-women] clinic and breast cancer screening. (Shani, Staff Nurse [SN])

Participants explained that many "old" women did not have public education opportunities. Therefore, their literacy level and ability to obtain information about health and available health services through text were limited. Furthermore, older women were often expected to carry out domestic responsibilities within their homes. Therefore, they were less exposed to health information available outside the boundary of home. As participants perceived, older women were likely to hold traditional beliefs about breast cancer, such as "Cancer is given by Allah; therefore, praying to Allah would

be the only way to be treated”, and be reluctant to the idea of BCS. On the other hand, younger women who were educated and working had access to health information through various media such as the Internet so that they were more aware of breast cancer and more open to BCS than were older women.

4.2.1.3 Unfamiliarity and unawareness of breast cancer screening

Although most physician participants perceived an increase in women’s knowledge and awareness of breast cancer and its screening, they suggested that the knowledge level of BCS among women in Qatar is still very low and that unfamiliarity and unawareness of BCS is a major barrier for women to access available BCS services. For example, Nayden (gynecologist) mentioned that it is still not a common practice for women clients to request CBE and/or mammogram proactively and that some women even decline CBE when offered. He said, “[Some women] refuse to be examined [their breasts]. They think, ‘No need. Why will I have this problem? I do not have any problem or any pain. Also, my husband will say no.’” Moreover, some physician participants perceived that most women did not know how to perform BSE correctly even after a few visits with repeat demonstrations and did not come in to check their breasts unless they had pain or other symptoms like discharge. They suggested that not knowing the importance and benefits of BCS delayed women’s BCS, with the result that, by the time that women sought medical assistance, the breast cancer was usually diagnosed at advanced stages.

4.2.1.4 The need to increase knowledge and awareness

All 15 participants suggested that women should know about the importance of BCS. They emphasized the need to increase knowledge and awareness of BCS among women in Qatar and the necessity of public health education as the first step toward instigating positive changes and raising awareness about breast cancer in the community. As an intervention strategy, participants recommended dissemination of information about BCS and available services through various modes of delivery including information leaflets, poster campaigns, mass media such as television, radio, and Internet, educational videos, and small group workshops at the primary health centers.

4.2.1.4.1 Information leaflets and posters

Participants from all three data collection sites mentioned that they did not have information leaflets about BCS for women clients at the health centers. Hence, they recommended designing “small booklets or leaflets with some pictures so that [women] can take, read, and understand” (Saeed, gynecologist) as a strategy to increase women’s knowledge level about BCS. Alima (GP) spoke about the importance of having leaflets about BCS at the primary health centers. She said:

We don’t have leaflets or brochures here [at the health center] actually. So it’s good to give [women] even like leaflets, not only in [the] well-women clinic but also other walk-in clinics. It is important for primary health clinics to have [information] pamphlets because patients first visit here before secondary or tertiary [health] centers.

Participants perceived that there was not sufficient BCS information available for women at the primary health centers and suggested that development of educational materials such as information leaflets would be essential to provide women with information about BCS.

Some participants shared a few strategies to design effective information leaflets and posters. Nayden (gynecologist) suggested that information leaflets and posters should contain a few but most important messages with images to aid understanding of the messages particularly for women with limited education and literacy skills. Moreover, Fatimah (GP) suggested that educational campaign images and messages should be culturally sensitive and appropriate, and should neither contradict the purpose nor reinforce myths, stigma, and fears. She said:

We have to design the [educational] campaign carefully so that it does not upset people. They have to know that we are screening to keep them away from the disease, not to find the disease in them. If you use [appropriate] language, people can accept [breast cancer screening ideas].

Like Nayden and Fatimah, other participants shared their insights about the importance of designing information leaflets and posters that were easy to understand and culturally sensitive with use of appropriate language and images that would motivate women to participate in BCS. Moreover, participants suggested that leaflets and posters be available not only at health centers but also at public places such as schools, malls, and work places.

4.2.1.4.2 Mass media

Some participants suggested that BCS education or advertisement of BCS services on Arabic television channels would be an effective way of distributing information to the public. When talking about how mass media could increase women's knowledge of BCS, some participants explained that many people tend to trust information on television or radio more than information given by health care providers. Therefore, using mass media might be an effective way of educating people. Other participants explained that Arabic people learn best by seeing and listening rather than reading and talking; therefore, "telling a story of a friend or a family of someone [using] pictures" (Shanit, head nurse [HN]) would help women to retain health information and increase participation in BCS practices. Based on the data, use of mass media might be an effective way of educating and advertising BCS services.

4.2.1.4.3 Educational videos

Many participants recommended playing educational videos about BCS at common waiting areas in the health centers as a way to deliver health information to women, increase their knowledge of BCS, and influence their decisions about BCS practices. For example, Shani (SN) shared her idea of playing an educational video:

Build more attraction like audio-visual materials to teach the skills how to do self-breast examination and what mammogram is. ... People can watch audio-visual materials in waiting areas, [when they] are waiting for the doctor, the lab, and the pharmacy like that. This can be very simple and indirect [way of health education.] But people would still get the new ideas.

As Shani mentioned, another benefit of playing educational videos is that it is a simple and indirect way of giving BCS information to women. Eman (social worker [SW]) shared her view that women in Qatar are reluctant to talk about breast cancer and its screening as they are taboo subjects in the society. Eman said, “When you try to talk to women, not everyone is interested. Some will tell you ‘I don’t have time, I need to go home, I have another appointment.’ But when you put the information on T.V., everyone will see it.” According to participants, playing an educational video about BCS at health centers can be a subtle way to penetrate public consciousness to increase knowledge and awareness about BCS. Participants from all three sites mentioned that they already have a T.V. in the common waiting area and that they have used it for playing educational videos in the past, indicating their willingness to play the video once it is available.

4.2.1.4.4 Small group workshops

Finally, some participants recommended having small group workshops at the health centers as a way of delivering BCS education to women. Although slightly different from participant to participant, the main idea was the same - to gather a small group of women, present information about breast cancer and its screening, answer questions, and discuss concerns or fears regarding BCS. For example, Saeed (gynecologist) shared an idea of how to carry out a workshop in a reasonably short time:

We can gather 10 – 15 ladies for 15 – 30 minutes, one session per week, 15 minutes for watching a film like breast cancer stories or any instructions, another 15 minutes for explanation and discussion. I don’t think it takes a long time! But this will be very efficient for them to learn. We should explain what breast cancer

is, what she should do to screen breast cancer, the importance of following up with the doctor, risks [and benefits] of screening methods.

Moreover, Saeed emphasized the importance of combining different teaching methods “like lectures, videos, pictures, self-demonstration, and discussion, and mak[ing] information simple for them, not complicated, in a proper way” when teaching women about BCS. Like Saeed, many participants suggested that health information should be conveyed in a simple way using different teaching methods to meet different learning needs of women with diverse backgrounds.

Although not a small group workshop, an event similar to the above idea was held at one of the data collection sites in the past. Bahar (SN) shared the success story of a BCS educational event where they collected a large number of women and promoted BCS. She said:

We did a special [breast cancer] education session in our health center in 2009.

That day, we had a nutritionist and a physician who gave a lecture. Many women came. We gave them appointment card for CBE, leaflets, and small gifts. We showed them how to examine breasts on a computer screen and let them [practice] with fake breasts so that they put their hands and try it out. It was prepared by our social worker. She invited all HCPs, staff, and everyone....

Everywhere was covered with pink color. ... When we started CBE and mammogram referrals in the well-women clinic, there were many, many patients.

So if we encourage people like this, there will be much [more] clinic visits.

According to Bahar, women were very receptive to the idea of BCS and participatory in the event. However, the one day event happened only once. She believed that more women would have participated in BCS if the educational effort was sustained over a period of time. Based on the data collected, it would be important not only to develop educational interventions, but also to sustain the efforts so that more women could be involved, informed, and encouraged to participate in BCS. “Not like medications [which] can cure illness within 1, 2, 3, 5 days. Primary health care takes [a long time] to affect the community. We don’t see its result right away. [It is important to sustain the effort for the long-term.]” (Shani, SN). As Bahar and Shani suggested, long-term planning for health promotion work would be crucial for sustained change.

4.2.2 Perception of pain

Participants identified pain associated with mammogram and the perception of “no pain, no illness” as barriers to women’s BCS practices. They spoke about the need to spread the concept of health promotion.

4.2.2.1 Pain associated with mammogram

About half of the HCP participants identified pain or physical discomfort during mammograms as a perceived barrier for some women to undergo mammograms. Participants said that pain seemed to outweigh benefits of mammograms for many women. Alima (GP) said, “Painful. Very painful.” This is a usual word [they use]. Because [mammogram pressure] is painful, sometimes they refuse to repeat mammogram.” Participants perceived that this concern about pain during mammograms

could be ameliorated with education about the importance and benefits of BCS and by giving ongoing encouragement.

4.2.2.2 Perception of 'no pain, no illness'

Some participants identified perception of 'no pain, no illness' as a barrier for women to utilize BCS services. They suggested that women do not usually come to the clinic unless they are visibly sick, with pain or physical discomfort being the primary cue to seek medical care. According to participants' accounts, women did not think they had a health problem unless they were experiencing unusual physical discomfort. Salma (GP) said, "Some women will tell me, 'if there is no symptom, no pain, I have no disease. I am very well.'" Therefore, it is very rare for women to see a doctor for only screening purposes as breast cancer is non-symptomatic in the early stages. According to the participants, many people in Qatar are unaware of health promotion or illness prevention and continue to live "sedentary life styles, eating much, not walking, not exercising, not caring about [healthy] diet or fresh food. ... and be affected by diseases like obesity, coronary artery diseases, hypertension, diabetes, and cancer" (Alima, GP) which are chronic illnesses with slow onset of symptoms. Consequently, chronic illnesses are not diagnosed until they are far advanced. Health was simply viewed as the absence of disease. Again, participants emphasized health education as the key to increasing knowledge and awareness of BCS and affecting women's decisions to access BCS services.

4.2.2.3 The need to spread concept of health promotion

Some participants discussed the importance of spreading the concepts of health promotion and illness prevention to encourage women to go to the WWC and participate in BCS. Alima (GP) said:

Well-women clinic doesn't mean that they have to have complaints. People usually think they should go to hospital when they have complaint. But if they understand what screening is as [a method of early detection] and how it is important to all people, maybe it will increase the number of clients, screening rates, and cancer cases.

Similarly, Shani (SN) echoed, "We should broaden [people's] mind to think that they can see the doctor [to screen for illness], not only when they are sick. They should know what primary health care means." Like Shani and Alima, participants stressed that people need to understand what primary health care and screening mean and access available health services to look after their own health. Furthermore, Fatimah (GP) suggested that "People have to look after their well-being and not to wait until disease comes. They have to find [out] what health means to them", implying that HCPs have important roles to explore women's beliefs in health and illness, discuss health promotion and illness prevention activities, and encourage them to seek and achieve health.

When asked what kinds of messages they would like to give to women regarding BCS, participants shared the following:

Screening can save your life. If we detect [breast cancer] early, treat early, it can be cured. (Shani, SN)

It is very good to check yourself. If something is wrong, then you will know [early]. Then the cure will be easy. The problem is when you neglect and ignore your health. (Rani, SN)

[Breast cancer screening] is a routine examination, and better to do this examination. It will not affect anything. Only if you have any problem, we can find out and treat it. (Asha, SN)

As well, participants highlighted the importance of early detection of breast cancer for good prognosis, treatment, and survival. They hoped that women would understand BCS as a routine examination, a part of illness prevention activities for everyone and that they would proactively participate in BCS activities such as BSE, CBE, and mammograms in the future. Furthermore, participants suggested that women whose family members, friends, and neighbors have done BCS tended to request CBE or mammogram proactively before they recommended it. They suggested it is important for HCPs to encourage women to support and empower each other by spreading words about the importance of breast health and cancer screening in the community.

4.2.3 Summary

In this section, the influence of knowledge and awareness on women's BCS practices from health care providers' perspective was described. Throughout the interview, all participants identified knowledge and awareness of BCS as a major factor that facilitates women's participation in BCS practices. On the other hand, unfamiliarity and unawareness of BCS was viewed as a barrier that hindered women's BCS practices. Participants perceived that women's literacy level and access to health information were

the key to utilizing available BCS services, suggesting that younger, educated, working women know more and are more open about BCS practices than older, unemployed women with less education.

Most physician participants noted that although women's knowledge and awareness seem to have increased over the past years, their knowledge and awareness of BCS is still very low. Participants emphasized the need to increase knowledge and awareness of BCS among women to improve their participation in BCS through public health education. They shared various ideas about distributing information about BCS and available services such as development of information leaflets and posters, use of mass media, playing educational videos at health centers, and holding small group workshops at the health centers for women clients. One of the participants shared a success story of an educational event they had at the health center in the past and suggested that more educational events would encourage women to learn about and participate in BCS practices.

Furthermore, participants described the influence of perception of pain on women's BCS practices. About half of the interviewees identified pain or physical discomfort during mammograms as a barrier to utilizing mammograms. It was suggested that some women did not repeat mammograms because of pain. On the other hand, perception of 'no pain, no illness' was identified as a barrier for some women to realizing the importance of BCS and accessing available services. Participants believed that public health education was essential to influence women's decisions regarding BCS. On the other hand, some participants emphasized the importance of spreading concepts of health

promotion and illness prevention and suggested that HCPs should explore women's beliefs in health and illness, meanings of health, and encourage them to seek and achieve health. Health care providers suggested that women would need to understand screening as part of illness prevention activities, that they actively participate in BCS, and support and empower other women to achieve breast health.

4.3 Influence of Culture on Women's Breast Cancer Screening Practices

An analysis of the qualitative data collected from health care providers revealed that culture has a significant influence on women's breast cancer screening practices. In this section, cultural beliefs including religious beliefs that influence women's BCS practices are reported.

4.3.1 Beliefs, attitudes, and practices

When talking about why some women in Qatar do not participate in BCS practices, health care provider participants shared the following understanding of cultural influences.

4.3.1.1 Beliefs about female breasts

Health care providers interviewed suggested that in Islamic countries, women's breasts have symbolic meanings of femininity and fertility. They suggested that breasts are a significant body feature not only for feminine beauty, but also for primary female roles of giving birth and raising children that are emphasized socially and traditionally. Participants suggested that traditionally most women in Qatar give birth to as many children as they can. Therefore, based on the data, breast cancer equalled the loss of femininity, fertility, and their position as a woman in the family and society. For

example, Shanit (HN) said, “Operation [mastectomy, breast removal] is hallas! [meaning “finished” in Arabic]”, implying that the reason for being and the meaning of life as a Arabic woman would end with the diagnosis of breast cancer. According to participants, breast cancer and its screening were taboo subjects to discuss in Arab society; therefore, women would not talk about breasts or breast cancer even between friends and families.

4.3.1.2 Fear of negative consequences of family/spousal relationship

Participants suggested that the cultural practice of a Qatari man having more than one wife hindered women’s participation in BCS. They explained that a man could marry up to four wives if his wife were critically ill or dying, and for that reason, women did not want to show any hint that they were sick. For example, Shani (SN) said:

Ladies in general don’t like to tell her husband that ‘I am sick. I want to check if it is a disease or not....’ They don’t like to look sick. They want to look healthy.

They don’t like to disappoint their husbands. They want to be always ladylike, fresh, and healthy.

Shanti (SN) echoed, “Culturally men will marry another woman if the woman is sick. Of course, sick means [that] nobody will marry [her].” Based on the data, there was pervasive fear of divorce among Arabic women. Rashida (GP) explained, “Any women here don’t want their husbands to know that they have any problem. Even if she has cough or pain in the legs, she’s afraid to tell her husband. So it’s a disaster to have breast cancer and tell her husband that she [wants to have screened for breast cancer].”

Regarding polygamy as a barrier to women’s BCS practices, Rashida added further:

Men understand the Islam not truly... They misinterpret their rights. Another marriage is allowed only in special cases like when wife died. Islam says, 'only one husband and one wife to be fair.' But he forgets this part. The majority of them think, 'I have money and power. I can marry more than one.'

Rashida suggested that misinterpretation of some Islamic religious teaching should be corrected in support of women's health and well-being.

4.3.1.3 Beliefs and attitudes toward illness and sick women

In continuing, participants discussed the influence of cultural beliefs and attitudes toward illness as shame, secret, and a family matter on women's BCS practices. They mentioned that critical illnesses such as breast cancer were considered something to be shameful of and to hide from others to save face for the family. For example, Shanit (HN) said, "[death or illness of family members] is bad. A secret! It is not [something] to talk about. [It is] for family", suggesting that illness is a family matter. According to the participants, some women might not tell the family the truth when they find out about breast cancer or any other life-threatening illnesses. The sick woman might tell her family that she has other less serious illness, instead of cancer, out of fear of being alienated or treated badly by her family. Some might not disclose her own or her family health history during health assessments in the clinic; and some might deny the need for BCS when offered by the physician.

Participants explained further that this understanding of illness as a family matter is due to social stigma that falls heavily on the ill person. They suggested that sick women were stigmatized and labelled as unwanted, partly because sick women were

considered no longer able to give birth to and raise children and carry out domestic responsibilities which were highly emphasized female roles in society. Hence, some sick women did not receive needed support from husbands and families, were alienated in a separate house away from the family, and were divorced. Eman (SW) described a conversation that she had with a client:

[Before, a sick woman] told me that all her families, husband, mother, refused her for her illness. I asked her, ‘Why do they refuse you? It’s from Allah! Not from you!’ Then she cried, ‘I don’t know. My husband will marry another woman. What can I do?!’ ... If she tells [her husband about her] sickness, he will say, ‘Go to your father’s home. Don’t sit with me.’

Participants suggested further that although Qatar society has been changing toward less stigma attached to illness and sick women, stigmatization and isolation of sick women could still happen in some families with strict traditional cultural values and customs. Therefore, some women might be afraid of participating in BCS activities that could spark a rumor, such as “[People will say,] ‘Oh, I saw her coming out of the clinic. She has cancer now! It is very bad’” (Shani, SN). Thus, “[Rather] let us live with cancer. No news is good news” (Fatimah, GP) was what some women would say when offered CBE or a mammogram by the physician. As evident in participants’ accounts, fear of stigmatization and isolation were identified as significant factors associated with not utilizing BCS services and neglecting health needs.

4.3.2 Beliefs about religion

Participants spoke about the influence of religious beliefs on women's breast cancer screening practices.

4.3.2.1 Religious beliefs about female bodies and modesty

The data suggest that religious beliefs (Quran, Translated Version by Syed Vickar Ahamed) about female bodies and modesty between men and women greatly influenced the ways in which Arabic women practice BCS. The religious beliefs made CBE challenging for not only women, but also health care professionals who were trying to promote BCS.

4.3.2.1.1 Challenges for women

Participants suggested that CBE was challenging for some women due to embarrassment and shame associated with exposing breasts. Their feelings were deeply rooted in cultural beliefs of female bodies that they were the property of the husband, and in a moral value of modesty that men and women were not to talk, interact, or be together. According to the participants, in Islamic countries, covering up and not exposing the female body was considered to be a virtue of women; only husbands could see and touch their wives' bodies (Quran). Maya (SN) shared the following:

[Women] don't want to expose themselves.... In all the English movies, I see people wearing very short [clothes]. Some male can be stimulated [by that]. Our holy book said that you have to cover yourself, your hair, up to your hand. (Is it because that can arouse sexual feelings?) Yeah, yeah! This is Haram (meaning something to be avoided; or else, will be punished by God) because you are

exposing, stimulating male. That's why people cover themselves to prevent stimulation. Shut down. Yes, it isn't good [for male physicians to examine women's breasts].

Maya explained that any act of arousing sexual desire, even exposing hair and face, was considered immoral and strongly prohibited in Islamic culture; therefore, exposing breasts for examination even in a health care context could be a huge challenge for Arabic women. Participants perceived that some women were even hesitant to talk about women's health issues that involve sexual body parts, such as breasts and cervix. The breast and cervix were considered the most private body parts of a woman's body and should not be seen or touched by others. Saeed (gynecologist) shared his understanding:

Some ladies feel ashamed to go to the doctor and talk about breasts. This is something hidden. That means it is a sensitive organ, very important to a lady. Very critical and very sensitive. Even between ladies, they will not complain to each other about breast pain or breast cancer. She will be ashamed to even mention something like that. So this could be one of the reasons [why some women do not have CBE or mammogram].

The above quote demonstrates the impact of cultural beliefs on women's breast health practices and shows how women are situated in a cultural context where their health care decision-making is constrained by cultural beliefs, attitudes, and practices.

4.3.2.1.2 Challenges for health care providers

Female HCP participants perceived that, although most women seemed to be comfortable with CBE and fewer women refused CBE/mammograms than in the past,

some women were still reticent about BCS. Maya (SN) mentioned, “Arab patients, especially Qatari ladies, even [refuse] to be touched by the doctor. They don’t want to go to the [examination] table even after reviewing risks and benefits of [CBE] and the procedure.” Similarly, Alima (SN) said, even though the well-women clinic was run by female nurses and physicians, some women still seemed uncomfortable to uncover breasts and let physicians examine their breasts for tumors, indicating the challenges of promoting BCS to Arabic women.

It is not surprising that the challenge of promoting BCS seemed to be experienced to a greater extent by male physicians as their offer of CBE was often refused by women. Rani (SN) mentioned, “[Women] want female doctors only. They will not go for male doctors especially in this country.” This was in spite of physicians in Qatar having strong public trust and autonomy in care decision-making; clients generally trust physicians more than any other health care providers. The male participants spoke about their frustrations with women not valuing their expertise when their offer of CBE was refused by women and when they had to delegate CBE either to staff nurses who did not have an optimal level of training or refer them to female physicians. For example, Nayden (gynecologist) said:

It [took] some time to adapt to work with Arabic women... There is a big difference [in working in Qatar and in other countries] because of the nationality, religion, age, education, tradition, and the family of the patients. Patients refuse to be examined by the male doctors. We must call female doctors to help us. I’d like to examine by myself to make the diagnosis, not depending on another person. ...

I like my job. But really... Sometimes I have difficulties with [working with Arabic women] here.... I am not feeling free as a doctor here to work as compared to when I worked in Europe. I feel that [there is] no trust for doctors.

These data add to understanding the challenges confronting HCPs, especially male HCPs, in promoting BCS to Arabic women and raise awareness about the tremendous impact of challenges that come with differences in cultural beliefs, attitudes, and practices on health care delivery and ultimately, on women's health and wellness.

4.3.2.1.3 The need to be empathetic and collaborative with women

In response to the influence of beliefs about women's bodies and the subsequent emotional barriers such as shame, embarrassment, and guilt on breast health care, Nayden (gynecologist) identified the need for HCPs to be empathetic when providing BCS care to women. He said, "Sometimes we should stop and [try to] feel what they are feeling. I think this visit to gyne clinic would be very difficult for her. She's ashamed, worried, and scared. The visit is not pleasant and not so easy for them." Nayden suggested that using empathy would be a strategy to understand women's feelings, thoughts, and decisions about BCS.

Nayden continued by discussing the importance of establishing trusting and collaborative relationships in care with women. It is his view that women's use of BCS services is influenced by their comfort with the client-clinician relationship. He shared the following:

[In provision of health care], we should work with women, give them a chance to trust you, speak with you, and be open. We should watch the way of our

behaviours and speech to break the barrier [between HCPs and women]. ... If patient feels that the [doctor] is in a hurry and doesn't have time for her, she will not be comfortable to talk about her intimate concerns. ... [We] must take time to talk with the patient and explain any procedure. Instead of just saying 'go there, take blood, ok? go, bye-bye', you should explain 'you are okay, prevention is as this, your case is as this, You need to do this because of this.' If you don't do that, she will be afraid and forget everything. But if you are relaxed and talking with her and encouraging her to ask questions, [she will participate in care]. Make a good atmosphere to ask questions.

As Nayden pointed out, HCPs have a significant role in working with women, spending enough time with them, establishing mutual trust and a balance in power, and communicating respectfully so as to establish an inviting atmosphere. The recommendations offered by Nayden are important in enabling women to take ownership of their own health by assisting them to openly speak about health concerns and participate in appropriate health care activities.

4.3.2.1.4 Availability of female health care providers as a facilitator to BCS

Some participants identified the availability of female HCPs at the well-women clinics as facilitating women's access to health care services such as breast cancer and cervical cancer screening as gender appropriate and sensitive care can reduce feelings of shame and embarrassments. Fatimah (GP) mentioned, "[Patient health] information can be collected better from women [if they are with female HCPs]. [They participate well in breast self-examination and CBE.]" According to the participants, having female HCPs

for female clients was a culturally appropriate practice. For example, when talking about why the well-women clinic has only female HCPs, Shani (SN) said, “[Qatar] is a Muslim country. For that, if she is a virgin, [even female HCPs] cannot touch her. So, absolutely no male doctors in well-women clinics.” Similarly, Salma (GP) echoed, “In well-women clinics, [we do] complete examination [on women’s body, including] breasts, lymph nodes, axillary, and pelvic examination. In our society, it is better to have [female HCPs].” For this reason, participants suggested that more female HCPs should be hired and encouraged to work in women’s health. Saeed (gynecologist) mentioned, “[We need] female doctors. Female to female will talk more frankly and friendly. She will feel thrilled to talk and explain. This will be number one to have.”

4.3.2.2 Religious beliefs about illness

Religious beliefs about illness have both constraining and facilitating influences on Arabic women’s utilization of BCS services.

4.3.2.2.1 *Constraining influence*

Participants suggested that it is rare but some older, more traditional women strongly believe in God’s will and that everything is given by Allah (God), even breast cancer and the cure. For example, participants shared that “[some] old women would say, ‘this [cancer] is from God to test if I am strong or not.... [I need] no medicine, no doctor.’” (Eman, SW) and “[breast cancer] is given by Allah, but also the cure is given by Allah.” (Bahar, SN). Therefore, despite a physician’s medical advice, some older women who firmly believe in God’s will might not seek screening or treatment, believing that any cure is up to God. However, participants suggested that such cultural beliefs are

less dominant among women who are educated and have biomedical understanding about breast cancer.

4.3.2.2.2 Facilitating influence

On the other hand, participants identified some religious beliefs as facilitating of BCS. For example, participants shared the following positive beliefs (Quran):

Allah told people to seek help and health before they get diseases. (Fatimah, GP)

Allah told you to take care of your body. (Bahar, SN)

Religion is not a barrier because most people know that Allah gave them the disease but Allah will also help them to take medications and treatment. This belief that ‘Allah gives the disease but also chances to manage’ is in their mind.

(Salma, GP)

Participants suggested that these beliefs not only promote personal responsibility for health and self-care, but also give women spiritual support. For example, Fatimah (GP) said, “Religion is a positive factor because it [helps women] not to be so afraid [of an illness] and [keeps her] on the positive side.” Rashida (GP) echoed, “Sometimes patients tell me, ‘Allah gave me this cancer. But I am sure Allah will cure me. God is only testing me if I am strong or not. Therefore, I will take care of myself.’” Rashida further explained that this belief is one of the Quran teachings; therefore, religious beliefs can serve to promote a positive influence.

Regarding religious beliefs as a factor that can either hinder or facilitate women’s BCS, it is important to note that a number of participants suggested that the barrier is not the religion of Islam itself but how people interpret religious teachings. For example,

Fatimah (GP) said, “Religion said that you have to take care of yourself and to look for treatment. [Not seeking professional help] is [due to] misunderstanding of the religious concept.” Therefore, addressing such misunderstanding would be important to reduce negative influences and promote BCS among women. “Even if the patient tells you [negative beliefs or misinterpretations], HCPs can tell her ‘Allah also gave you this body and told you to take care of.’” (Bahar, SN).

4.3.3 Summary

In this section, the influence of cultural beliefs, attitudes, and practices on Arabic women’s utilization of BCS services was described. The theme of influence of culture on health was prevalent in every HCP participant’s account of BCS experiences by women in Qatar. For example, cultural beliefs about women’s breasts as symbolic of femininity and fertility coupled with cultural emphasis on female roles of giving birth and raising children resulted in avoidance of discussing breast cancer or its screening and of utilizing BCS. Besides cultural beliefs about women’s breasts, the practice of polygamy created fear of divorce in many women, further discouraging women’s utilization of BCS services. Furthermore, cultural beliefs and attitudes toward illness as defect, shame, secret, a family matter and sick women as unwanted, resulted in women’s fear of stigmatization and isolation and neglect of their own health needs. Participants suggested that although there is less stigmatization of illness and of sick women than before, social isolation of sick women can still happen in families with strong traditional cultural values and customs.

The beliefs about women's bodies as the property of the husband and the moral value of modesty whereby men and women should not be together outside of marriage resulted in pervasive feelings of embarrassment and shame with the exposure of breasts even in a health care context. Participants suggested religious beliefs and values of concealment and modesty made CBE challenging for women as well as for HCPs when discussing breast health and promoting BCS. Therefore, participants agreed that availability of female HCPs at the well-women clinics and primary health centers facilitates access to health care services by women. In addition, participants discussed facilitating and constraining influences of religious beliefs on women's decisions and behaviors of BCS. For example, a belief that 'both breast cancer and the cure are given by Allah' can be constraining or facilitating, depending on the woman's interpretation of it. Therefore, participants suggested that the barrier is not the religious teaching itself but how people interpret it and that it would be important to address women's interpretations of religion in order to encourage them to practice BCS.

4.4 Influence of Gender and Power Relations on Breast Cancer Screening

The data analysis of interviews with HCP participants brought to view the influence of gender and power relations on BCS practices for women in Qatar. In this section, power differentials between men and women, female roles and responsibilities, and spousal support as factors influencing women's BCS are reported.

4.4.1 Unequal gender relations of power

Participants mentioned that cultural gender hierarchy and male domination in the marital relationship which place women in vulnerable, dependent positions affect

women's timely access to health services. Women are perceived by some as "dependent on their husbands, financially, socially, and politically" (Nayden, gynecologist) and are "isolated, shy, ... [with] no social power" (Salma, GP). Moreover, the participants described the typical husband-wife relationship as:

Men are the [key] element of the family.... The roles of the husband come first before the wife's. ... Arabic women need permission [from their husbands].

(Nayden, gynecologist)

Men have more power than women. She must get agreement from the husband on everything, [even] to come to hospital for examination. Anything, she must tell her husband. (Rashida, GP)

As demonstrated in these quotes, decision making, even for women's health activities, lies with husbands, indicative of unequal gender relations of power. Although many employed women are now driving and carrying on activities outside of their homes, they are expected to consult their husbands for permission to participate in activities, such as seeing a physician, and are expected to follow their husbands' wishes. Some participants suggested that the majority of husbands support their wives' health care and that it is rare to see men objecting to their wives' breast examinations. However, other participants suggested that some men would object to their wives' participation in CBE/mammogram because their wives would need to expose breasts in front of strangers, even though he/she is a physician.

Participants suggested that unequal gender relation of power in Arab countries is a barrier for women in terms of having sufficient time with physicians. They perceived

that some women were always in a hurry to leave the clinic because they depended on their husbands to drive them, and their husbands were not patient about waiting until their wives finished with their medical appointments. Bahar (SN) said, “This is the most problem. Women are in a hurry. They say, ‘my husband is angry outside. I have to leave soon.’ Sometimes, she will not even come to the clinic.” Consequently, some Arabic women might not be able to use available health services or accept additional care offered by physicians due to unequal gender relations of power and women’s dependency on men.

4.4.2 Female roles and responsibilities

Participants identified traditional, cultural female roles and responsibilities as a barrier for women to participate in BCS activities. They perceived that women in Qatar are too busy to attend to their own health needs due to their many roles as a mother, wife, step-daughter, and sister, and heavy domestic responsibilities such as taking care of her family (and sometimes extended family members) plus house chores. Salma (GP) explained, “Because [a woman] must do much for the family and spend all the time for her children and husband, she may forget herself and [forget] to take care of her health. Her first [priority] is her family. And herself is maybe the third or fourth.” Participants suggested that, in the Islamic culture, men adhere to traditional gender roles and responsibilities; they are reluctant to engage in activities such as cooking, looking after children and family, and cleaning the house. Accordingly, it remains strictly a female role to take care of family members and the house. Hence, working women are still responsible for fulfilling this role after work outside the home. Therefore, some women

might choose not to have a mammogram or to postpone it if they perceive it takes too much time away from family and/or work.

In continuing, participants mentioned that most women clients do not stay long enough for a complete health assessment or health education, creating a challenge for them to promote public health. Salma (GP) shared her view about women clients:

The woman has a [busy schedule]. When a woman [comes in] for health care, she has specific demands [such as medications or referral forms] and... only discuss something about disease only. Many women do not stay for health promotion and illness prevention education such as life-style modification.

Similarly, Nayden (gynecologist) echoed:

Some ladies want to finish in hurry. They are coming only for something [i.e., prescriptions] and ignoring other important things [like health education]. They want to finish quickly because they are engaged with other things. They don't understand things well and need more explanation. [But] they don't give themselves enough time.

As reflected in these quotes, some participants perceived that time constraints were out of the women's control with the result that they ignored their health needs. When talking about how to reduce this barrier for women, most participants believed that women would participate despite busy schedule if they had knowledge and awareness of BCS and emphasized the need for public health education.

4.4.2.1 The need to be non-judgmental

Bahar (SN) highlighted the importance of working with women's schedules and life circumstances without making judgments in order to encourage them to undertake health care activities. She affirmed, "Actually we welcome her if she comes back after missing her appointment. We will give her another appointment [without making it] a problem. I would ask her which day would work for her, and she would choose the time that fits with her schedule." Like Bahar, Salma (GP) also affirmed the role of HCPs to create trusting, non-judgmental relationships with clients. She mentioned, "Breast cancer screening promotion depends on the health care provider's potential to create a trusting client-provider relationship without judgments." In situations where many women are greatly dependent on men while carrying out many roles and responsibilities, understanding women's circumstances and working with them without judgment would be critical in building trusting relationships with them.

4.4.3 Spousal support

Nine out of 15 participants identified husband support as a facilitator for engaging women in BCS practices. They suggested that husbands' authoritarian decision-making power over women's health could serve as a facilitator rather than a barrier if the men could be convinced to use their power to support and encourage the women to have BCS. They perceived that more women would participate in BCS. For example, Shani (SN) said:

[Women's decision on breast cancer screening] depends on the husband. If the husband is [understanding], has good knowledge, and supportive, women will do it.

This is the main point. But if the husband does not understand, it will [cause her] psychological pain and [women will not use cancer screening services].

Participants suggested that, although more men now are supportive of women's health needs than before, current husband support is limited to only driving women around. HCPs reported that they rarely see husbands encouraging wives to access BCS. They suggested that men can encourage their wives by "sitting and speaking with her about [health issues]" (Eman, SW) and "learning together about each other's [health issues or concerns]" (Fatimah, GP).

4.4.3.1 Education level and knowledge

When talking about influences that would determine a husband's support, participants suggested that it depends on the individual man's education level and his knowledge and awareness of breast cancer and its screening. For example, Shanit (HN) said, "If he has the knowledge and education, he can understand mammogram, clinic appointments, no problem. But if he is the old case [meaning traditional and not open to new ideas] and with no education, both women and husband will have difficult time learning and [understanding why breast cancer screening is needed]." Like Shanit, other participants concurred that men without education or knowledge of BCS may question the need for it and object to their wives' participation in CBE and mammogram.

4.4.3.2 The need to involve men

Consequently, all participants stressed the need to involve men in public health education about BCS to help them understand women's health issues and needs. Bahar

(SN) shared her perspective in providing men with educational opportunities about women's health issues, specifically BCS:

Men should also receive education, not only women. He should know and understand that [breast cancer] is serious. Most women patients come and tell me, 'my husband will not allow me to come again' or 'my husband will be angry with me.' Husbands hold more power than wives. So she will try finishing [her visit] soon and [will] not discuss any other complaints with the doctor. But if he understands that this is serious and knows that [breast cancer screening] is important for him and his wife, he will be supportive.

Similarly, Nayden (gynecologist) echoed:

[Health care providers] should explain to husbands, 'Your wife can be in danger. Please encourage them to go have mammogram.' For women [living in Qatar], their decisions [are greatly affected by family members because] she's not the head of the family. ... We must educate men because husbands should take care of their wives. They must encourage and [help] their wives to have mammograms. If they don't know, they can't be supportive.

Like Bahar and Nayden, other participants perceived that educating men about BCS would improve women's participation level in BCS and that HCPs have an important role in doing that.

4.4.3.3 The need to involve whole family

Some participants discussed the importance of family-centered care at the primary health centers in creating support systems for women and raising awareness of unspoken

women's health issues. For example, Nayden (gynecologist) affirmed, "Health education should be [designed] for the whole family, husband, wife, and children, not only women. Daughters can explain to her mother, 'mommy, there is breast cancer, cervical cancer, go and do check-up.' And explain to male, 'your wives can be in danger. Please [tell] them to go.'" As participants perceived, family-centered care was particularly important in their cultural context because women seldom visit health clinics for their own health concerns but they would for their children. Therefore, Shani (SN) suggested that when women come because of health concerns for their children, it is an opportunity to inform them about health activities such as BCS. For example, Shani (SN) said:

Primary health care has important role in taking care of the whole family. For example, if the child comes in for vaccination, it is also important for [health care providers] to encourage women and the whole family to take care of their health. HCPs can talk about services like breast cancer screening and pap-smear test and ask them if they even know about it, if they had pap-smear or breast cancer screening.

As participants perceived, shifting the focus from the individual to the family as a unit of care may facilitate information distribution and increase people's awareness about available resources and programs such as BCS.

4.4.3.4 The need to involve youth, both girls and boys

Some participants suggested public health education should start in the schools, targeting both boys and girls, to effect change in society. They believed that health education provided to younger generations would reduce social stigma attached to breast

cancer and sick women and increase men's support for women's health care issues.

Participants shared the following perspectives in involving youth in BCS education:

[Health education] must be given to boys and girls at school and university especially. They will [grow up] to become husbands, [wives], brothers, sisters, and they can support women. Give small ideas to younger kids and more ideas for the grown up kids. And give more education to university students. (Shani, SN)

Boys will be partners of the female, then they also should know. (Shanti, SN)

If children have good knowledge, they will grow up and know that breast cancer is not shameful. They will grow up and change the future. (Rashida, GP)

Participants believed that starting public health education in the schools would be an effective way to bring about positive changes in society. Shanit (HN) and Rashida (GP) noted that BCS education, more specifically how to perform BSE, has already started at some primary and secondary schools.

Asha (SN) mentioned that health education for teenage girls is important because some of them get married early. She said, "Girls at the age of 14, 15. They will get married soon. So we should teach girls that they should take care of themselves after delivery and do examination and all. Girls at the puberty age or more, they [would be] interested to learn." Based on the data, targeting younger generations for BCS education would be imperative in the cultural context not only to create support systems for women who are at risk currently, but also for girls themselves as some of them will get married at a young age and enter motherhood.

Physician participants commented on increasing cases of breast cancer in younger women population. This correlates with information from Shanit (HN) and Bahar (SN) who reported that some teenage students were diagnosed with breast cancer after BCS education at schools, reinforcing the importance of BCS knowledge in facilitating early diagnosis.

4.4.4 Summary

In this section, the influence of gender and power relations on Arabic women's BCS choices and practices was described. As in many societies, men have more power than women in Arab society, and women are often expected to consult their husbands for permission to participate in health care activities and respect their wishes. Therefore, some Arab women might not be able to access available BCS services or accept additional care offered by physicians if their husbands disagree. Furthermore, the emphasis on traditional female roles of mother, wife, step-daughter, and sister with responsibilities for taking care of family and house limited women's ability to attend to their own health needs. Health was not viewed as the first priority for some Arab women; they often placed their own health needs second to other family members' needs thereby neglecting their own. Based on the data, more husbands are supportive of women's BCS needs than before, but the support may be limited to driving women to hospitals or clinics. Participants highlighted the importance of educating women about BCS, working with women's schedules and life circumstances without making judgments, and building trusting relations with them in order to encourage them to engage in health care activities.

All health care providers interviewed identified husbands' understanding and support as a facilitator for women's BCS practices and suggested that more women would participate in BCS if men encouraged women to get screened for breast cancer. Participants reported that a husband's support depends on his education level and knowledge of breast cancer and its screening; hence, they emphasized the need to involve men in public health education about BCS to help them become aware of and understand women's health care issues and needs. Moreover, they suggested the importance of family-centered care at primary health centers to involve both men and women in health care and increase people's awareness and knowledge about family health issues and available resources and programs. Finally, participants suggested that public health education should start in the schools, targeting both girls and boys, to reduce stigma attached to breast cancer and cancer screening which ultimately, over the long term, will promote social and cultural environments where men can be supportive of women's health care issues.

4.5 Influence of Systemic Factors on Breast Cancer Screening

Participants consistently voiced concern about systemic factors that influenced women's access to breast health care services, such as client-clinician time, health care infrastructure, cost for mammograms, and public transportation.

4.5.1 Client-clinician time

Participants suggested that insufficient time to discuss BCS is a barrier to providing breast health care and discussed the need to increase client-clinician time.

4.5.1.1 Insufficient time to discuss breast cancer screening

Participants identified insufficient client-clinician time as hindering provision of comprehensive health care. A shortage of HCPs and an increasing number of health care visits contributed to heavy workloads and time issues as they had to see a high volume of clients within a limited time span. Fatimah (GP) mentioned, “[I spend] moderately 7 to 10 minutes with each patient. We cannot [spend enough time] because we see 60 patients. At least 50 over nine hours. You know... I have a block of patients outside [waiting to see me].” Similarly, Rashida (GP) echoed, “We saw more than 100 patients on the same day. It is very difficult. [It is] not enough time even to make simple examinations. [It is going] too fast, but we must complete all patients.” Therefore, promotion of BCS or any other health promotion work or even complete health assessments were difficult. For example, Salma (GP) said, “You know, four out of five patients coming to see me say ‘nobody told me anything [about breast cancer screening] before’, indicating how insufficient client-clinician time limits a physician’s work with women and subsequently, women’s access to health information and available and appropriate health services.

4.5.1.2 The need to increase client-clinician time

When talking about why sufficient client-clinician time is important for physicians and clients, participants suggested that it is because they need time “to explain [to clients] about [breast cancer], [screening] guidelines and tests, to explore the condition [of the client], to persuade her about how to go [get mammogram], and to [discuss] and help them how to accept things at ease” (Salma, GP). Participants believed that they have a significant role in encouraging and educating women about BCS and that

continuous education and encouragement will increase women's participation in BCS activities. For example, Salma (GP) said, "It is a HCP's role, nurses, doctors, any other health team members, to initiate for the women if she falls in the specific age, you must refer her for cancer screening." Fatimah (GP) suggested, "HCPs should ask clients questions other than their presented complaints. If they have any family history or risk factors, HCPs should be proactive to ask questions and address the risk factors." Fatimah continued further, "Many people are waiting outside. I cannot see a patient in two minutes. I [would like to] stay with each patient for 15 to 20 minutes. [Health care system] must [employ more] doctors and give us enough time." Sufficient client-clinician time was essential for HCPs to conduct a complete health assessment beyond immediate concerns and refer them to appropriate health services such as mammograms.

According to participants, physicians working at primary health centers were particularly challenged with time due to the lack of appointment system. As a strategy to deal with the time issue other than hiring more HCPs, Salma (GP) suggested implementing an appointment system at primary health centers. She said, "This is a walk-in clinic. We don't have appointment. [But] it is better by appointment because if we have appointment time [for each patient], we will take enough time for each patient to explain, explore, and manage [health issues and concerns]." Indeed, time seemed to be less of an issue at the well-women clinics which were run by appointments where a physician could see each client for 15 to 20 minutes.

4.5.2 Health care infrastructure

Another barrier voiced by the participants was underdeveloped health care infrastructures for BCS. This was the result of lack of a national protocol for BCS, deficient health records, lack of reminder service for mammograms, insufficient support for health care providers, lack of breast health educators, lack of collaboration among health care providers, and insufficient health promotion services.

4.5.2.1 Lack of a national protocol for breast cancer screening

Some participants observed that there is currently no national protocol for BCS although the Qatar Breast Cancer Screening clinic and Qatar Cancer Society have published recommended guidelines for BCS. However, some participants were not aware of the guidelines. Most physician participants stated that their practice is to offer CBE every three years for women below the age of 30 years and annually for women above the age of 30 years. They refer clients for mammograms if the client is above the age of 40 years and/or if she has any change in the breasts such as pain, swelling, cracked nipples, abscesses, discharge, or family history of breast cancer. Participants suggested that they refer women below age of 40 years for ultrasounds instead of mammograms if the woman has any high risk factors such as a history of breast cancer in first degree family members. They suggested that they would order mammograms annually and every two to three years after two consecutive normal (negative) results. There were discrepancies in the guidelines. Although most participants agreed to the above practice for CBE and mammograms, participants' responses differed about the age for an initial screening mammogram, ranging between 40 and 50 years. Furthermore, when speaking

about BCS guidelines, some said they do not have written guidelines, and some said that they have one but do not know where they can find it. In addition, some physician participants indicated that they do not always refer women for mammograms unless the women ask first or complain of pain. It seemed as though HCPs lacked accurate knowledge about current recommended guidelines, resulting in inconsistent BCS referral and care across health care providers. Participants indicated a strong recommendation that a national protocol for BCS be developed and communicated to the front line HCPs to encourage their provision of consistent, needed care for all women in Qatar.

4.5.2.2 Deficient patient health records

Eleven out of 15 participants identified insufficient information in health records as a barrier to promoting BCS. They said that it was not uncommon to see incomplete health records, consultation, and referral notes, missing valuable information that could otherwise inform them about women's health needs. For example, Fatimah (GP) said, "Our record is deficient. [It is] very hard to find [needed documents and forms]. Sometimes we will not get [needed health information from the patients].... [It would be helpful if] we have previous records either in computer or in paper." Fatimah explained that some women might not disclose a family history of breast cancer as it is taboo in the society. Therefore, without health records, the need to make a mammogram referral may be unclear. The physician participants stressed the importance of thorough documentation so that ongoing communication between health care providers can be possible.

Participants reported that mammogram results from the HMC were not being collected. Shanti (SN) said, “We are collecting pap-smear records and keeping them in the file. But mammogram results, we are not collecting them. So after the patient’s visit, some of them will come back for the follow-up, some will not.” Salma (GP) voiced concern, “Communication is cut out. This is the main barrier [for me]. When I give a referral letter, [there is] no feedback! So the patient just go[es] and [we] lose [her referral results/information].” Participants suggested that BCS records should be collected and kept in files.

4.5.2.2.1 The need for electronic health records system

Some participants attributed deficient patient health records to paper documentation. They explained that currently patient files are kept in the paper form, except investigation results done in the Hamad Medical Corporation (HMC), so locating patient health information in a timely manner was difficult. Some participants recommended implementing electronic health records system so that HCPs can have patient health information readily and refer women to appropriate health services. Alima (GP) said:

Our health center is very busy. You will just go fast sometimes. So it’s [not feasible] to search for mammogram history [flipping through every papers in the chart.] [Currently] we are doing manually [to find mammogram record] but I think [computerized system] is a very nice idea.

Participants believed that having electronic health records and documentation system will mitigate issues of deficient health records and inefficient records keeping, thereby ultimately increasing patient health outcomes.

4.5.2.3 Lack of reminder service for mammograms

Participants suggested that currently there is no reminder service for mammograms. Consequently, many women forget and miss their mammogram appointments as mammograms are scheduled one to two years apart. Alima (GP) said:

Sometimes I am writing down for the patient when to come back [for CBE/ mammogram]. ‘You should return to WWC for mammogram and breast examination.’ But usually they [misplace] the paper. So it will be very nice to have a message that they receive just for a reminder. But we don’t have it [now].

Based on the data, there is a strong recommendation that mammogram appointment reminder services, either by telephone/letter/person, be developed and made available to women to improve their return rates.

4.5.2.4 Insufficient support for health care providers

Participants suggested that knowledge and skills support for HCPs is essential for provision of effective BCS care. For example, Zainab (HN) spoke about nurses working at suburban hospitals, where there is a shortage of female physicians, who perform CBE delegated by male physicians. However, there has been no BCS workshop or any knowledge support for HCPs. Zainab said that there was one workshop on cancer in Doha in the past, but not many staff could attend the workshop. In relation to physicians, Alima (GP) said, “Doctors need experience [to perform CBE correctly]. Some physicians

are not doing the exam properly. Sometimes they do it fast [due to lack of time], missing breast cancer mass.” Consequently, insufficient skills and knowledge support for HCPs exists acting as a barrier.

Participants asserted that support may not be limited to clinical skills; communication and teaching skills are also essential. For example, Saeed (gynecologist) said, “[Health care professionals] should be educated otherwise how will you teach clients. Also we should be able to teach clients and send out educational information at the level that lay people can understand.” Suggestions for support by the health care system included providing workshops, courses, and trainings to update knowledge and information and clinical, communication, and health education skills.

4.5.2.5 The need to expand nursing roles and the lack of breast health educators

Participants identified the lack of a breast health educator as a barrier to providing BCS care to all women. Shanti (SN) said, “Health educator from the Hamad [Medical Corporation] is coming to [the] well-baby and antenatal clinics. Even dietitians are coming. They will sit in room, collect two to three patients, and give education after patients saw the doctor. But nobody has come to [the] well-women clinic.” According to the participants, health education about BCS and CBE is primarily a physician role. However, it is challenging for them to provide BCS education and care due to heavy workload and insufficient client-clinician time. Thus, a recommendation for creating a breast health educator role at each health center and/or a BCS education team that could travel to hospitals and primary health centers to teach colleagues and women was put forth.

Thirteen out of 15 participants, physicians and nurses, advocated for nurses to provide health education to clients as they closely interact with women clients, and nurses are often females. Nayden (gynecologist) suggested, “Teaching and explaining here is much work. [We need] one or two nurses for only health education for patients. [Nurses can] teach, explain, and answer question [about breast cancer screening].” Alima (GP) also supported nurses for taking part in BCS education. She said:

Sometimes there is a shortage, not enough staff [to provide necessary health education to all clients]. But if you have a well-trained nurse [who] knows how to give education for the patient, it will be [helpful.] For example, there are some nurses who have taken workshops and courses about breastfeeding. They are very active with education role for our [breast feeding] clients. It’s nice to have them in a busy health center such as this.

Salma (GP) also echoed, “The role of nurses in this clinic is already very important in explaining every details of the well-women clinics, steps of things must be done, why they are done, what’s the benefit for them before seeing the doctor”, indicating that nurses can take part of an educator role. Likewise, most physician participants perceived that nurses could confidently carry out the role of BCS education, thereby disseminating BCS knowledge and information to more women.

Participants suggested expanding nursing roles to include CBE so that more women can be examined and pressure on physicians can be reduced. Bahar (SN) said, “There are too [many] patients on the physician. I can help the doctor by performing CBE. If I find something suspicious or abnormal, I can tell the doctor. Then he can

interfere with me [my work].” Moreover, Zainab, a head nurse at a suburban health center said, “It is very nice to have nurses to do CBE. Especially female to female, it will be very easy [at this clinic where it is difficult to find female doctors.] Very nice to have a special nurse with some certificate prepared.” The potential role of the nurse in performing CBE was recognized and supported by many physician participants. On the other hand, one physician participant was concerned with the nurse’s ability to perform CBE correctly as she argued that even experienced physicians would miss abnormalities and that patients trust physicians more than nurses. Therefore, to ensure quality of care, all participants agreed that nurses would require necessary training and education to perform CBE accurately. Fatimah (GP) said:

The nurse should be trained first. There should be a tailored course [that teaches] full knowledge and how to apply the knowledge [in practice]. Nurses can do! If they taught better, they can do! Some of [the nurses] are very good [at health education]. But [it would be] better to give them training to know exactly what information they will give [to the patients and accurately perform CBE].

Although nurse participants believed that breast health assessment and education were part of nursing work, they saw their current roles in BCS very limited to assisting physicians and filing paper works. When nurses described their work, they often identified themselves as assistants, helpers, and someone less important compared to their physician colleagues. Participants believed that expanding nursing roles and competencies would change public perception of nursing and increase public trust in the profession. Shanti (SN) said, “We can do it. Training and role expansion will boost our

self-confidence, not just knowledge. That means people will also trust [nurses] because we have good knowledge and [skills]. [Patients' trust] will give us self-confidence. In turn, if I do [my job] confidently, the patient will also trust me.” Similarly, Bahar (SN) affirmed:

[People] know that in this clinic, the doctor will do [health education and CBE]. But if they have the idea that the nurse is specialized in breast examination, they will come to [us]. No problem. But they already have the idea that this is a doctor's job in their mind. But actually CBE and education are my job also. Many times, we ask the doctors to teach us. My colleagues who work with me, we agree with that [we want to do more].

All nurse participants were enthusiastic about taking up the new roles in breast health and BCS education and CBE.

4.5.2.6 Lack of collaboration among health care providers

Participants perceived that collaboration among HCPs is missing in the current health care system. They perceived that “it [is] the health team's role to initiate BCS awareness for women. Not only doctors, but nurses and every health team members should share the role” (Salma, GP). Fatimah (GP) said, “Right now we are working as an island. Every health center is [working] alone. Unless there are some protocols, guidelines, or systems that keep relationships among different health centers, it is so difficult to work as a team. This limits each of us.” She suggested that it is important to collaborate not just within the same health center, but across different health centers and to create strong infrastructure for effective communication among HCPs at different

institutions. As well, participants argued that health promotion work cannot be done by one person or one health center. Different HCPs in different departments and institutions must come together to create a collective power in raising awareness of BCS and encouraging women's participation in BCS practices.

4.5.2.7 Insufficient health promotion services

One participant suggested that there is a need to expand and invest in health promotion and illness prevention services in Qatar to promote health of the population.

Salma (GP) spoke about the importance of preventive public health services:

Health promotion takes a bulk of services. At least more than 60% of health services must be spent on preventative services, starting from immunization [through] health education and early detection [of cancers]. Preventive health services are important all throughout the life of all women from the child-bearing age and even after menopause. With preventive health services, we can detect problems early and easily manage them, much improving survival rate.

Specific to breast cancer, Salma added, "Breast screening programs need to be more systematic, arranged well, and take much effort to attract people toward preventive care and help them understand the importance of breast cancer screening."

4.5.3 Cost for mammograms

About half of the participants identified free or low-cost mammograms subsidized by the government as a facilitator for women in Qatar to access BCS services.

Mammograms are free for Qatari nationals and are majorly covered for women who do not hold Qatari citizenship. Shanit (HN) explained that non-Qatari (all people who are

born, live, and/or work in Qatar but do not have the Qatari citizenship) pay 100 riyals annually to renew the health care card. With the card, a mammogram costs 50 to 100 riyals (about \$13 CDN; a loaf of bread costs about 10 riyals). Salma (GP) said, “I did not see any barrier about [cost]. I don’t think [50 riyals] is too much. In Gulf area, 50 riyals is not too much. And it is not done everyday.”

However, the cost for a mammogram is still a barrier for some women who struggle to meet daily basic human needs such as shelter and food because many non-Qataris are immigrants who work at poor paying jobs. For example, Bahar (SN) said:

Many people don’t have enough money. Some of them, they don’t have enough money to pay... even for medication. Medication costs only two to five riyals.

(Then 100 riyals is huge money.) Yeah! ... [For example, when a woman wants to have a mammogram] husband will ask, ‘Why? Do you have a problem?’ She will say, ‘No, only to check.’ Then the husband will say, ‘I pay 100 [riyals] for check-up? I don’t want to pay.’

Whether cost for a mammogram was interpreted as a barrier or a facilitator, all participants agreed that free mammograms for all women would be the most ideal way to promote BCS.

4.5.4 Public transportation

Participants identified lack of access to health services by public transportation as a barrier. According to them, although more women drive nowadays, many women still depend on husbands or male family members for driving. Rani (SN) said, “Many women [tell me that they have] no car to come, that they don’t know how to drive, and have

nobody to pick [her] up or drop [her] off to hospitals.” Consequently, these women often miss medical appointments. An additional barrier for those who depend on husbands to drive them lies with the operating hours for the well-women clinics. They are open only in the morning when most men are at work. The participants recommended changing the WWC hours to the afternoon or establishing longer hours so that more women could attend the clinic.

In terms of using taxis as a means of transportation, participants reported that Muslim women are not allowed to ride in a car with a male stranger because being in a vehicle with a non-family male was considered improper in Islamic culture. Bahar (SN) said:

It is actually something religious and traditional. Ladies should not be in a taxi [where] she will be alone with a strange man in the car. It is [considered] very, very bad to take a taxi alone. Some of [the families] allow only in urgent [cases] but mostly they won't allow. Some families have a driver in their house. They know the driver. But women still will take her children or a maid with her in the car. Even my father will not allow me to ride a taxi to come to work. It is in our culture.

Accessing mammograms is even more challenging for women who live outside Doha as they would need to get permission from her family to travel a long distance away from home and would need a male family member who could drive them to Doha. Currently, most women access mammograms from the Hamad Medical Corporation, Women Hospital in Doha, a State funded hospital in Qatar.

4.5.5 Summary

In this section, a number of systemic factors that have influence on BCS practices among Arabic women in Qatar were described. First, insufficient client-clinician time was identified as a barrier for women to accessing available BCS services by limiting physicians' time to inform and discuss BCS with women clients other than immediate health concerns. Physician participants at the primary health centers perceived that they were seeing too many clients per day and not spending enough time with each client to complete health assessments or promote preventive/screening care due to a shortage of physicians and lack of an appointment system at the health center. They recommended that the health care system should employ more physicians and develop an appointment system in order to increase the client-clinician time.

Second, underdeveloped health care infrastructure for BCS was identified as a barrier for HCPs to promoting BCS, thereby limiting women's access to available services. First of all, participants suggested that lack of a national protocol for BCS was a barrier to providing consistent BCS care for all women and suggested a national protocol for BCS be developed and communicated to the front line HCPs. Moreover, participants suggested that deficient patient health records, lack of BCS records, and patient records kept in the paper form limited their ability to refer women to appropriate BCS services, follow up with them on referrals, and exchange patient health records and documentations with other HCPs working at different health institutions. They reinforced the importance of thorough documentation and collecting BCS records and recommended adopting an electronic health records system that could assist them to

organize and share patient health records between HCPs. Besides, participants suggested that there is no reminder service for mammograms; therefore, developing a mammogram appointment reminder service would be another way to improve women's participation in BCS. Furthermore, participants suggested that they did not receive sufficient knowledge and skills support from the health care system to provide effective BCS care. Participants recommended that health care system could support them by providing workshops on BCS and skills training that are not limited to performing CBE, but also include improving communication skills and health education skills. Participants also suggested utilizing the nursing workforce to provide BCS education and CBE so that more women can be informed and screened for breast cancer. Thirteen out of 15 participants perceived that nurses could carry out the roles confidently with formal training. Finally, participants spoke about lack of collaboration among HCPs, lack of collaborative practice environment, and insufficient health promotion services as barriers to BCS. By and large, participants perceived that organized, systematic screening program for breast cancer is needed to be developed and implemented.

Third, cost for mammogram was identified as both a facilitator and a barrier for BCS. HCPs interviewed suggested that free or low-cost mammograms subsidized by the government was a facilitator because mammograms would be very expensive otherwise. On the other hand, some participants suggested that the cost for mammogram was still a barrier for some women who live in poverty and struggled with daily basic needs such as shelter and food. Regardless of difference in interpretations whether cost for

mammogram was a facilitator or not, all participants agreed that free mammograms for all women would be the most ideal way to promote BCS for all women in Qatar.

Finally, lack of access to health care services by public transportation was identified as a barrier for women to accessing available BCS services. According to participants, although more women drive these days than before, many women are still dependent on their husbands or male family members for driving. Participants also explained that Arabic women in Qatar cannot use taxies as transportation means because riding a car with a stranger male was considered improper in Islamic culture. Although all perceived that lack of public transportation was a barrier to BCS, there was no recommendations given for this barrier.

Besides factors that were described in previous sections, HCP participants shed some light on systemic factors that influence women's BCS practices. Without interviewing HCPs and obtaining their views and understandings, these factors might have remained uncovered. These factors identified by the participants demonstrate that women's health related decisions and behaviors are very influenced by health care and social structural factors. Most of the recommendations offered by the participants require systemic changes in the health care system, needing ground work for constructing the infrastructure for effective and sustainable BCS. Participants agreed that much work is needed to make BCS accessible to more women and reach all, different women populations in Qatar.

Chapter Five: **Discussion and Conclusion**

This qualitative study presented a basis for understanding factors influencing breast cancer screening (BCS) practices among Arabic women living in the State of Qatar from health care providers' perspectives. A qualitative analysis of the participants' narratives revealed themes beyond the biological understanding or personal/physical barriers to BCS to encompass cultural and religious beliefs, traditional values and customs, and systemic barriers in Qatar. This chapter recaps relevant information from preceding chapters to further analyze and discuss the findings and significant implications arising from them. Implications for health care, practice, education, and research, as well as the role of nursing as a discipline and advanced practice are presented to explicate a better understanding of what would be helpful in providing breast health care for women in Qatar. The chapter will conclude with limitations and conclusion.

5.1 Influence of Knowledge and Pain Perception

Personal factors such as knowledge and awareness of BCS and pain perception related to the procedures were found to impact women's breast health.

5.1.1 Knowledge about breast cancer screening

All participants in this study identified knowledge and awareness of BCS as the major facilitator for participating in screening for which a benefit was subsequent earlier detection of breast cancer. Conversely, lack of knowledge of BCS was found to be a hindrance to some women's participation in BCS. Similar results were found in studies with Arabic women that reported knowledge and awareness of BCS was a significant factor that either hindered or facilitated women's BCS practices (Amin et al., 2009;

Azaiza et al., 2010; Benner et al., 2002, 2009; Cohen 2006). Participants in this study noted that, although the number of women who are aware of breast cancer and its screening and request clinical breast examination (CBE) or mammograms has increased, many still do not know much about breast cancer, signs and symptoms, and screening modalities. Donnelly et al. (2012) reported that 93.4% of the Arab Qatari women participants were aware of breast cancer and its screening but only 7.6% had basic, accurate knowledge of BCS and that women who were aware of BCS recommendations were more likely to practice BCS. The findings of this study suggest that access to health information is a contributor to an increase in knowledge of women. Having identified the need for increasing knowledge and awareness, the question arises as to how health information and knowledge are made available and accessible to women. As health care provider (HCP) participants suggested in this study, information about BCS can be made available through development of information leaflets and posters, use of mass media, playing educational videos at primary health centers, and holding small group workshops at the primary health centers for women clients. However, the research findings revealed that these educational interventions were not enough; supportive health care policies that would serve as guidelines for HCPs were also needed. Additionally, it was recognized that both women as consumers of BCS and HCPs as deliverers of BCS must share responsibilities for enabling it to be accessible.

5.1.2 Pain perception with breast cancer screening

The findings from the study suggest that perceived pain during mammograms can be a barrier to seeking mammograms for some women in Qatar. Similar to the findings

of this study, Soskolone et al. (2007) reported that Arab Israeli women's fear of pain was a greater barrier to accessing mammograms than were physical barriers such as lack of accessibility by public transportation. Participants in this study suggested that fear of pain or physical discomfort during mammograms could be overcome with increased knowledge of BCS and constant encouragement by HCPs. However, it is equally important to communicate with women clients regarding the mammogram procedure, how it is done, the short-lived nature of discomfort or pain caused by pressure, and any other fears that women have about BCS. Instead of giving information only about benefits of BCS and making quick referrals, HCPs would need to spend time with women to make informed and mutual decisions about care. In this way, women may feel that they are informed enough to have more choice over BCS and be responsible for any decision made about procedures related to screening.

5.1.3 Perception of 'no pain, no illness'

The perception of 'no pain, no illness, therefore no need for medical services' was identified as a barrier to utilizing BCS services. Similar to the findings of this study, Petro-Nustas (2001) reported in a study with Jordanian women that feelings of no need hindered women's participation in BCS. Although this perception of 'no pain, no illness, no need' was pointed out as a barrier, it needs to be understood also from a broader context, i.e., there has been little public discourse about health and healthy living when the focus was primarily the disease and disease treatment. Therefore, some women's conceptualization of health as absence of illness or pain and of health care as a service to use when sick can be re-interpreted as lack of high priority on health promotion in health

care. “Health is more than the absence of disease – it is a broad manifestation of wellness of body, mind, environment and is viewed as an essential resource for everyday living” (Vollman et al., 2004, p. 4). Therefore, prioritizing health promotion as an important component of health care and disseminating concepts of health promotion and illness prevention would be important future strategies to broaden people’s view of health, encourage public discourse about healthy living, and heighten understanding about screening activities as part of improving health and wellness. The Qatar society is changing rapidly; there is much attention on health promotion and illness prevention in Qatar. HCPs have an important role in exploring women’s beliefs in health and illness and negotiating with them about ways they can use available health information, services, and resources to achieve health and wellness.

5.2 Influence of Culture

Kleinman (1978) contented that eliciting cultural EMs allows HCPs to provide alternative explanations within a broader cultural framework. In alignment with Kleinman’s (1978) EM of health and illness, the findings of this study suggest that health-seeking behaviours are mediated by culture-specific beliefs and attitudes. Arab women’s experiences of BCS are unique and complex as influenced by various culture-specific beliefs, attitudes, and practices.

5.2.1 Beliefs of female breasts and their significance to identity as a woman

The findings of the study revealed cultural beliefs of female breasts as being symbolic of femininity and fertility, and significant to the construction of socio-cultural identity as a woman. Additionally, there is much cultural emphasis on the traditional

Arabic female role of giving birth and raising children in Qatar. These findings are supported by Azaiza and Cohen (2008), Baron-Epel et al. (2004), Hammad, Kysia, Rabah, Hassoun, & Connelly (1999), and Offenbauer (2005) who described the cultural meaning of breasts as a symbol of femininity, sexuality, and fertility, the primary female role as childbearing and rearing in Arabic countries, and absence of a female role or identity outside the home. Baron-Epel et al. (2004) wrote in their report that without the role of the Arab women in society as marrying, having children, and being totally committed to her family, the woman's life is purposeless and her place in society is lost if she becomes sick and no longer able to function as a wife and a mother. Similar to many women of other ethnocultural backgrounds worldwide, including women living in the Western societies, female breasts are treated as a body feature significant to traditionally constructed female roles. The diagnosis of breast cancer and potential loss of a breast/breasts could equal the loss of femininity, fertility, female roles and identity, and loss of position in the family for Arabic women. Therefore, some women might be dissuaded from screening practices. Understanding how Arabic women conceptualize breasts in relation to their roles, identity, and reasons for being as Arab women would be critical in understanding how women view and use BCS services.

5.2.2 Practice of polygamy and women's fear of divorce and abandonment

The findings of the study suggest that the cultural practice of polygamy in Qatar, although this practice is changing, can hinder Arabic women accessing BCS. This is supported by Azaiza and Cohen (2008) and Baron-Epel et al. (2004) who reported that some Arab Israeli women might avoid accessing BCS due to fears of divorce and

isolation if breast cancer was detected. As with the Arab Israeli women, participants in this study noted that some women feared divorce leading to loss of position in the family and social isolation. Subsequently, it was important for them to look “always ladylike, fresh, and healthy” and not to give men any hint or impression that they might be ill, thereby refraining from screening practices. What is implicit in the narratives of the participants is that with the cultural practice of polygamy, value as a woman rests on being able to bear and rear children and take care of the family. This belief held by some Arabic women is shaped by cultural traditions, expectations, norms, and ways of being about women. Without challenging the belief that women’s value solely rests on being able to carry out culturally sanctioned gender roles and relations and also challenging how this belief is perpetuated in society. It would be difficult to empower women to overcome the barrier to accessing BCS services that is created by polygamy and fear of divorce. Understanding the influence of cultural practices such as polygamy on women’s decisions about health adds another layer of understanding BCS practices in Qatar and raises awareness of cultural influences on women’s breast health.

5.2.3 Beliefs and attitudes toward illness as defect and shame

Cultural conceptualizations of illness as defect, shame, and a family secret add further stigma to breast cancer and cancer screening activities. This finding is supported by Baron-Epel et al. (2004) and Hammad et al. (1999) who documented cancer as a stigmatized, fatal disease characterized by feelings of uselessness, worthlessness, and isolation. Hammad et al. (1999) explained how the concepts of shame and honor of the family were highly emphasized within the Arab context and how some illnesses were

viewed as a matter of shame, thereby being kept within the family. Therefore, some illnesses, especially cancer and mental disorders, were hidden and highly shunned in the Middle East countries for fear that people would view the condition as a hereditary defect which then might affect the family's social standing and desirability (Hammad et al., 1999). Although these findings have been found among many other populations from different societies, this view of cancer was also apparent in the findings of this study.

Furthermore, it was found that cultural beliefs about illness shaped social attitudes toward sick women as being unwanted and replaceable; thus, some women might refrain from BCS for fear of stigmatization and isolation. Similar results from previous studies conducted within Arab contexts suggested that a woman who has a BCS might be socially labelled as sick and potentially defected; therefore, some women might not participate in BCS for fear of gossip and potential troubles (Azaiza & Cohen, 2008; Baron-Epel et al., 2004). These findings add to understanding why some women in Qatar do not participate in BCS despite knowledge and awareness of breast cancer and its screening. Similar to many other societies, it seems as if the stigma attached to illness and ill women perpetuates itself to continue to position women at a disadvantaged situation for achieving health. Thus, the chain of stigma of illness and sick women as defect, shame, undesirable, unwanted, useless, and replaceable would need to be broken in order to assist women to access BCS and to gain needed social support.

5.2.4 Beliefs of female bodies and moral values between men and women

The findings of the study suggest that shame, embarrassment, and guilt associated with exposing breasts can be barriers for women to participate in CBE. This finding is

supported by previous studies that reported the same (Azaiza et al., 2010; Azaiza & Cohen, 2008; Bener et al., 2009). HCPs interviewed consistently focused on women's refusal of care as a challenge in promoting BCS. However, women's refusal of care should not be quickly judged as lack of responsibility for health or lack of knowledge and awareness of health, but it needs to be understood within religious context where modesty and concealment of sexuality is expected and viewed as virtuous qualities of women (Quran). In a society with high religious orientation where exposure of female body parts is considered immoral and unacceptable, exposing the breasts even for examination or talking about breast in the health care context would be difficult for Arabic women. Rather than identifying the problem as the women's health behaviour, it would be important to challenge a notion that a woman's virtue is determined by total concealment in order to reduce emotional barriers experienced by women and mitigate the stigma attached to BCS. Furthermore, as suggested in the findings, collaborating with women empathetically by attending to their feelings and thoughts would be important for HCPs to invite women to speak about their health needs and concerns.

Moreover, the findings of the study indicate CBE performed by male, (and sometimes even female), health care professionals was viewed as a shameful act and something to be avoided if possible. Therefore, promoting breast health can be especially challenging for male HCPs. As suggested in the findings, male HCPs may perceive women's refusal of care as a loss of freedom and professional autonomy as a physician. However, as an alternate interpretation of the data, a shift of focus in health care practice could be warranted to support interprofessional collaboration where interdependence and

collaborative care with other physicians, nurses, and other health care providers including women and family becomes a standard for health care delivery. Perhaps the current health care environment is not yet conducive to interprofessional collaboration without putting more emphasis on it. Nevertheless, participants in this study agreed that availability of female HCPs in women's health care is a strength. Yet, to the best of my knowledge, there is no research study to date found in the literature search that identified female HCPs as facilitators to BCS in Arab countries; however, embarrassment with exposing breasts, being examined by male physicians, and unavailability of female physicians at primary health care centers were described as central barriers to having CBE in many studies (Amin et al., 2009; Azaiza & Cohen, 2008; Bener et al., 2002, 2009). These findings reinforce the importance of retaining and recruiting female HCPs in women's health services and primary health care centers in Qatar. Moreover, health care providers have responsibilities to be open to and knowledgeable about shared, collaborative multidisciplinary team practice, to practice to honor human dignity of clients, to be respectful of and sensitive to what they ask of women and its potential effects. As well, it would be important to increase understanding about how health care providers' practices and a lack of responsiveness to gendered differences could perpetuate sexism.

5.2.5 Dual influences of religious beliefs of illness on health-seeking behaviours

Congruent with the results of previous studies with Arab women on their BCS behaviors (Azaiza & Cohen, 2008; Baron-Epel et al., 2004; Bener et al., 2002), the findings of this study suggest that religious beliefs (Quran) can have both facilitating and

constraining influences on Muslim women's health-seeking behaviors. However, slightly different from the previous studies that suggested that pervasive belief about cancer as God's will and a test devised by Allah (God) hindered women's access to BCS by leading to fatalism and reducing the incentive to seek screening (Azaiza & Cohen, 2008; Baron-Epel et al., 2004; Bener et al., 2002; Petro-Nustas, 2001), the findings of the present study suggest that such beliefs were held only by older women with more traditional religious beliefs. Participants indicated that religious beliefs about God's will and breast cancer as God's test are less of a barrier now than before as more women, young and educated, have integrated biomedical understandings of breast cancer. In contrast to other study findings, beliefs such as mammograms bring bad luck and breast cancer is a death sentence (Azaiza & Cohen, 2008; Soskolone et al., 2007) were not mentioned by the HCP participants of this study. Perhaps this finding reflects the changing demographics of Arab women adjusting to Westernization and urbanization in Qatar. However, interpretation of the findings must be cautious as the women were not asked directly about the influences of religious beliefs on BCS. Considering Qatar is an Islamic country with a strong religious orientation, where "a feeling of dependency on God, the fear of God's punishment, and a deep-seated-respect for tradition and for the past" (Hammad et al., 1999, p. 16) could be pervasive in everyday life, the potential influence of religious beliefs over women's health related decisions and behaviors cannot be overlooked.

On the other hand, the findings of the study suggest that some religious beliefs continue to have facilitating influences on women's health-seeking behaviors. For

example, beliefs such as “You should take care of your body because it is given by Allah; you should seek help and health before you get sick; Allah gave you the disease, but also ways to overcome it and healing; Allah is only testing me to see if I am strong or not” were found to be facilitators for accessing BCS services. This finding is consistent with those from previous studies conducted with Arab women that beliefs in God’s will regarding life, death, health, and illness and God’s test through illness (Quran) could encourage responsibility for their own health through self-care and seeking health care services (Azaiza & Cohen, 2008, 2010; Baron-Epel et al., 2004; Bener et al., 2002). These findings suggest that religious beliefs can either hinder or facilitate women’s participation in BCS depending on the women’s personal beliefs and interpretations of religion. Ignorance or mistaken religious views can lead to passivity and lack of self-care (Azaiza & Cohen, 2008). Therefore, it would be especially important for HCPs to explore and address beliefs that women hold, understand their effects on health-seeking action, reinforce facilitating beliefs, and work with women to support change.

5.3 Influence of Gender and Power Relations

An analysis of the findings revealed the role of gender and gendered relations of power in Arab women’s BCS practices in Qatar. Factors such as power differentials between men and women, female roles and responsibilities, and spousal support were found to impact women’s health-seeking behaviors.

5.3.1 Culturally constructed gender power relations

As in many other societies, the findings of the study suggest that unequal power relations between men and women in Arab countries can be a barrier for women to

accessing BCS services. In participants' narratives, much focus was on women's behaviors such as hurrying to finish the clinic visit, not allowing enough time for additional interventions such as CBE or health education, refusing the need for BCS, and their inability to make decision about their own health. However, analysis of the data suggests that Arabic women's relationships with men embedded in a gendered hierarchy is socially, culturally, religiously, and traditionally enacted and maintained as the norm. In traditional Arab society with clear male dominance, the lower status of women has been emphasized and reinforced (El-Safty, 2004) with the effect that women appear more passive and act more passively when with men, in the face of authority. Although it varies in degree, a classic patriarchal model of the family and society, where men exercise authoritarian power and women are subordinate, manifests as core to the patriarchal social structure (Offenhauer, 2004). Qatari society is changing quickly, valuing equity in relations and abilities and respecting the voice and agency of women where masses of women enter the workforce, drive, and carry on activities outside of their homes. Many Arab men are supportive of women's BCS activities. However, women are still expected to consult their husbands for permission to participate in activities and to follow their husbands' wishes. As a result, even if women know about BCS, they might not be able to access it if their husbands oppose their wives getting screened. This finding is supported by previous studies (Azaiza & Cohen, 2008; Baron-Epel et al., 2004) in which the authors reported that passive and submissive roles of women in the traditional Arab society and husbands' objections to their wives' BCS were barriers for women to access available BCS services. Consequently, women's refusal of

care such as BCS and health education must be interpreted with careful attention to personal biases and pre-assumptions, within a broader, socio-cultural context. Arabic women occupy a unique position in the androcentric, patriarchal society. These findings raise awareness of the influence of worldwide existing gender inequities in women's health care and health outcomes. By adopting a different focus that targets the total context as the point of intervention, future BCS strategies can negotiate BCS care with women, men, and community to reflect understanding of their perspective as an alternative.

5.3.2 Female roles and responsibilities and low priority on health

Similar to other cultures, traditional Islamic society was characterized by a sharp division of roles with the male as breadwinner and the female as homemaker (Hammad et al., 1999). These socio-cultural expectations on gender roles and responsibilities, coupled with a cultural construction of women's lower status and authority in relation to men, may create a hindrance to women's BCS practices. In the findings, it was suggested that more women are working outside the home now, which might suggest a move toward more gender equity, but women still assume the domestic responsibilities by themselves without help from men. Therefore, BCS might not be in women's agendas at all or come at the very last after other priorities. There is no Arab study that suggested female roles and responsibilities as a barrier to BCS; however, similar findings were reported in studies with Iranian and African-American women where low priority being placed on BCS in the context of other family priorities was a barrier to accessing BCS services (Hoffman-Goetz & Mills, 1997; Lamyian et al., 2007). Many participants in this

study perceived that women would access BCS despite busy schedules if they had good knowledge of BCS. However, education itself might be insufficient in the face of a strong tradition in the patriarchal culture. As a few participants suggested, working with women's schedules without a judgmental attitude would be important for HCPs' practice with Arabic women. Equally, it would be important to advocate BCS interventions that target the society as a whole to mitigate contextual barriers such as gender inequity and traditional gender role relations.

5.3.3 Spousal support

Congruent with previous studies (Azaiza & Cohen, 2008; Baron-Epel et al., 2004; Bener et al., 2002; Donnelly et al., 2012), the findings of the study indicate that husband support can be a strong facilitator for women in participating in BCS activities because husbands play an important role in Muslim women's lives. In the quantitative study of the same research project conducted with women in Qatar, Donnelly et al. (2012) indicated that only 1.5% of women participants perceived that their husbands or other family members would object to breast examinations. Participants in this study also perceived that a husband's objection to BCS is rare; however, husband support is limited to driving women to hospitals and many women still fear divorce. The findings also indicate that husband support seems to depend on the husband's education level and knowledge and awareness of BCS. This finding is supported by Donnelly et al. (2012) that husbands' higher education levels, presumably higher knowledge and awareness of BCS, were significantly related to women's knowledge and higher participation rates in BCS activities. Therefore, it would be important to give men opportunities to learn about

BCS thereby strengthening their understanding of and support for BCS. Future BCS strategies and public health education can involve both women and men and offer them opportunities to be aware of BCS and women's health issues and their role in supporting and encouraging female family members in achieving health and well-being. Participants in this study also emphasized the need to involve children, both girls and boys, to effect positive social change in terms of reducing social stigma attached to breast cancer and its screening and sick women, increasing men's support on women's health issues, and raising awareness of women's health issues for girls themselves. As suggested in the findings, shifting the focus of care from individual to family, and to community and society, might contribute to heightened awareness of population health issues, available health services, and increase public discourse about health and wellness.

5.4 Influence of Systemic Factors

The data analysis revealed systemic factors that implicate the broader health care and public systems in health and wellness. Insufficient client-clinician time, underdeveloped health care infrastructure for breast cancer screening, cost for mammograms, and lack of public transportation were identified as factors impacting women's BCS practices.

5.4.1 Insufficient client-clinician time

The findings of the study indicate that insufficient client-clinician time can be a barrier for women accessing BCS services. Physician participants suggested that they did not have enough time to even conduct complete health assessments; therefore, discussing BCS with women clients was challenging. Similar to the findings of this study, Al-

Amoudi et al. (2010) found that most physicians in Saudi Arabia did not perform CBE because of lack of time (37.9%), follow by patient refusal (48.5%). Previous studies conducted with Arabic women indicated that receiving information from their doctors was one of the strongest predictors of participating in BCS (Petro-Nustas, 2001; Soskolone et al., 2007). Particularly, Donnelly et al. (2012) found that 94% of women participants in Qatar reported that they would access mammogram services if their doctor recommended it. These findings indicate that a doctor's recommendation is one of the strongest facilitators of screening practices for women in Qatar and that increasing client-clinician time would be essential. Furthermore, it illustrates how health care structural factors such as shortage of HCPs and limited client-clinician time affect women's health by limiting HCPs' work with women. Health care decision makers and administrators must be able to dedicate sufficient time to educate women about BCS and create the practice environment supportive of HCPs' work.

5.4.2 Health care infrastructure for breast cancer screening

The data analysis revealed facilitators and barriers within the current health care infrastructure for breast cancer screening.

5.4.2.1 Facilitators

Although participants did not explicitly identify the well-women clinic (WWC) program as a facilitator, it should be recognized as a strength in the Qatari health care system. With the primary aim of early detection and health promotion, this community-based program equipped with female HCPs offers a range of services including breast and cervical cancer screenings and blood tests for CBC, thyroid function, and vitamin D

and health education about obesity and life style modification. It is offered in each primary health center located in each community. There is an opportunity for the Qatari health care to construct female friendly health care environments, basing its foundation on WWC programs by expanding its effort such as expanding clinic hours, inviting various women populations, advertising their programs, and educating the client, families, and community about women's health issues.

Qatar has had a pink hijab day for breast cancer and annual national breast cancer awareness walk since 2008. However, not many participants in this study were aware of the events. This indicates that communicating BCS efforts would be important as much as developing and implementing them. There is a need for advertising available resources and events nation-wide, expanding current resources and strengths, and collaborating with community organizations and health centers to maximize the public health education efforts.

5.4.2.2 Barriers

Underdeveloped health care infrastructure for BCS was a systemic barrier for women in achieving breast health. All in all, as participants identified, a national protocol for BCS, complete patient health records, reminder service for mammograms, support for HCPs' ongoing competency development, breast health educator, collaboration between HCPs and between health institutions, and sufficient investment in health promotion services were missing; otherwise, these could have facilitated physicians' work with women and women's access to information and available BCS services. Based on data such as: mammogram results were not being collected while

pap-smear results were; there was no breast health educator while there were educators for the well-baby and antenatal clinics; no information brochures about BCS were available for women at the health centers; BCS was seldom discussed/ offered by physicians and other health care providers, it seems as though promotion of BCS was low in priority among the health care providers, not just among women clients. Health care providers interviewed identified several ways that the health care system can build a strong infrastructural foundation for effective BCS in Qatar, such as developing a national protocol, electronic health records system, and reminder service for mammograms, providing HCPs with knowledge and skills support, expanding nursing roles to include breast health education and CBE, creating a collaborative health care practice environment, and investing more in health promotion services. All of these recommendations are valuable. The Qatar health care system can start by increasing awareness of breast cancer and the importance of BCS within the health care system and then working its way up to construct a functional infrastructure for population-based BCS programs. Currently, a national protocol for BCS is being developed. It is encouraging to know that the change is already happening and that it is congruent with a recommendation given by participants of this study.

5.4.3 Free or low-cost mammograms

In this study, cost for a mammogram subsidized by the government was identified as both a facilitator and a barrier. The differing interpretations of mammogram cost as a barrier or a facilitator for women seemed to depend on clinical experiences of each HCP. For example, Bahar, a staff nurse, reported that immigrant women who could not buy

medications which cost only five (5) riyals can view 50 riyals as a barrier. However, physicians who stay in the examination room and never witness whether women buy medications or whether they go to the referral appointment, may not know if cost was a barrier or not. Unless the women are asked this question, HCPs will not know whether or not the mammogram cost is perceived by women as a barrier to accessing mammograms. Furthermore, the answers might also vary depending upon the situation of a particular woman.

Participants' perception of free or subsidized mammogram cost as a facilitator is strengthened by a recent study in Qatar by Donnelly et al. (2012) who suggested that, although socioeconomic status influences Arab women's BCS practice, cost was not a significant barrier in accessing the mammogram service in Qatar. This finding is encouraging as the costs for a mammogram were reported to be a barrier to BCS in Palestine (Azaiza et al., 2010). These findings indicate that other barriers may be more significant than the cost for mammogram as women's participation rates in mammogram are low while the service is free or subsidized. Nevertheless, as all participants agreed, given that breast cancer is the number one cancer that contributes to morbidity and mortality of women in Qatar, perhaps free mammograms for all women and active advertisement of the free service nation-wide might increase women's awareness and participation rates in BCS.

5.4.4 Lack of access by public transportation

In the findings, lack of access to health services by public transportation was identified as a barrier for women to achieving health. Similar to the findings of this

study, lack of public transportation (Soskolone et al., 2007), insufficient number of mammography facilities, their remoteness and difficulty reaching them (Azaiza & Cohen, 2008; Azaiza et al., 2010), and living in non-urban areas (Bener et al., 2009) were identified as barriers to BCS in previous studies. Based on the findings, accessing government funded health services was particularly challenging for women living in suburban/rural areas outside Doha (the capital city) due to difficulty travelling a long distance to the mammogram clinic in Doha and dependency on husbands for driving. However, according to participants, this barrier was not only specific to women in suburban/rural areas; women in Doha experienced the same but to a less degree. However, Donnelly et al. (2012) reported that urban versus semi-urban was not significantly related to participation in BCS activities, suggesting that there are other barriers more significant than this access barrier. Regardless, the influence of urban-biased, inequitable geographic distribution of health care and human resources on health should be considered in planning future BCS strategies to generate solutions that can lessen the barriers experienced by women who are even further marginalized due to geographic location.

5.4.5 Summary

The findings of this study concur with previous studies with Arabic women. Various personal, cultural, gender, and systemic factors affected women's access to BCS services. These findings are also similar to women's BCS experiences in Canada wherein knowledge, fear, shame and embarrassment, language, transportation, access to mammogram center, access to physician, client-clinician relationship, cultural beliefs and

practices, self-care, socio-economic status, and family dependence were identified as factors influencing women's BCS practices (Ahmad, Mahmood, Pietkiewicz, McDonald, & Ginsburg, 2012; Donnelly, 2006, 2008; Donnelly & McKellin, 2007; Vahabi, 2005). Because Canada is a multi-cultural society, one in five people in Canada is an immigrant with a different cultural background (Statistics Canada, 2007). Hence, the influence of religion, cultural conceptualization of female body parts, modesty, and patriarchal marital relationship could exist in Canada as well. Issues that some Arabic women are facing are not unique to them. Some women from other societies experience the challenges as well. However, in general, Arabic Qatari women's experience would still be unique and different from Canadian women's as they live in the society with a strong religious orientation and clearly visible gender and class hierarchical differences. In addition, the findings of the present study are based on the interpretations and perceptions of health care providers. Therefore, facilitators and barriers as experienced by Arabic women themselves are not known. More exploratory, narrative inquiry exploring Arabic women's perspectives and interpretations of reality, as the women see and understand it, would be essential to deepen the understanding of their unique experiences and to develop knowledge for health care provision.

With the increasing integration of Qatari society in the international global market, and especially after the discovery of vast deposits of oil and natural gas, ethnic, technological, financial, intellectual, and ideological influences have led to rapid changes in the social and economic life of society. During the last few decades, these changes include: (a) family living standards and levels of consumption are rising each year (b)

family structure is changing from the extended family to the nuclear family; (c) family functions and values such as gender relations and responsibilities are changing from patriarchal to liberal and shared roles; (d) husbands are becoming more supportive of their wives' autonomy (e) the status of women is changing from lower to higher status with opportunity to participate in decision-making; (f) more women are getting educated and entering the workforce than before; and (g) the tradition of marriage is changing from arranged marriage to marriage based on romantic love (El-Haddad, 2003; QSA, 2010). These changes were echoed in the narratives of some participants of this study. Health care solutions addressing challenges of accessing BCS services would need to reflect these transforming changes in society to better support women and their families.

What was intriguing during the interview with HCPs and data analysis was that great emphasis and focus was put on individual women's knowledge level as the major factor influencing their BCS behaviours. Therefore, there were repeated recommendations for improving women's knowledge and awareness of BCS despite other varied contextual factors identified. The interpretations of HCP participants paralleled some of the previous studies which based their theoretical lens on the health belief model which emphasizes self-care and personal responsibilities for health (Cohen, 2006; Petro-Nustas, 2001; Soskolne et al., 2007). The literature and findings of this study indicate that a person's education, literacy level, knowledge and awareness of breast cancer, its screening, and perception of pain do influence Arabic women's BCS practices. However, women's lack of knowledge and awareness might be related to inadequate efforts to educate women and disseminate information to women, and lack of social

environments that are conducive to speaking of and advocating for women's health issues. As revealed in this study, Arabic women's health related decisions and behaviours are largely compounded by multiple layers of environmental factors such as culture (beliefs, norms, conduct), religion, tradition, gender, health care structural constrains, and social resources. It was illustrated that Arabic women's health and illness, especially breast health, was not fully under the control of women. As with many women worldwide, Arabic women were positioned in asymmetric power relations which influence the socio-cultural construction in which they live, make decisions, and behave the way they do. Therefore, under-utilization of BCS services in Qatar should be understood within that context. Addressing problems on a personal level isolated from the context will not be adequate and effective. Therefore, what seems immediately personal must be examined within its context; change needs to attend the total context to foster health equity and accessibility to health care.

The findings of this study revealed significant information related to BCS practices of Arabic women that are relevant for nurses, but also for policy makers and other HCPs such as physicians, health educators, and social workers. Policy makers and HCPs have opportunities to explore factors relating to Arabic women's BCS practices and provide a health care environment that is conducive to achieving health.

5.5 Implications for Health Care

The findings have important implications for comprehensive health care. Due to the contextual nature of human experiences, attention must be paid to the total context, making linkages between health experiences and the physical, social, cultural, political

environments. Without establishment of the linkages between holistic human experiences and the environment, the focus is on treating the individual who presents for care. An ecological perspective provides an instrument for linking health promotion and illness prevention by highlighting a shared framework for change targeted at the individual and the environment (McLeroy et al., 1988). With an ecological perspective as a theoretical foundation in health promotion research and intervention, the focus can shift from individuals to a broader socio-cultural-political context. Furthermore, it is important for health care decision makers to recognize that health services do not have sole responsibility for administration and management of health care; responsibility is shared with other sectors including education, justice, and social services that impact the health of the population. Thus, multiple points of entry to planning and implementation are essential to come up with viable solutions that address contextual barriers to health. Health care systems must cooperate and collaborate with other sectors such as the government, education, religious institutions, and community organizations. With emphasis on both health promotion and illness prevention, the health care system can build a functional infra-structural foundation for health of the population, advocate healthy public policies, increase public knowledge of health and wellness, and give opportunities to consumers to participate in health care strategies.

Empowerment is the main focus concept of the WHO's vision of health promotion (Greacen 2010). In nursing, empowerment is defined as giving power and authority (Wåhlin, Ek, & Idvall, 2006). Interventions aimed at empowering women and men to make informed decisions in BCS must be addressed from the point of view of the people

affected by the interventions so that the interventions are accepted and utilized, thereby effective. Despite many barriers, this study identifies numerous facilitators present in Qatar such as availability of female HCPs, free or low-cost mammograms, increased knowledge and awareness of BCS, increased spousal support, and positive influences of religious beliefs. In empowering a community, it is important not to focus primarily on deficiencies but on community resilience, a dynamic and ongoing process that can be developed at times of adversity through interaction between individuals/ communities and their environments and experiences (Gillespie, Chaboyer, & Wallis, 2007). Qatar has a bright future on which to build further existing community strengths, and enable populations to take ownership of their own health.

The findings have important implications for equitable and inclusive health care that is female and family friendly. Despite the current emphasis on the human rights of health, health promotion, and health for all (WHO, 1978, 1986, 1997), Arabic women remain susceptible to increased health risks such as breast cancer in part due to their lower socio-economic status in society. Some of the women's health issues, such as breast cancer and its screening, are very sensitive topics often avoided in discussion in Qatar. In order to make the health care environment supportive for women and women's health care, health care policy makers can raise public consciousness about women's health issues, challenge socio-cultural attitudes toward illness, and offer opportunities to talk about how some illnesses are stigmatized and shunned. Through consciousness-raising of issues of women's health and illness, the health care system can take part in advocating for women's health by "move[ing] in the direction of health care which

provides the greater care, ease, and respect for women's bodies" (hooks, 2000, p. 33).

Women's health is important; women will need to consider their own health as seriously and respectfully as other priorities, and their families will need to recognize this as a priority. There is a need for culturally sensitive and competent breast health services tailored to the unique needs of women in Qatar by overcoming cultural barriers including gender barriers, advocating equity in health, relocating health services and resources, and engaging male partners and family members in breast health promotion. Furthermore, by honoring women's voices, by making sure that everyone is heard, and by involving women in research, intervention planning and implementation, and evaluation, health care can ensure environments conducive to health for all.

5.6 Implications for Practice

The findings from this study have important implications for practice for HCPs and registered nurses. Firstly, HCPs must listen for, acknowledge, understand, and value the meanings ascribed to Arabic women's unique experiences within the broader socio-cultural-historical context to understand how their health-related decisions and behaviours may be influenced by the context so that they can work with the women in a meaningful, relational, respectful, and responsible way. Through understanding the women's own values, beliefs, and cultural practices in breast health care and BCS, HCPs can collaborate and negotiate appropriate breast health care with them, provide holistic, comprehensive health care that focuses on the total context, and alleviate tension that arises from differing values and discrepancies between cultural views and the dominant Western biomedical perspective on health and wellness. Narrative and relational practice

would offer opportunities to encourage and value differences and multiplicity while seeking mutuality and “shared collective meaning over the voices of persisting differences” (Ewashen & Lane, 2007, p. 260).

Anderson (1998) and Kleinman (1978) suggested that both HCPs and the women are engaged in producing a new culture and new knowledge within reciprocal relationships. It is important for HCPs to understand their own historicity, reflect on origins of their understanding and knowledge of health and illness, and challenge their own biases, pre-assumptions, and judgmental attitudes that they bring in to the care of Arabic women. It is also important that HCPs respect the client as a partner in care who has a right to accept, alter, and reject health information given to them (Kleinman, 1978). HCPs must acknowledge that they are situated within the broader social-historical-political-economic contexts of health care.

Furthermore, the study findings challenge some of the stereotypical assumptions of Arabic women as non-compliant, difficult to work with, and unable to take responsibility for their own health. Generalizations, stigmatization, and labelling are not only damaging to the therapeutic relationship by creating misconceptions even before the initial contact with the women, but also have significant material, physical, psychological, and emotional consequences on the health status of the vulnerable women. HCPs have an important role in facilitating health promotion of individuals and communities (WHO, 1986); they must understand cultural tensions as cultural differences, raise the issue of cultural differences, and enable strengths-based health promotion approaches by building on the capacity and resiliency inherent in Arabic

women in order to enable women to empower themselves. This can begin by helping the women identify their personal strengths and commence building from there.

Finally, collaborative leadership and team functioning are vital domains of interprofessional practice and achieving best health outcomes for clients (Canadian Interprofessional Health Collaborative, 2010). HCPs must work together in partnership with an inter-disciplinary health team to deliver integrated health services and address the health care needs of populations. Moreover, HCPs must collaborate with the clients, families, and community to help them confront internalized sexism and patriarchal thinking and action that might impede women's health. Consciousness-raising about women's health, illness, and body without connecting them to sexist thinking would be essential for both women and men to help them "maintain a healthy respect for female body, female health, and female autonomy" (hooks, 2000, p. 79). Health care providers have an important role in not only promoting breast health, but also advocating and speaking about other women's health care issues that have been silent and perhaps unrecognized.

5.7 Role of Nursing as a Profession and Advanced Nursing Practice

The findings from this study indicate that nursing in Qatar has opportunities to grow as a credible health care profession. The role of nursing as a profession and advanced nursing practice are described.

5.7.1 Role of nursing as a profession

The majority of participants believed that nurses have the potential to promote women's access to BCS through formal knowledge and skills training. However, the

current status of nursing as profession and discipline in Qatar does not support this. This is exemplified in several ways. Currently, there is no credential as “registered nurse” in Qatar; all nurses are titled as staff nurse after two years of formal education. Although nursing has recently been designated as self-regulating profession, its full status as a profession remains limited, i.e., the GCC Code of Professional Conduct for Nursing (GCC Health Ministers’ Council Executive Board, 2001) described three primary values of accountability, dignity, and privacy and confidentiality. In comparison, the Canadian Code of Ethics (CNA, 2008b) documented seven core values as: (1) providing safe, compassionate, competent, and ethical care; (2) promoting health and well-being; (3) promoting and respecting informed decision-making; (4) preserving dignity; (5) maintaining privacy and confidentiality; (6) promoting justice; and (7) being accountable. To develop as a discipline, nursing must be recognized as having a specialized body of knowledge which is articulated through evidence-based practice. Finally, the context in Qatar presents further challenges through its existence within a socio-cultural milieu where nursing, a traditionally female occupation, is undervalued and confounded by a lack of trust and credibility in terms of expanding the scope of practice.

Nursing in Qatar has opportunities to grow as a credible health care profession. Nursing as a discipline must prepare competent, knowledgeable nurses and support their ongoing professional development. Moreover, it is important to prepare nurses as critical thinkers who are aware of social injustices, social power differentials, and how they are happening in everyday lives of nurses and clients. Nurses must advocate for nurses and nursing in the hierarchical health care system, make nursing’s voice heard in health care

decisions and in health care policies, advocate for a healthy work environment that supports values critical to nursing, invite gender equity in the profession, and collectively move to establish nursing as a trusted, valued, and knowledgeable profession within Qatari health care organizations. Finally, through ongoing involvement in research, nursing can make explicit the significance of the profession in providing “safe, compassionate, competent, and ethical care” for the public (CNA, 2008b), subsequently seek the attention of policy and decision makers who have the power to effect change at legislative, organizational, and community levels. Nursing leaders in the Middle East and Qatar must strive to establish nurses’ legitimate position in the health care field as recognized leaders and elevate the profile of nursing to knowledgeable and caring health care professionals.

5.7.2 Role of advanced nursing practice

Currently, there is no nursing credential of advanced practice nurse (APN) in Qatar. The lack of such role in the health care system, coupled with traditional beliefs about the nursing role as assistants to physicians, cultural context of viewing nursing as traditionally women’s work, and political tensions within the hierarchical health care system, implementation of the APN role in Qatar remains challenging. However, the master’s program in nursing has just been launched in the University of Calgary-Qatar in 2013. It is expected that master’s prepared nurses will make a difference for women in Qatar. Nurses prepared in advanced practice are well positioned to respond to the complex health issues in the women population because of their advanced knowledge and skills, clinical expertise, and leadership skills (CNA, 2008a). An APN’s coaching and

guidance, patient education, fostering self-care, health promotion efforts, leadership and innovation, and holistic, individualized, evidence-based care (CNA, 2008a; Hamric et al., 2009) can benefit women by helping them learn about women's health issues and how to manage them and adhere to treatment and health promotion. APN care not only benefits the individual by helping them obtain best health outcomes and quality of life, but also benefits health care by reducing illness complications, the number of emergency room visits, and re-hospitalizations through provision of timely, accessible, cost-effective, and high quality care (Brooten, Youngblut, Kutcher, & Bobo, 2004; Bryant-Lukosius, DiCenso, Browne & Pinelli, 2004). Furthermore, an APN's ability to analyze critically how organization, health policy, and decision-making play a role in client and system outcomes within the context of a changing health care environment can benefit policy by analyzing critically the current health policy and advocating for policies that promote equal access to care and appropriate interventions for everyone (CNA, 2008a; Hamric et al., 2009). Finally, the APN's ability to critique, utilize, evaluate, and participate in collaborative research can benefit nursing and human science research by building on the evidence-based knowledge that informs practice and theory (Brown, 1998).

5.8 Implications for Education

The findings of this study have important implications for education of nurses and physicians. Collaboration with education sectors is essential to improve breast health care.

5.8.1 For nurses

The findings of the study offer important implications for education of nurses. Firstly, nursing education will contribute to effective BCS in Qatar by developing curricula and preparing nurses with necessary knowledge and skills through theory and hands-on practice with actual clients. Secondly, in partnerships with the health care system, nursing education can provide an expanded scope of nursing practice and competency by adding educational supports for nurses and preparing knowledgeable, competent, and confident nurses. Thirdly, nursing education will assist nursing students and nurses to be aware of issues of accessibility and availability of health care services for women in Qatar so that they might advocate for health equity and social justice. Finally, nursing education will better inform students and nurses about the importance of cultural competency in health care so that provision of culturally acceptable health services is possible. Understanding the influences of cultural and religious beliefs and values on women's BCS practices would not only help nurses become more aware of women's cultural conceptualizations of illness and health practices, but also encourage women to become more observant about their health practices and participate in health care activities. Raising the awareness of nursing students to be more culturally sensitive with Arabic women in Qatar would be a valuable educational goal to deliver holistic and contextual care.

5.8.2 For physicians

The findings of this study also offer implications for medical education. The physicians' role in BCS cannot be underestimated. It would be important for physicians,

as gatekeepers, to recognize the importance of early detection in improving chances of survival and informing women about available options and choices. Efforts should be directed to emphasizing the physician's role in referring women to BCS, implementing a complete physical examination, and not forgetting to examine the breasts. Medical educators can contribute to effective BCS in Qatar by providing more motivation to physicians by incorporating CBE workshops and cross-cultural and -gender competency training into continuing medical education for physicians. Embarrassment to touch patients' breasts and concern about the response of the patient can be barriers for HCPs to perform CBE (Al-Amoudi et al., 2010). Training in cultural competency and in gender-informed, sensitive approaches to care would be especially important for physicians practicing in Islamic countries. HCPs' work is not limited to information giving; they have an important role to collaborate with women by exploring the client's beliefs, concerns, fears and myths associated with BCS, and formal and informal support systems to encourage them to take the action. It would be important to recognize that HCPs themselves might hinder early detection of breast cancer by not being aware of their role in encouraging, collaborating, and working with women and their families.

5.9 Implications for Research

An ecological perspective and Kleinman's (1978) explanatory model of health and illness laid the groundwork for analysis of contextualized BCS experience of Arabic women in Qatar. The findings of the study indicate that it is necessary to examine and analyze carefully various contextual factors that shape the ways in which Arabic women access existing BCS services. It is important to recognize that the human experience is

interwoven with history, traditions, customs, practices, and languages and can only be understood by interpretations of subjective narratives of the person or the group in the context (Carspecken, 1996). Further research is needed to examine and capture a more comprehensive picture of Arabic women's health and illness experiences and the meanings they attribute to them. This research generates more questions to explore and answer, such as: (1) what is the meaning of the experience of living with cultural gendered roles and responsibilities for Arabic women? and (2) what are the meanings of the body, health, and illness for Arabic women? How are they different from Western health care's reductionist approaches to the body? It is important for researchers to engage the women in research as co-researchers, make explicit their worldviews and the contexts, and illuminate seemingly trivial aspects of human experiences and their meanings through thoughtful interpretation in order to develop culturally sensitive health care policies and services that are appropriate, accessible, and affordable for the women. With critical analysis, curiosity, and an open mind to possibilities as yet unknown, nurse-conducted research can advance toward development of knowledge that has the potential to make significant contributions to the creation of facilitative environments and the promotion of human health.

5.10 Limitations of the Study

The findings of the study are not generalizable to other groups of Arabic women due to the purposive sampling method and nature of qualitative design. Although the preliminary analysis of the findings was validated with second interviews with seven of the 15 participants, self-report/narrative may pose another limitation to transferability of

the study findings. Research studies with a larger sample size and a more diverse population would enhance credibility and generalization of the study findings. Furthermore, even though my best effort was put forth to understand participants' narratives and confirm the understanding of the meanings, language and cultural differences between the researcher and the participants might have altered some of the interpretation of the data. Research studies with a bilingual researcher from Arabic culture, who can speak both English and Arabic, might have resulted in different interpretations of meanings. Moreover, the themes and subthemes discovered through this research are based upon subjective, value-laden interpretations by the participants and the researcher; therefore, the findings of the study are only one of many possible interpretations and realities of the human phenomenon of interest. It is important to recognize that some of the participants are not Muslim themselves and that their narratives may be based on personal assumptions, not facts. As such, it is important to acknowledge that some interpretations of the findings may reflect stereotypical generalization of Arabic women based on the personal experiences of participants. Finally, time constraints of the interviews and lack of data collection experience and skills on the part of the researcher could have affected interviews and the findings of the study. Replication of the study would be needed to further validate the findings and deepen the understanding of the research phenomenon. Nonetheless, the findings of the study shed considerable light on the complexity of the factors that influence Arabic women's breast cancer screening practices in Qatar and open up an opportunity for critical reflection, discussion, and further research.

5.11 Conclusion

Breast cancer is the most common cancer in Qatar with high incidence rates compared to other Middle East countries. Mortality rates as a result of breast cancer are also high in Qatar partly due to delayed diagnosis of the disease. As a result, there is a critical need for health care providers and health care system to increase strategic efforts in screening and early detection of breast cancer. Despite growing attention to the importance of BCS in Qatar, little is known about how the women view, understand, and participate in BCS and why they seldom participate in the screening practices. Previous studies have focused exclusively on individual factors. The less visible ecological influence of socioeconomic, cultural, religious, political, and historical factors was explored much less. Therefore, this study, using qualitative critical ethnography methodology and with worldviews of an ecological perspective and Kleinman's (1978) explanatory model of health and illness, explored and described the factors influencing BCS practices among Arabic women in Qatar by acquiring the perspective of HCPs.

Many of the study findings were encouraging; participants identified a number of facilitators for effective BCS in Qatar. From the participants' perspective, (a) some women were knowledgeable about breast cancer and aware of BCS; (b) availability of female HCPs at the well-women clinics was encouraging for women to participate in CBE and mammogram without shame, embarrassment, or guilt; (c) cost for mammograms was free for the nationals and subsidized by the government for all other residents; (d) some Islamic religious beliefs were encouraging women to take care of own health; and (e) some women were receiving supports from husband and other family

members. Furthermore, although it was not explicitly identified as a facilitator, (f) the well-women clinics specially designed for women's health promotion and illness prevention and (g) national BCS awareness campaigns such as a pink hijab day and annual national breast cancer awareness walk are considered as strengths in Qatar.

However, many deterring factors also were found. Women in Qatar could not easily access available BCS services because of (a) unfamiliarity and unawareness of BCS and its methods; (b) pain perception during mammograms and lack of perceived needs; (c) cultural beliefs about female bodies and breasts, polygamy, and cultural attitudes toward illness and sick women; (d) religious beliefs about female bodies, modesty, and illness; (e) power differentials between men and women and women's dependency on men within the classical patriarchal family structure; (f) female roles and responsibilities; (g) insufficient client-clinician time to discuss BCS other than immediate health concerns; (h) underdeveloped health care infrastructure for BCS; (i) cost for mammograms; and (j) lack of access to health services by public transportation.

Health inequities are often created unknowingly within the context of health care, positioning Arabic women in disadvantaged situations for health and illness, especially breast cancer that takes away well-being, health, and life of women. Health care policy-makers at the Ministry of Health and HCPs would need to consider these mediating factors in Arabic women's lives in Qatar. Through examination of the influences of culture, religion, tradition, gendered power relations, and social structure on health, factors that shape the way women access BCS services and its impacts on women's health can be understood and initiated for the best health outcome. Future interventions and

strategies that promote BCS in Qatar must capitalize on the facilitators and eliminate barriers as much as possible. Moreover, planning and implementing services and programs that are culturally sensitive and acceptable to women and their families would be essential to assist women to access health services without guilt, shame, or fear.

Participants' recommendations targeted multiple sectors – the health care system, the education system, health care professionals, and women themselves.

Recommendations posed to the health care and education systems include: increasing public health education efforts, making mammogram and CBE a national protocol, developing electronic health records system for effective referral/follow-up, supporting HCPs' continuing competency, expanding nursing roles to include BCS education and CBE, educating and preparing nurses with necessary knowledge and skills pertaining to their new roles, encouraging collaboration between HCPs, and expanding and investing in health promotion services. Furthermore, recommendations given to HCPs and women include: collaborating with other HCPs as a team, being empathetic and non-judgmental toward women, collaborating with women and their families, and encouraging women to encourage each other about BCS. These recommendations offer direction for addressing women's breast health both in practice and broader social and health care context.

The present study offered several implications for health care, practice, education, and research. At the health care system level, health authorities and policy-makers have opportunities to create a comprehensive health care environment that focuses on total context of health care, enable populations to take the ownership of their health, and make equitable and inclusive health care environment that is women and family friendly and

respect women's bodies and health. HCPs therefore have a tremendous responsibility to listen to women's concerns and needs, honor their understanding of illness and choices, and provide ethical, relational health care, one that promotes mutual health decision-making. Nurses have the opportunity to grow as trusted, knowledgeable professionals by establishing nursing as a legitimate profession in health care and expanding nursing roles, capacities, and leadership through ongoing research and political participation. Furthermore, nursing education can contribute to better health status of women in Qatar by preparing nurses who have knowledge and skills to provide culturally sensitive care. Further research on Arabic women's and HCP's experiences with BCS that focuses equally on the context rather than just women's individual characteristics, would benefit nursing, public health, and human science research by generating evidence-based knowledge that can inform practice and theory development.

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Appendices A: Agency project information letter

Dear:

Re: Factors Influence Breast Cancer Screening Practices Amongst Arabic Women Living in the State of Qatar

Research team:

Dr. Donnelly, Tam Truong (Lead Principal Investigator). Associate Professor. University of Calgary-Qatar.

Dr. Al-Hareth Al-Khater, Assistant Chairman, Department of Hematology and Oncology, Al Amal Hospital, Chairman of Medical Research Centre, Hamad Medical Corporation.

Dr. Mohamed Ghaith Al-Kuwari, Consultant in Public Health Medicine & Health Promotion, Director of National Health Programs – Primary care.

Dr. Nabila Al-Meer, Executive Director of Nursing, Hamad Medical Corporation.

Dr. Salha Bojusoom, Consultant Oncologist, Al Amal Hospital.

Dr. Mariam A Malik, Director Primary Health Care Department.

Dr. Rajvir Singh, Senior Consultant Biostatistician. Hamad Medical Corporation.

We are writing to ask for your assistance and support in the above project. We are a group of researchers at the University of Calgary-Qatar, Hamad Medical Corporation, and Primary Care. We are conducting a study in Qatar to learn about Arabic women's breast cancer screening practices. Because Arabic women are often diagnosed at advanced stages of breast cancer, they are at significant risk due to the lack of early diagnosis and treatment for this disease. Early detection and treatment can reduce breast cancer morbidity and mortality significantly. The main **purpose** of this study is to identify promotional strategies that may increase Arabic women's participation in breast cancer screening programs, thus decrease their risk of having this cancer as life threatening disease. The study **objectives** are: (1) to obtain information about the participation rate of breast cancer screening among Arabic women, and barriers and facilitators to their participation in this cancer screening activities, (2) to determine whether the decision to engage in breast and cervical cancer screenings is affected by the women's cultural knowledge and values, how they view their roles within social and health care contexts, their socioeconomic status, social support networks, and their perception about accessibility of available breast cancer screening services, and (3) to identify culturally and socially appropriate intervention strategies that will increase Arabic women's participation in and accessibility of breast cancer screening programs.

In this study, we will be recruiting 753 Arabic women age 35 and over who live in Doha, Al Wakrah, and Al Khor, Qatar as participants. Our main method of data collection will be individual interviews. Each woman will be interviewed for approximately 30 to 40 minutes. Interviews will be conducted in Arabic by female interviewers fluent in both Arabic and English. Because women's participation in breast cancer screening is very much influenced by how health care professionals and men think about breast examinations, therefore, we will also conduct in-depth individual interviews with Arabic women, Arabic men, and health care professionals. Arabic men will be interviewed in Arabic by a male interviewer.

With the woman's permission, the interviewer will ask the woman about whether or not they had ever heard of breast cancer and this cancer screening, whether or not they had received breast examinations, what they view as barriers preventing them from having cancer screening, and what would help to increase the likelihood of their participation in breast and cervical cancer screening programs, which include mammogram, clinical breast examination, and breast self-examination. In addition, interviewing questions will also inquire into the women's attitudes and beliefs towards breast cancer and its examination. Socio-demographic data will also be obtained to get a profile of the women. Similar questions will also be asked of the men and the health care professional participants.

The result of this study will help to raise Arabic women's awareness of breast cancer and its screening. The study's results will help health care professionals and health care policy makers to gain insight on how Arabic women utilize cancer screening services. We anticipate that the data will provide information about promotional strategies that may increase Arabic women's participation in breast cancer screening programs. This information will also contribute to the Screening Mammography Program planning and recruitment efforts. The findings will be made available to women in Arabic with the aim of increasing their awareness and practice of breast cancer screening.

Finally, we wish to emphasize that all participation in the study is voluntary and participants are free to withdraw at any time without prejudice. To maintain the participants' confidentiality and anonymity, the name of the locations and the participants will be changed in all of the data and report for this project, and any information identifying the participant personally will be removed from the questionnaires. Data that identify individuals will not be made available to anyone. Although the data of this project will be retained until the completion of the study, at the conclusion of the study, all identifying information will be destroyed. Interview questionnaires stripped of identifying information will be retained for educational and other research purposes, subject to ethics approval according to standard procedure. If the participants have any concerns about their rights or treatment as a research participant, they may contact

Chairman of the Hamad Medical Research Center at 974-439-2440/439-6166 or
Associate Director, Internal Awards, Research Services, University of Calgary, at (403)
220-3782.

If you have questions about the project, please feel free to contact Dr. Tam Donnelly at
_____ or our research co-coordinator: _____ at _____
Thank you for taking your time to read this letter and for your support.

Sincerely,
Tam Truong Donnelly, Ph.D.
Associate Professor.
University of Calgary-Qatar
tdonnell@ucalgary.ca
Al Rayyan Campus, Al Forousiya Road
P.O. BOX 23133, Doha, Qatar
Tel: _____
M: _____
Fax: _____

Appendices B: Consent form



WAIVER OF SIGNED INFORMED CONSENT/VERBAL/ORAL CONSENT FORM

HGH WH RH AAH
 AKH OTHERS

HC NO:
PATIENT NAME:|
DOB:
GENDER:
NATIONALITY:

تحويل موافقة خطية / لفظية / شفوية

م. حمد العام م. النساء م. الرميثة م. الأمل
 م. الخور م. أخرى

رقم المسجل:
إسم المريض:
تاريخ الميلاد:
النوع (ذكر | أنثى) :
الجنسية:

Information to Participants

1. You are free to ask as many questions as you like before, during or after this research, should you decide to consent to participate in this research study.
2. The information in this form is only meant to better inform you of all possible risks or benefits. Your participation in this study is entirely voluntary.
3. You are entitled to participate in this study if you satisfy certain eligibility criteria
4. You do not have to take part in this study, and your refusal to participate will involve no penalty or loss of rights to which you are entitled.
5. You may decide not to participate in this study at any time without penalty or any loss of rights or other benefits to which you are otherwise entitled.

- (1) لك مطلق الحرية في طرح أي سؤال أو إستفسار عن هذا البحث وذلك قبل , أثناء أو بعد إكمال إجراء البحث الذي قررت موافقة المشاركة فيه.
- (2) الهدف الرئيسي من المعلومات الواردة في هذا النموذج هو أن تقدم للمشاركة التشرح الوافي والمستفيض عن كل الأخطار والفوائد التي يمكن أن تتمخض عن إجراء هذا البحث. المشاركة في هذا البحث عمل طوعي.
- (3) لك حق المشاركة في البحث المطروح وذلك بعد إستيفاء الشروط المطلوبة.
- (4) لك الحق الكامل في إتخاذ قرار عدم المشاركة بالبحث. قرارك بعدم المشاركة في هذا البحث العلمي لا يترتب عليه أي تبعات أو حرمان من حقوقك المستحقة.
- (5) لك مطلق الحرية في إتخاذ قرار عدم المشاركة بالبحث وذلك في أي وقت من غير تبعات أو حرمان من حقوقك المستحقة.

Research Project #: NPRP 09 - 261 - 3 - 059

رقم المشروع: NPRP 09 - 261 - 3 - 059

Project Title : Factors Influencing Breast Cancer Screening Practices Amongst Arabic Women Living in the State of Qatar

عنوان المشروع : العوامل المؤثرة في ممارسة الفحص الدوري لسرطان الثدي بين النساء العربيات في قطر

➤ Name of Principal Investigator: Dr. Tam Truong Donnelly

اسم الباحث الرئيسي: د. تام ترونغ دونيلي

➤ Name of the Co-Principal Investigators:

مساعد الباحث الرئيسي:

Dr. Al-Hareth Al-Khater
Dr. Mohamed Ghaith Al-Kuwari
Dr. Nabila Al-Meer
Dr. Salha Bojusoom
Dr. Mariam Malik
Dr. Rajvir Singh

د. الحارث الخاطر
د. محمد غيث الكواري
د. نبيلة المير
د. صالحه بوجسوم
د. مريم مالك
د. سنغ

Contact address and phone number: [Provide appropriate information for contact during daytime, after working hours and during weekends]

موقع إجراء البحث وأرقام الهواتف (أثناء أوقات الدوام , بعد الدوام وفي العطلات):

University of Calgary-Qatar
Al Rayyan Campus, Al Forousiya Road
P.O. BOX 23133, Doha, Qatar
Tel:
Fax:
Email: tdonnell@ucalgary.ca.

جامعة كالجارى - قطر
الحرم الجامعي في الريان شارع الفروسية
صندوق البريد: ٢٣١٣٣
تليفون:
فاكس:
البريد الإلكتروني: tdonnell@ucalgary.ca.

Each item given below has to be filled in. Please write NA, if not applicable. This form may be read to the participant or the participant's legally authorized representative by the principal investigator or his/her representative.

يجب ملئ كل البنود أدناه وفي حال عدم توفر الإجابة الرجاء كتابة غير متوفر. يمكن للباحث الرئيسي أو احد مساعديه في إجراء الدراسة قراءة هذا النموذج للمشارك بالبحث أو الوصي الشرعي للمشارك بالبحث.

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1. Introduction: [Give details that the study involves research, who the investigators will be, where it would be conducted, the number of sessions it will be conducted in, the duration of the research and the expected time of completion of the research, approximate number of participants, the costs of participation and why the person has been selected for inclusion in the study]

We are a group of researchers at the University of Calgary-Qatar, Hamad Medical Corporation, and Primary Care. We are conducting a study in Qatar to learn about how best to promote Qatari women's health and breast cancer detection. In Qatar, breast cancer is the most frequent cancer diagnosed among women. Al Amal Hospital reported that 20% cancer cases receiving treatment in 2007 were breast cancer among women. Early detection and treatment can reduce breast cancer morbidity and mortality rate significantly. However, Arabic women are at significant risk due to the lack of early diagnosis and treatment for this disease because they are often diagnosed at advanced stages of breast cancer. Thus, it is of urgent need to develop culturally appropriate and effective health promotion and services that will increase breast cancer awareness and women's participation in breast cancer screening practices, thus reducing this disease's morbidity and mortality rates.

With the support of staff at the health care and community clinics and facilities, this study will be conducted in Doha, Al Wakrah and Al Khor, Qatar. We will invite Arabic women who are 35 years and over as research participants. We will also invite Arabic men and health care providers as research participants. We anticipate the total time required to conduct this project will be 36 months.

2. Purpose of the research study: [Give a brief description of the purpose, goals, aims/ objectives of the study]

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(1) مقدمة عن البحث الطبي (صف وصفا موجزا للدراسة مع تحديد مكان إجراء الدراسة، الوقت المطلوب من المشاركين تخصيصه لمشاركته والمدة الزمنية المتوقعة لإتمام الدراسة، ومن يقوم بإجراء البحث. أعطى بالنتقريب العدد المتوقع للمشاركين بالدراسة والتكلفة الفعلية للمشاركة. اشرح للمشارك الأسباب والدوافع التي تم بموجبها اختياره للمشاركة بالدراسة.)

نحن مجموعة من الباحثين من جامعة كالغاري- قطر ومؤسسة حمد الطبية والرعاية الأولية. نقوم بإجراء دراسة في دولة قطر للإرتقاء بصحة المرأة القطرية وتقليل نسبة الإصابة بسرطان الثدي في قطر. يُعد سرطان الثدي هو أكثر أنواع السرطانات إنتشاراً بين النساء. يُذكر ان 20% من حالات السرطان ممن تلقين العلاج بمستشفى الأمل سنة 2007 كُن من النساء المصابات بسرطان الثدي. الكتف والعلاج الميكر يظل من نسبة الإصابة والوفيات بشكل واضح. غير إن النساء مُعرضات لخطر الإصابة بسبب عدم التشخيص والعلاج الميكر عن هذا المرض أو تشخيصها في مراحل متقدمة من سرطان الثدي. وبالتالي، لذا باتت الحاجتضرورية لإستحداث وتطوير حملات توعوية وخدمات صحية فعالة ملائمة ثقافياً والتي من شأنها زيادة التوعية حول سرطان الثدي وخضوع المرأة لفحوصات الكتف عن سرطان الثدي، وبالتالي تقليل معدلات الإصابة والوفيات من هذا المرض.

بدعم من العاملين في الرعاية الصحية والعيادات ومرافق المجتمع، سيتم إجراء هذه الدراسة في مناطق الدوحة، الخور، والوكرة- قطر. وسوف ندعوا النساء العربيات اللاتي أعمارهن 35 وما فوق للمشاركة في البحث. وسوف ندعوا الرجال العرب أيضاً ومقدمي الرعاية الصحية للمشاركة في البحث. وقد تم تقدير الوقت الإزم لتنفيذ هذا البحث بحوالي 36 شهراً.

(2) الغرض من إجراء الدراسة البحثية (قدم وصفا موجزا عن الغرض من إجراء هذه الدراسة.)

To assist health care providers in identifying effective health care strategies that promote women's health, increase awareness of breast cancer and breast cancer early detection, we would like to understand why some women engage in breast cancer screening activities while others do not. We will ask you questions about what you know about breast cancer and breast cancer screening, what problems you think women would experience and what help you think women would need to engage in regular breast cancer screening activities such as breast self examination, clinical breast examination, and mammogram. Answers to these questions will help us understand and plan for culturally appropriate and effective intervention strategies to promote awareness of breast cancer and early detection of this disease.

لمساعدة مقدمي الرعاية الصحية في تحديد استراتيجيات الرعاية الصحية الفعالة التي تعزز صحة المرأة ، زيادة وعي المرأة عن سرطان الثدي وإجراءات الفحص المبكر ، كما نود أن نعرف أسباب ممارسة أو عدم ممارسة بعض النساء للكشف المبكر لسرطان الثدي. سوف نطلب منك الإجابة عن بعض الأسئلة حول ما تعرفه عن سرطان الثدي وفحوصات الكشف عن، في اعتقادك ما هي المشاكل التي تواجه المرأة وما الذي تحتاجه النساء للخضوع لفحوصات الكشف عن سرطان الثدي مثل الفحص الذاتي للثدي، الفحص السريري للثدي، وأثناء الثدي. إن الإجابة عن هذه الأسئلة سوف تساعدنا على فهم العوامل وتخطيط استراتيجيات للتدخل الفعال والمناسب ثقافياً لتعزيز الوعي الصحي بسرطان الثدي ومزايا الكشف المبكر عن هذا المرض.

3. Description of the procedures that will be followed during the research: [Give a brief description of the procedures involved. Explain how the research data will be handled. Include any alternative procedures or courses of treatment than the ones proposed by the study]

(3) شرح الإجراءات التي يتعين استخدامها في الدراسة (أشرح **بإيجاز الإجراءات المطلوبة والمتعلقة بالدراسة. قدم شرح وجيز عن كيفية التعامل مع المعلومات المتحصل عليها. وصف كافة الإجراءات البديلة أو خيارات العلاج المتاحة و غير المطروحة في الدراسة البحثية والمحتملة للمشاركة بحيث تتوفر حرية اختيار المشارك لإسلوب العلاج البديل.**

To find answers to those questions, we would like to interview you. The interview will be done at the health clinic location by a female interviewer (or a male interviewer if you are a male). It will be done in Arabic or English and should last about 1 to 1 ½ hours. With your permission, the interview will be audio-taped and then transcribed after which the tapes will be destroyed when the study is done.

للوصول إلى الهدف من البحث وللحصول على إجابات للأسئلة المطروحة، فإننا نود أن تجري مقابلة شخصية معك. سوف تجري هذه المقابلة في العيادة الصحية عن طريق باحث أو باحثة. وستكون المقابلة باللغة العربية أو بالإنجليزية وستستمر من ساعة إلى ساعة ونصف. وعند موافقتك، سنكون المقابلة مسجلة صوتياً ومن ثم ترجمتها وبعد ذلك سيتم تدمير الأشرطة عند إتمام هذه الدراسة.

To understand more about your situation, we would like to collect information about you, such as your age, marital status, financial

لفهم المزيد حول الوضع الخاص بك، نود أن نجمع معلومات خاصة عنك، مثل: سنك، الوضع العائلي، والدعم المالي... الخ. كما أننا مهتمون لمعرفة طرق اتصالك بالآخرين والدعم الاجتماعي لك، لمعرفة وفهم علاقتك مع الآخرين، مما يساعدنا

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support, etc. We are also interested in your social support network so we would understand your relationship with other people and more about factors influence women's health care.

4. Description of any foreseeable risks or discomforts to the participants: *[Describe risks and discomforts to participants. Include risks of the procedures, and any physiological, psychological or social discomforts that the participants might face because of their involvement in the study and where they might get information on these aspects]*

This study's ethics approval has been obtained from the Hamad Medical Research Centre and the University of Calgary's Conjoint Health Research Ethics Board. There should not be any risk to you because your participation in the study will be completely voluntary and kept confidential by the researchers. All the information you provide will be kept private and strictly confidential. Your real name will not be revealed nor will it be used in any reports that arise from the research. There should be no physical risks to you. You might find it emotionally upsetting to tell your story. If so, we will stop our conversation and we can refer you to counseling and/or supportive services if you think that would be helpful.

5. Description of any benefits to the participant or to others which might be reasonably expected from the research:

[Give a description in brief of the expected benefits – direct or indirect from the research in straightforward statements, without introducing elements of bias or coercion into them]

Some people feel better when they are able to talk about their experiences. Findings of this study will help to raise awareness about breast cancer and breast cancer screening. The results of this study will enable planning of health care services to better serve and meet the health care needs of Arab women

على معرفة المزيد حول العوامل التي تؤثر في صحة المرأة.

(4) وصف المخاطر والإزعاج الذي قد يتعرض لهما المشارك:
(وصف مخاطر الإجراءات المتخذة و أي إزعاج فيزيولوجي، نفسي أو اجتماعي قد يتعرض له المشارك بسبب مشاركته في الدراسة و أين يمكنه الحصول على المعلومات في هذا الجانب).

لقد تمت الموافقة على أخلاقيات هذه الدراسة من مركز البحوث بمؤسسة حمد الطبية وجامعة كالغاري بالإشتراك مع مجلس أخلاقيات البحث الطبي. لا توجد أي خطورة عليك بما يخص هذه الدراسة لأنها ستكون طوعية تماماً وستحفظ سريتها من قبل الباحثين. كل المعلومات التي تقدمها ستكون سرية وفي طي الكتمان.
لن يتم الكشف عن اسمك الحقيقي عند استخدام أي تقارير تبعد البحث. كما لا توجد أي مخاطر بدنية عليك. إذا شعرت بالإزعاج العاطفي خلال سردك لقصتك، فإننا سنوقف المحادثة معك، كما يمكننا تحويلك إلى الخدمات الإستشارية أو أي خدمات داعمة، إذا كنت تعتقد أن ذلك سيعود بالنفع والفائدة عليك.

(5) شرح الفوائد المتوقعة من البحث لصالح المشارك بالدراسة أو لغير المشاركين *(وصف بايجاز وبدون تحيز للفوائد المتوقعة المباشرة أو غير المباشرة والمترتبة للمشارك بهذه الدراسة).*

يشعر بعض الناس بالتحسن عندما يكون بمقدرتهم التحدث عن تجاربهم. سوف تساعد نتائج هذه الدراسة على رفع مستوى وعي المرأة القطرية عن سرطان الثدي وفحوصات سرطان الثدي. كما أن نتائج هذه الدراسة ستمكنا من التخطيط لخدمات الرعاية الصحية، وذلك لتقديم خدمة أفضل ولتلبية احتياجات الرعاية الصحية عند النساء في قطر. إن معرفتك أن الخرض الأساسي من هذا البحث هو المساعدة في الحد من خطورة سرطان الثدي والحد من نسبة الوفيات في النساء العربيات عن طريق الحصول

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living in Qatar. Also, knowing that the purpose of the research is to help reduce the seriousness of breast cancer and to decrease the mortality of this disease for Arab women might make you feel better supported. The findings will be made available to people in Qatar with the aim of increasing their awareness and early detection of breast cancer.

6. Confidentiality : [Give a description of the steps that would be taken to ensure confidentiality of the records ,laboratory specimens, or results which might identify the participant will be maintained]

You will be identified by a pseudonym in the audiotapes and transcriptions. A research assistant will transcribe the tapes privately. Once transcribed, the transcriptions and the audiotapes will be stored in a locked drawer in a locked office and only the researchers will have access to them. All information will be confidential, and will be kept in a locked cabinet and password protected computers. Five years after the conclusion of the study, all identifying information and audiotapes will be destroyed, according to the ethic approval procedure.

I, _____ have fully explained to Mr. / Mrs. _____ the nature and purposes of the above describe research project.

I believe that he/ she understands the nature, purpose and risks of the study.

I have also offered to answer any questions relating to this study that he/she might have and I declare hereby that I have completely and fully answered all such queries.

Signature of the person obtaining the consent:

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على دعم أفضل. وسيتم الإعلان عن النتائج للعامة في قطر وذلك بهدف زيادة وعيهم وزيادة فحوصات الكشف المبكر عن سرطان الثدي.

(6) السرية: (صف خطوات حماية سرية البيانات، العينة المختبرية أو أي نتائج أخرى من شأنها الكشف عن هوية أو اسم أي مشارك بالدراسة)

سوف يتم تعريفكم تحت باسم مستعار في أشرطة التسجيل والملاحظات. حيث أن مساعد الباحث سوف يدون الأشرطة بسرية ، والتي سيتم نسخها مرة واحدة. هذه الأشرطة الصوتية سيتم تخزينها في درج مغلق في مكتب مغلقة، ويسمح للباحثين فقط الوصول إليها. جميع المعلومات ستكون سرية، وسيتم الاحتفاظ بها في خزانة مغلقة وأجهزة الكمبيوتر مؤمنة بكلمة مرور سرية. وسوف تدمر جميع المعلومات والشرائط الصوتية بعد خمس سنوات من الانتهاء من الدراسة، وفقاً لإجراءات أخلاقيات الموافقة.

أقر أنا _____ بالشرح الوافي والمستفيض للسيد/السيدة _____ وذلك عن طبيعة ودوافع دراسة البحث المنتظرة.

وبحسب الشرح الوافي والمستفيض، أعتقد أن السيد/السيدة قد فهم طبيعة ودوافع البحث وكذلك ما يمكن أن ينجم من اخطار نتيجة مشاركتهم بالبحث.

كما أقر بأنني قد قدمت بطرح إستعدادي للإجابة عن كل الاسئلة والاستفسارات الخاصة بالدراسة والبحث. وبموجب ذلك اكون قد إستوفيت الشرح الكامل للبحث المنتظر واجبت عن كل ما يمكن أن يطرح من سؤال أو إستفسار.

توقيع الشخص طالب الموافقة

Name of the person obtaining the consent:

إسم الشخص طالب الموافقة:

Date:

تاريخه:

Note : Waiver of signed informed consent or informed consent is given to prospective studies in the situations given below:

1. That the only record linking the participant and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. (When the Research Committee waives the requirement for documentation of consent under this condition, each participant must be asked whether he/she wants documentation linking him/her with the research, and the participant's wishes will govern.)

2. That the research presents no more than minimal risk or harm to the participants and involves no procedures for which written consent is normally required outside of the research context.

ملاحظة : تخويل موافقة خطية / لفظية / شفوية وذلك بغرض إجراء دراسة بحث طبي أو الموافقة الخطية للابحاث السريرية في مؤسسة حمد الطبية , لا تعطى إلا للدراسات المستقبلية في الحالات الواردة أدناه :

1. ان تكون هذه الموافقة هي حلقة الوصل بين المشارك و البحث و ان الخطر الرئيسي سيكون الأذى نتيجة خرق الخصوصية. (عندما تحول لجنة الابحاث الى طلب لهذا المستند. في هذه الحالة يتم سؤال المشارك ان كان يرغب في مستند يصل بينه و بين البحث و رغبة المشارك لها الأهمية.)

2. ان يقدم البحث أقل مخاطر أو أذى للمشارك و ان لا يحتوي على إجراءات تتطلب الموافقة خارج إطار البحث ذاته.

It could be used in situations such as the ones given below:

1. For researches which involve drawing of additional blood samples when blood is already being obtained for clinical purposes or during blood donations
2. For researches which involve sampling of additional bodily secretions when such secretions are already being sampled for clinical purposes
3. For researches that involve no more than minimal risk of harm to the participant and the research does not involve any intervention/procedure/invasion of privacy of the

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كما يمكن استخدام هذه الموافقة لإحدى الحالات التالية:

- * للابحاث التي تتضمن سحب عينات إضافية اخرى غير التي سحبت للأسباب السريرية , أو عند التبرع بالدم .
- * للابحاث التي تتضمن أخذ عينات إضافية من جسم المريض كإفرازات غير التي سحبت للأسباب السريرية .
- * للابحاث التي يكون الأضرار والأذى المنسب من هذا البحث طفيفه , على ان لا يكون للبحث صلة بالإجراءات المطلوبة الأخرى.
- * للابحاث النوعية الاستبيانات و المقابلات.

participant

4. For qualitative researches like surveys using questionnaires or interviews with participants.



Digitally signed by لجنة الأبحاث الطبية

DN: cn=لجنة الأبحاث الطبية, o=مؤسسة حمد

, ou=مركز الأبحاث الطبية, الطبية

, email=research@hmc.org.qa,

c=US

Date: 2011.10.10 07:56:21 +03'00'

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Appendices C: Initial interview questionnaire for health care providers

Introduction

Thank you for taking the time from your busy schedule to speak with me today. As you know, we are very interested in hearing about your experience with providing breast health and breast cancer care to Arabic women. Our goals are to find ways to help to reduce breast cancer morbidity and mortality among Arabic women. We will be asking for your opinion about breast cancer screening among Arabic women, what you think as the best way to support and promote breast cancer screening among women and men in Qatar. I want to assure you that all the information will be confidential. If there is a question which you don't want to answer, all you have to do is to say "I don't want to answer that question". You have the right not to answer any question which you don't want to answer.

First, I would like to start with some personal questions regarding your work with clients in Qatar.

Personal, demographic questions:

Country of Origin, Age, Gender, Ethnicity, Religion, Employment Title & Status, and Years of Clinical Experience in Breast Health

Some individual questions:

- How long have you been providing health care to women and men in Qatar?
- How many years have you been providing health care?
- In what capacity do you work with your clients?
- Did you work with Arabic women and men prior to this experience?

Next, I would like to find out about your experience and what you think as the best possible strategies to assist women and to promote breast cancer screening in Qatar.

Probing questions:

Please tell me about your practice experience with Qatari women for their breast cancer screening and breast health needs.

- 1) What is your experience in working with Arab women?
- 2) Regarding mammogram and breast examination, are there certain women whom you would referred/recommended or examined, and why?
- 3) Whom you would not referred or recommended and why?
- 4) What kind of problems do you encounter?
- 5) What do you identify as their issues and concerns?

- 6) Do you have any ideas why some Arabic women go for breast examination and mammogram while others do not?
- 7) What else do you think influences the ways in which Arabic women practice health care, in particular breast cancer screening?
- 8) What are the strengths of Qatari women that can contribute toward improving their breast health care access and cancer screening?
- 9) What do you think would be the most culturally and socially appropriate and effective health promotion strategies to increase Arabic women's participation in breast cancer screening? What recommendations would you give to the women or to the health care system or to policy to increase participation in breast cancer screening?
- 10) What else would you like to tell me? Is there anything important that I did not ask?

Lead ins:

I am wondering about....

I am curious about....

Could you help me understand....

In what ways might....

What else could make a difference....

Do you believe it would make a difference if....

How would it make a difference if....

This may seem like a really strange/unusual/unexpected question, but I was wondering if....

If you could change one thing....

Other people have told me that..., and I was wondering if....

I'd appreciate hearing from you about....

If your clients were here with us, what do you think they would say about....

Appendices D: Coding analysis of themes and sub-themes

Name	Sources	References	C	C	M	M
Background Description	0	0	J	1	J	
Available Services	0	0	J	0	J	
Hamad (Mammogram)	6	11	J	1	J	
Hamad (Women's Hospital)	3	6	J	0	J	
Well Women Clinic (WWC)	12	50	J	1	J	
HCP's Work with Women	0	0	J	1	J	
Doctors' Work - Examination and Referral	14	46	J	1	J	
Nurses' Work - Assistance n Health Education	13	54	J	1	J	
Social Worker's Work - Health Education	3	7	J	1	J	
When do HCP makes a Referral	14	26	J	1	J	
Barriers for HCPs	0	0	J	0	J	
Inter-Personal Barriers	0	0	J	1	J	
Clients who Hurry to Finish	9	9	J	1	J	
Cultural Barrier (Female HCPs)	4	7	J	1	J	
for Male Doctors	6	28	J	1	J	
Language Barrier	11	18	J	1	J	
Systemic Barriers	0	0	J	1	J	
Poor Pt Clinical Records n Lack of FollowUp System	11	18	J	1	J	
Staff Rotation System (No Specialization)	7	8	J	1	J	
Time n Heavy Workload (No apmt system n shortage of HCPs)	16	36	J	1	J	
Barriers for Women	0	0	J	0	J	
Environmental Barriers	0	0	J	1	J	
(Systemic Barrier) Cost for Mammogram	9	12	J	1	J	
Cultural Beliefs n Practices	16	37	J	1	J	
Gender Power Relations leading to Dependency & Low Status	14	22	J	1	J	
Lack of Social Support from Family n Friends (especially Spousal)	8	13	J	1	J	
Religion (Negative Influences)	13	17	J	1	J	
Transportation	14	21	J	1	J	
Personal Barriers	0	0	J	1	J	
Fear of Unknown, Abandonment, Stigma, n Death,	16	36	J	1	J	
Lack of Awareness, Knowledge, n Information	20	54	J	1	J	
Language Barrier	2	3	J	1	J	
Pain n Physical Discomfort	7	10	J	1	J	
Shame and Embarrassment	7	15	J	1	J	
Time (due to Family Responsibilities and Work)	21	53	J	1	J	
Facilitators for Women	0	0	J	1	J	
Awareness n Knowledge about BRCA	17	36	J	1	J	
Female Doctors n Nurses	14	15	J	1	J	
Government Covers the Cost	11	13	J	1	J	
Religion (Positive Influences)	13	16	J	1	J	
Social Support (especially Spousal)	15	21	J	1	J	

Name	Sources	References	C	C	M	M
Recommendations	0	0	I	J	0	J
Recommendations to Education System	3	6	I	J	1	J
Recommendations to HC System	1	1	I	J	0	J
For Infra-Structure	0	0		J	1	J
Develop Computerized Documentation and Referral and FollowUp Systems	9	16	I	J	1	J
Expand and Invest in Health Promotion Services	9	24	I	J	1	J
Expand Nursing Roles to CBE and Pt Education	16	41	I	J	1	J
For the HCPs (Support via Training, Workshop, More time, etc)	14	25	I	J	1	J
Make Mammogram and CBE a Protocol	11	17	I	J	1	J
Public Education	21	86	I	J	1	J
Educate Both Men and Women	7	10	I	J	1	J
Educate Younger Generations	10	18	I	J	1	J
Recommendations to Other HCPs	0	0	I	J	0	J
Collaborate with Clients	10	16	I	J	1	J
Collaborate with other HCPs as a Team	14	35	I	J	1	J
Encourage Women for BRCA Screening	13	21	I	J	1	J
Keep Competency n Professionalism	3	7	I	J	1	J
Recommendations to Women	0	0	I	J	0	J
Encourage Friends and Family	3	6	I	J	0	J
Screening can Save Ur Life	8	9	I	J	1	J
Screening is a Routine Examination	5	5	I	J	1	J