

**Knowledge, Beliefs, Attitudes and Perceptions About Breast and
Cervical Cancer and Screening Among Arabic Speaking
Immigrant Women in Halifax, Nova Scotia.**

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Abstract

Women of all races and ethnicities are at risk for breast cancer and cervical cancer. These types of cancer have remained major public health issues across the world. Although effective strategies for preventing breast and cervical cancer have yet to be developed, following early detection practices can reduce the impact of the disease and allow for a greater range of treatment options (American Cancer Society, 2005).

Informed by Black feminism and critical social theory relevant to Adult education this qualitative study was conducted to explore the knowledge, beliefs, attitudes and perceptions Arabic speaking immigrant women in Halifax, Nova Scotia towards breast and cervical cancer among. The data were collected in two phases. The first phase consisted of a survey in which 100 Arabic speaking women who are all married and are 21 years and older participated. In phase two semi-structured interviews were conducted with five of Arabic speaking women who were from a range of backgrounds and age groups.

The study's findings reveal that there is a lack of knowledge about breast and cervical cancer and screening for these cancers among Arabic speaking women. Results indicated that the health care system in itself presents a number of challenges for Arabic speaking women to obtain screening. Different factors influence Arabic women's decisions about going or not going for screening and thus related to the delay in seeking help for breast and cervical screening. These factors are related to cultural or other factors such as lack of knowledge, fear, and social influence as well as language. Strategies to reach Arabic speaking women include a variety of recommended methods such as through educational sessions at clinics and/or in community sites. This study will be helpful in planning and delivering screening services to women in the Arabic community in Halifax and elsewhere.

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Dedication

To my parents... your love and appreciation for education has always motivated and inspired me.

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Definition of Terms

&

Acronyms

The following definitions pertain to terms used in this study. The definitions are according to the National Cancer Institute dictionary of Cancer Terms n.d.:

Breast Self-Exam (BSE):

BSE is an exam performed by a woman of her breast to check for lumps or other changes.

Breast Clinical Exam (BCE):

BCE is an exam of breast performed by a health care provider to check for lumps or other changes.

Mammogram:

A mammogram is an X-ray of the breast.

Mammography:

The use of X-rays to create pictures of the breast.

Papanicolaou test (Pap test):

A procedure in which cells are scraped from the cervix for examination under a microscope. The cervix is the opening to the uterus. It is used to detect cancer and changes that may lead to cancer. A Pap test can also show non-cancerous conditions, such as infection or inflammation.

BC: Breast Cancer

CV: Cervical Cancer

Chapter One

Introduction

My thesis in Adult Education focuses on the knowledge, beliefs, attitudes and perceptions of Arabic speaking immigrant women in Halifax with regard to breast and cervical cancer screening practices. According to Spencer (1998), “adult education, as a social activity, takes place within specific social, political and economic relations and links with community development” (p. 16.) This is very true in my study, as I, a member of the Arabic community, try to develop my community’s knowledge, beliefs, attitudes and perceptions about breast and cervical cancer. “Adult education can be viewed as the process by which men and women (alone, in groups or in institutional settings) undertake systematic and sustained learning activities to improve themselves or their society by increasing and improving their knowledge, skills, attitudes, abilities and sensitivities”(Sloane-Seale, 2001, p.117). The ultimate goal of this investigation is to increase the awareness of Arabic speaking immigrant women about breast and cervical cancer through formal and informal education programs.

With that goal in mind, I conducted a qualitative study to explore the knowledge, beliefs, attitudes and perceptions of Arabic speaking immigrant women through the use of survey and interviewing techniques. Furthermore, as an adult educator the goal of my study is to bring the important findings to the attention of educators, others interested in immigrant health promotion and policy makers.

Both Black feminist and critical social theory form the theoretical framework for my study. I situate my research in the literature about breast and cervical cancer and minority groups, focusing especially on Arabic speaking women living in both Western and Arabic speaking countries. My research questions are aimed at understanding the factors that influence Arabic-speaking women’s breast and cervical cancer screening practices to shed light on their level of participation in breast and cervical screening, as well as the accessibility and suitability of the current breast and cervical screening practice guidelines.

The immigrant population in Canada has increased over the last two decades and the Arabic speaking community is no exception (Citizenship and immigration, 2006).

Since 1990, Canada has accepted approximately 230,000 immigrants per year and women comprise just over half (51%) of the annual intake of all immigrants to Canada (Anderson, 1987). Immigrant women represent 19 percent of all women living in Canada (Chard, Badets & Howtson, 2000). According to 2001 census (Statistics Canada, 2003), there is a large number of Arabic speaking immigrants in Nova Scotia, accounting for 11.6 % of the total visible minority population. Understanding the factors that determine the use of cancer screening of this specific group is necessary so as to provide suggestions and solutions for improving the current screening guidelines and policies. These findings will also contribute to the education and increased awareness of Arabic speaking women about both the availability and the importance of breast and cervical cancer screening.

Women of all races and ethnicities are at risk for breast cancer and cervical cancer. These two types of cancers have remained a major public health issue across the world. Although effective preventive strategies for breast and cervical cancer have yet to be developed, following early detection practices can reduce the impact of the disease and allow for a greater range of treatment options (American Cancer Society, 2005). The effective way of reducing the mortality of these cancers is through screening and early detection. Many women still go unscreened, even where screening is freely available (Goel, 1994; Grunfeld, 1997; Remennick, 2006). The screening behavior of women depends on their knowledge, beliefs, perceptions and attitudes towards breast and cervical cancer (Goel, 1994; Shirazi, 2006). Evidence from the literature suggests that reasons for lower incidence of cancer screening are advanced age, lower levels of education and ethnic origin (Azaiza & Cohen, 2006). Additionally, the literature indicates that women who are recent immigrants and are not comfortable with the English language have lower incidence of cancer screening as do those who do not have access to female physicians or who have not received a physician's recommendation for screening (Goel, 1994; Raja-Jones, 1999). Religious and cultural differences that shape perceptions about health prevention may reduce the incidence of screening practices (Goel, 1994; Remennick, 2006; Raja-Jones, 1999; Maxwell, Bancej, Snider, & VIK, 2001).

Although immigrant women experience the same health problems as Canadian born women, they face multiple barriers in obtaining access to health care services (MacKinnon & Howard, 2000). There are number of factors contributing to immigrant women's increased health risk. These factors include lack of time due to multiple responsibilities such as in their jobs and families but also a lack of social support and employment stress (MacKinnon & Howard, 2000). Language and culture issues can also severely limit access to adequate care (Meleis, Lipson, Muecek & Smith, 1998). Due to these reasons, women are often over-burdened with health concerns. Therefore, they often seek help only after the onset of the disease and when they are in need of treatment.

Many factors, such as income, education, culture and gender determine access to healthcare (Sharif, Dar & Amaratunga, 2000). In addition to the culture, the socio-economic status also plays a crucial role in women's perception about the use, knowledge, availability, and understanding of health care services (Sharif, Dar & Amaratunga, 2000). Ethnic background plays an important role in shaping cultural values; therefore, it affects the willingness to access health care services (Sharif et al., 2000).

Immigrant women may encounter a clash between their ethno-cultural beliefs and accessing Canadian health care, which can erect barriers to their utilization of health care services (Weerasinghe & Mitchell, 2007; Ferran, Tracy, Gany & Kramer, 1999). Moreover, immigrant women perceive health services as being culturally competent only when they are in accordance to the women's belief models (Kramer, Ivey & Ying, 1999). It is important to understand the context of immigrant women's lives in terms of their language proficiency and pre-migration experiences in order to develop culturally appropriate and accessible health care practices and programs (Anderson, 1987). To meet the diverse healthcare needs of immigrant women, health care providers must be culturally sensitive and responsive (Weerasinghe & Mitchell, 2007). Furthermore, to deliver culturally relevant services to multicultural communities, it is crucial to integrate multicultural health issues into the educational curriculum of health care providers (Kramer & Bateman, 1999).

Ferran, Tracy, Gany & Kramer (1999) mentioned that in order to provide culturally sensitive and appropriate health care to immigrant women there should be an increased awareness that each woman has a unique culture that must be respected and understood. This will enhance the relationship between the health care provider and the patient leading to more integration and accurate diagnosis (Weerasinghe & Mitchell, 2007). Racial oppression occurs when the dominant group has the power to oppress resulting in fewer resources for the subordinate group leading to poor health outcomes (Anderson, 1987). Racial oppression affects immigrants' health (Anderson, 1987). This can be seen in the negative attitudes and behaviors exhibited by a number of health providers toward clients of certain ethno-culture backgrounds, which in turn reinforces the immigrants' unequal access to health care (Weerasinghe & Mitchell, 2007). Another reason that contributes to immigrant women's lack of access to health care in general and cancer screening specifically is health care providers' lack of understanding of immigrant women's backgrounds. As Weerasinghe & Mitchell (2007) state pre-migration experiences with the health care system must be understood. They further notes that, it is necessary for health care providers to understand immigrant women's cultural beliefs, values, and priorities and to ensure equal treatment for immigrant women, as individuals to avoid stereotyping. This thesis research attempts to fill this gap in knowledge by exploring the attitudes, beliefs and practices of Arabic women towards cervical and breast cancer screening.

Significance of the study:

According to Cancer Care Nova Scotia (2004), the NS women's participation rate in screening for breast and cervical cancer was below the provincial target. My research explores the screening practices of a specific group of women, Arabic speaking immigrant women living in Halifax, Nova Scotia. This study will be of value to physicians and other health care providers as I identify knowledge, belief, attitudes and factors associated with breast and cervical cancer in general and specifically screening, among Arabic speaking immigrant women. This study will aid health educators along with healthcare providers in developing specific educational strategies to promote

screening practices of Arabic speaking women. As an adult educator concerned with social change and empowerment of immigrant women I think it is very important to help those women to enhance their knowledge and attitudes on cancer screening. I am also hoping that women can achieve this knowledge through their involvement in formal and informal educational programs. In the long run, this may lead to future research and development of health education programs, specifically adapted to the cultural beliefs and needs of Arabic speaking women. This study finding might help in encouraging early detection. As Arabic idiom reminds us: “Dirham (a basic unit of currency in some Arabic countries) of prevention is better than Quintal (metric unit of mass) of treatment”. Identifying the factors associated with knowledge and attitudes about breast and cervical cancer screening will allow planning health promotion and educational strategies that are appropriate for Arabic speaking immigrant women. Research on breast and cervical cancers and their screening behavior of Arabic speaking immigrant women remains very limited, especially in Nova Scotia. This study is the first attempt to address this health issue of an ever-growing ethnic group in Halifax.

Research Questions:

The overarching research question guiding this study is: what are the knowledge, beliefs, perceptions and attitudes towards breast and cervical cancer and screening among Arabic speaking immigrant women living in Halifax? Therefore, the following questions will guide the data collection and analysis:

1. What does breast cancer mean to you?
2. What do you know about breast cancer?
3. What does cervical cancer mean to you?
4. What do you know about cervical cancer?
5. What do you know about breast and cervical cancer screening?
6. How do you learn about breast and cervical cancer screening?

Probes:

A. Have you ever participated in breast /cervical cancer screening? How do you participate in breast and cervical cancer screening?

- a. What leads you to seek the service?
 - b. From whom do you usually seek help?
 - c. Where would you / do you go for screening?
 - B. Do you find the current preventive cancer service suitable to your culture, religion and accessible to you as an Arabic speaking immigrant woman?
 - a. If you have mammography or Pap test done, describe your experiences from a cultural and religious perspective.
 - b. Is it difficult for you to get these tests done? Explain, why it is difficult?
 - c. What would make it easier for you to get these kinds of tests done?
4. What changes should be in place in order for you to seek breast and cervical cancer screening?

Probes:

- A. Do you need information to make decision as to whether or not you would get Pap test or mammogram done? What kind of information do you think would be most helpful to increase your knowledge?
 - B. In your opinion, what would make Arabic speaking immigrant women go or not go for breast or cervical screening?
5. What influences your decision to access breast and cervical screening?

Probes:

- A. Cultural factors (e.g. traditional practices, your responsibilities to your family, lack of knowledge and time).
- B. Social factors (e.g. lack of time, lack of motivation, misunderstandings about cancer, perception of cancer as shameful).
- C. Religious factors (modesty, one has no control over disease, life or death).
- D. Knowledge factors (e.g. level of education, knowledge about cancer risk factors).
- E. Language factors (e.g. difficulty in understanding referrals, communication barriers).

Chapter two

Literature Review

The purpose of this study is to explore the knowledge, beliefs, attitudes, perceptions and experiences of breast and cervical cancer screening among Arabic speaking women living in Halifax, Nova Scotia, Canada. I consider breast and cervical cancer screening as largely a personal behavioral choice, which may be influenced by factors related to culture, socio – demographic status and access to and use of available health care services. In this review of the literature, I start with some brief information pertinent to the above factors; the geographical coverage of the Arab immigrants to Canada, patterns of Arabs immigration to Canada as well as the Arab culture. I include a discussion on cervical and breast cancer rates, associated risk factors, screening methods in Canada and in Halifax particularly. Screening is an important factor for early detection when there is a range of treatment options are available. The literature review focuses on different cervical and breast cancer studies pertaining to ethnic minorities with special attention paid to Arabic speaking women. Thus the literature review provides an in - depth context for this topic.

The Arab world extends from the Arabian Gulf through North Eastern Africa (North Africa and the African horn). It is a region diverse in physical geography, climate and natural resources, but its inhabitants share common cultural traditions, Arabic language, socio political experience and a memory of their role and place in history (Barakat, 1993; El-Badry, 1994). “Arab” or “Arabic” people refer to people whose first language is Arabic, who share the values and beliefs of Arab culture and can trace their lineage to one of the Arabic countries (Meleis, 1981). The Arab world, stretching from the Middle East to the Persian Gulf to North Africa, consists of many countries in the region. There are 22 Arab countries/territories: Algeria, Bahrain, the Comoros Islands, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Mauritania, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates, and Yemen (El- Badry, 1994).

Arabs are culturally, linguistically and religiously diverse. Despite the common use of the Arabic language, different countries and regions have different accents and dialects (Hatter -Polar, 2003). Only a small minority of citizens of Arab countries do not speak Arabic as their mother tongue and therefore lack the sense of being Arab (Barakat, 1993). Islam, Christianity and Judaism are all represented in the Arab World. The majority of Arabs are Muslims; the two identities are often lumped together. Arab cultures are frequently assumed to be "Islamic" and have "Arabic" as their language regardless of their diversity. Different tribal, ethnic, religious and sectarian affiliations are common in most of Arab countries. These give the Arabic society its heterogeneous characteristic (Barakat, 1993; El-Badry, 1994). The Arab culture has its own dominant culture constructed from what is most common among Arabs. In addition, it has sub-cultures which are represented by the pattern of living (rural, urban or Bedouin), social formations, ethnicity and religious affiliation (Barakat, 1993).

The early wave of Arabs immigrants to Canada was from Syria, what is now called Lebanon. In the 1980's and the early 1990's a large number of refugees arrived from countries of the Arab world, notably Somalia, Lebanon, Iraq, Kuwait, Saudi Arabia and the United Arab Emirates, but with strong representation from Egypt, Iraq, Jordan and Syria (Barakat,1993). According to Statistics Canada, in 2001 there were over 347,000 people of Arab origin in Canada. Canadians of Arab origin always tend to settle in urban areas but not in neighborhood concentrations. According to Canadian Census the most common allophone languages in Nova Scotia was Arabic (0.5%) followed by Micmac (0.4%) and German (0.3%) (Statistics Canada 2001). The Arab communities of Nova Scotia (largely in Halifax) ranked the fifth largest ethnic community among the provinces.

With regard to health believes, many Arabs do not view a person as sick until he/she is not able to perform his/ her usual duties and often will not go to a doctor unless they cannot function (Lipson & Meleis, 1990). Certain illnesses such as diagnosis of cancer of a family member are kept as secrets within the family (Hatter-Pollara, 2003). According to Hatter-Pollara (2003), in Arab culture, women are socialized to be wives and mothers. Women are entrusted to protect the family's honor and uphold proper

cultural conduct at all costs. Marriage and family are central in Arab culture. Consequently, women are expected to be virgins at marriage. Usually, sexual activity begins after marriage (Salamah, 1993).

An increase in the number of immigrants to Canada has changed Canadian social structure and approaches to health service delivery. Immigrants, refugees and women of diverse ethnic background form an increasingly large percentage (38%) of the Canadian "mosaic". These Canadian women are neither French nor British in origin (Statistics Canada, 2001; Citizenship and Immigration Canada, 2002). Many health care providers have recognized that immigrant women often encounter difficulty in accessing health care services (Meleis et al., 1998; Sharif, et al., 2000). Granting equal access to appropriate health care service for ethno-culturally diverse immigrants is a challenge for health care providers (Weerasinghe & Mitchell 2007). Barriers to accessing the health care delivery system include: limited language skills, different cultural health beliefs and practices, lack of cultural acceptance and appropriate health care services (Anderson, 1998).

Cervical cancer:

Cervical cancer is an important health problem for all women, especially for those of diverse ethno-racial origins. Cervical cancer is the second most common cancer among women worldwide. According to 2002 Global Cancer Statistics, there are 493,000 new cases identified globally every year. Out of this estimate, 274,000 women died in the year 2002 (Parkin, Bray, Ferly & Pisani, 2005). Cervical cancer accounts for 15% of female cancers and are more common in developing countries than in the developed countries. The risk of developing cervical cancer before the age of 65 is 1.5%. Survival rates are fair and mortality rates are lower than incidence (Parkin et al., 2005).

The Papanicolaou smear (Pap test) as a screening test for cervical cancer has been available in Canada for over 50 years. Screening for cancer has resulted in an ample decrease in mortality and incidence rates. The Pap test can identify precancerous lesions before leading to cancer. It can also help in detecting cancer at early stages where treatment is most effective (Canadian Cancer Statistics, 2006).

According to Canadian Cancer Statistics (2006), incidence and mortality rates for cervical cancer have declined by 50% and 60 % respectively since 1997 because of Pap test screening. The estimated new cases for cervical cancer are 1,350 in 2006 with 390 deaths. In N.S the estimated number of new cases in 2006 was 55 with 11 deaths. Early detection from Pap smear screening and treatment has led to a significant decline in invasive cervical cancer rates. In 1977, the incidence and mortality rates were 15.4 and 4.8 per 100,000 respectively, compared to 7.5 and 1.9 per 100,000 in 2006. Cervical cancer is the 11th most common cancer diagnosis among Canadian women and the 13th cause of mortality (Canadian Cancer Statistics, 2006). According to Elkind et al, (1988 cited in Maaita and Barakat 2002) women need to understand that screening does not protect against cancer rather it is for detecting early lesions.

Papanicolaou test (Pap test): Pap test is a non-invasive screening tool. A spatula and a brush are used to scrape off some cells from the surface of the cervix and then cancer cells are identified through a microscopic examination. Canadian guidelines recommend the Pap test for cervical screening within three years of the initiation of sexual activity or at the age of 21 whichever occurs earlier. Re-screening is reduced to every two to three years until the age of 69 if the first two smears are normal at the discretion of the physician (Canadian Cancer Statistics, 2006). Effective screening can reduce the risk of developing invasive cervical cancer by 90% (Canadian Cancer Statistics, 2006).

Risk factors involved in the occurrence of cervical cancer include sexual behaviors, age at first pregnancy and the contraception use in addition to characteristics such as occupation, social class, and smoking, being infected with the human Papilloma virus, early age initiation of sexual activity and multiple sexual partners. A woman who has sexual intercourse with a male partner who in turn has had intercourse with multiple women also confers a significant risk (American Cancer Society [ACS], 1999).

The early detection of cervical cancer increases the five-year survival rates to 90%. Pap tests contribute to a decreasing rate of cervical cancer incidence and mortality rates (Canadian Cancer Statistics, 2006). However, many women are at risk including sexually active young females and minority women with language and cultural barriers

to health services. A key factor in reducing mortality from cervical cancer is to achieve and maintain a high level of participation in regular screening, mainly the Pap smear test. In NS, the participation rate of triennial screening was 66% in 2004. This is below the 85% of the provincial target. Incidence and mortality rates of cervical cancer were declined by about 50% and 60% respectively, since 1977. However, Nova Scotia continues to have the highest incidence in Canada (Canadian Cancer Statistics, 2006). In Nova Scotia, Halifax has the highest incidence of mortality rate due to cervical cancer.

Since the introduction of the Pap test, cervical cancer ranking as a major cancer type has dropped to be a rare form. Still it is the principal cause of death among women in most developing countries (Grunfeld, 1997). Though there is a decrease in deaths due to cervical cancer, the rate continues to be higher among the native population in Canada. Studies show that among new cases there is a relatively high proportion of women, 50% of whom report no or poor participation in Pap screening programs (Grunfeld,1997). This group accounts for the majority of women who die from cervical cancer. The 1994 National Population Health Survey showed that elderly women, women of low socioeconomic status and immigrant women are likely to be under screened or never screened (Goel 1994 ; Grunfeld , 1997). Similarly, Maxwell et.al (2001) in their analyses of the 1996-1997 National Population Health Survey, found that about 87% of women surveyed had never had a Pap test or had not been screened in the last 3 years. Accordingly, they found that the groups at higher risk for not having a Pap smear included immigrant women (those who lived in Canada 10 years or less); elderly women, women of low socioeconomic status and those who do not speak English or French.

There is a gap in knowledge about incidences of cervical cancer rates by ethnicity as ethnic origin is not recorded (Luke 1996). Incidence rates among immigrant populations are similar across country of origin for the first generation of immigrants (Luke, 1996).

Language also creates a barrier to accessing health. Jacobs et.al (2005), examined the relationship between limited English proficiency and breast and cervical cancer screening in a multi-ethnic population. They found that women who report that they do not read or speak English at all or that they are less fluent in other languages are less

likely to participate in breast and cervical cancer screening than women of the same race who speak / read English fluently. The sample included 1247 women at different sites in the United States and there were African American, Hispanic, Chinese, Japanese and White Caucasian women ranging in age from 42 – 52 years old. Women included were those who spoke or read another language or were more fluent in a language other than English, or fluent in English and another language. The findings of this study are consistent with those of Woloshin, Schwartz, Katz and Welch (1997) where the relationship between language and the use of preventive medicine was established. The study sample consisted of 22,448 women aged 18-74 years, who completed the 1990 Ontario Health Survey with information about their native language and ethnicity. More than 10% of women in Ontario spoke a language other than English. Woloshin et al (1999) stated that these women who do not speak English at home are less likely to receive important preventive services than women who speak English at home due to a communication barrier.

Thomas, Saleem and Abraham (2005) studied barriers to effective uptake of cancer screening knowledge among Black minority ethnic groups living in Brent and Harrow in the United Kingdom. The participants' ethnicities were African Caribbean, West African, Pakistan, Greek, Arabic, and Indian. The sample consisted of 85 women. Thomas et al (2005) found that the women associated cancer with death and preferred not to talk about it, due to it being a taboo. Knowledge about screening services was poor. Barriers to screening included language and cultural beliefs. Thomas et al (2005) stressed that cancer screening must be sensitive to religious and cultural needs. In the same vein, Matin and Le Baron (2004) explored attitudes toward cervical cancer screening among Muslim immigrant women in the San Francisco Bay area through focus groups. Participants were from Middle Eastern backgrounds. Women mentioned that their religion and culture such, as the value of virginity for unmarried women, made them concerned about how the Pap smear might affect this. The participants pointed out that doctor were not sensitive to cultural differences on this topic.

Smith, Phillips and Price (2001) analyzed published articles, books and reports to determine socio-cultural factors affecting breast and cervical cancer screening among

women of minority ethno - cultural and racial groups. Participants were from nine different ethnic groups living in the United States. Lack of knowledge, embarrassment, traditional folk medicine and decision-making processes (family or authority within the group) were common barriers to women of all cultures studied.

Lesjak, Ward and Rissel (1997), studied the knowledge of Arabic speaking women in Australia towards cervical screening using a self-administered questionnaire. The number of women participating was 526. Participants were 18 years or above of age. Sixteen percent of foreign born Arabic speaking women in their study did not know about cervical screening compared to 2% of Australian born women. Moreover, older women were at greater risk because of the language barrier. In the same vein, Matuk (1996) examined the newcomer women's Pap smear test screening practices using the data from Newcomers Health Survey in Windsor, Ontario in 1991. Participants were newcomers to Canada within the last 3 years. Participants were from Central and South America and Eastern Africa (of whom most were Muslims). Fifty-six percent of these women reported never been screened for cancer or unsure about cancer screening. This study points out that those newcomer women did not have a Pap test either because of their low understanding about its importance or the lack of recommendation by a medical practitioner.

Although cervical cancer incidence rate is lower among minority ethnic women research shows that among later generations the incidence of cancer is similar to those in the indigenous populations, so minority ethnic groups should be aware that cervical cancer might be a problem in second and subsequent generations.

It is clear from the literature review that only a small number of studies exist about cancer screening practices among Arabic speaking women. Limited information is available concerning Arabic speaking women and cervical cancer screening. However, there were no studies on screening practices of Arabic immigrant women living in Canada. Therefore, a review of cervical screening literature in other ethno-cultural groups helps to identify insights that might help to inform research with Arab women. To complete the picture, studies on cervical screening in the Arab speaking countries will also be examined.

The conservative nature of Arab societies hinders the collection of data on such topics. According to Ministry of Health of the United Arab Emirates (1992), cervical cancer deaths in 1991 represented 6.4% of all cancer deaths. Cervical cancer accounts for 20% of all deaths (Bakhiet & BuHaroon, 2004). According to the Jordanian cancer registry, in 1997 there were 48 cases of cervical cancer (Maaita & Barakat, 2002). In 1998, breast cancer and cervical cancer ranked first and second respectively as the major causes of death among women. In the United Arab Emirates, as well as in other Arab countries there are no population based cervical screening programs and screening is carried out only in secondary healthcare settings either on patients request or if a physician decides that it is required for a particular patient (Maaita & Barakat, 2002).

Information about knowledge, attitudes, barriers and practices related to cervical cancer screening among Arab women is rare. Bener, Denic and Alwash (2001) studied knowledge, attitudes barriers and practices related to cervical cancer screening among native women in United Arab Emirates. From 1398 women, who participated in the survey with ages ranging from 46-60 years, only 15.4% of those women had ever had a Pap test before. Barriers to screening included fear, embarrassment, fear of bad diagnosis and communication difficulties with the physician.

Arevian, Nourneddine and Kabakian (1997) studied Lebanese/American women's knowledge for attitudes towards and the practice of Pap smears for cervical screening using a self-administered questionnaire. Participants were 290 Lebanese/ American women selected from the American Relief Cross in Lebanon and were aged 18 years and older. Arevian et al (1997) stressed that knowledge about Pap smears increased with the level of education. The percentage of women who wanted to have a smear increased with education level too. In conclusion, a low level of knowledge and practice rate was found in one third of the sample.

Bakheit and Bu Haroon (2004) studied the knowledge, attitudes and practice of Pap smears using a detailed questionnaire, among local school teachers in United Arab Emirates. Participants were 350 married female teachers from 18 schools in Sharjah city in United Arab Emirates, ranging from 20-59 years. Eighty-four percent had a good knowledge about cervical cancer screening, but the majority of them had never had a Pap

smear test done. The reasons for not having the test were fear, embarrassment and shyness due to cultural influences. Similarly, Maaita & Barakat (2002) studied attitudes towards cervical cancer screening among Jordanian women. They had 600 participants who were all women aged between 20 and 40 years old. Forty –three percent of those women had a college degree. Researchers found that 75% had never had a Pap smear although a majority agreed it was important. Seventy-seven percent did not know about cervical cancer risk factors. As for the reasons for not having the test done, the women mentioned fear, embarrassment and belief that it was unnecessary.

Badrinath et.al (2004) studied the knowledge, attitudes, and practices of cervical screening among female primary care physicians in the United Arab Emirates. The sample size was 98 physicians with different professional backgrounds who participated in a self-administered questionnaire survey. Forty percent reported having performed a Pap smear. More than 90% insisted there was a need for a cervical screening program. This study stresses that the front line physician needs to be more aware before implementing a screening program.

In summary, in my review of the literature on ethno - cultural communities and cervical cancer screening several factors are associated with immigrant women's screening participation. These include the ability to speak English, their level of education, length of stay in the host country, openness to the topic of sexuality, cultural related behaviors such as ‘shyness’, and a lack of knowledge of health promotion tools. The literature also indicates that income and age also influence women’s participation in Pap tests. Moreover, support from family, friends and community play a significant role. Several studies revealed that the tendency of women getting a Pap smear test done depends on their knowledge and awareness of the importance of early detection as well as their beliefs and attitudes toward screening. Researchers had frequently realized those women’s knowledge, attitudes and practice in terms of the prevention of cervical cancer and doing Pap smears are not satisfactory.

Breast Cancer (BC)

Breast cancer is the most invasive and life threatening type of cancer for women all over the world, and represents 10% of the global cancer burden. According to the 2002 global cancer statistics, 1,151, 298 new cases of BC are diagnosed each year, with 410,712 deaths occurring annually in the world (Parkin, et al., 2005). BC incidence varies throughout the world with the lowest rate found in Chinese, Japanese, Arabic women and women from the Indian sub continent (Hoare, 1996). According to Kliewer and Smith (1995), breast cancer incidence and mortality rates for the majority of immigrant women originating from the countries with low breast cancer risk have approached the rates of their destination countries. This change indicates that the influence of environmental and lifestyle factors, in the host countries, on breast cancer for immigrant women.

Among Canadian women, breast cancer remains the leading type of cancer in terms of incidence and the second leading cause of cancer related deaths, with about 22,200 new cases and 5,300 deaths estimated to have occurred in 2006. Just over 50% of all BC cases occur in women between the ages of 50 and 69 (Canadian cancer statistics, 2006).

Incidence and mortality rates vary across the world, with higher rates in high resource countries. In contrast, BC fatality rates are the highest in countries with limited resources where survival is worsened due to the advanced stage of disease diagnosis combined with inadequate resources to afford treatment (Parkin et al., 2005). BC is the second leading cause of cancer deaths in women. In NS, 3,260 were diagnosed with invasive BC with 890 deaths between 2000 and 2004. Incidence rate increased by 101 cases per 100,000 in 2004, mortality rates are 21 deaths per 100,000 (Cancer Care NS, 2004). Incidence rates of invasive BC increased with age with a decline for age groups 55-69 years old due to the increased use of mammography within this group.

Risk factors for BC include age, gender, family history, diet, alcohol consumption, body weight, age at menarche and menopause, age at first full pregnancy, taking exogenous hormones (oral contraceptive or hormone replacement therapy), and exposure to radiation (Health Canada, 2004).

It is not possible to prevent BC with current knowledge and available technology but the most important action women can take is to follow early detection guidelines. The earlier the diagnosis the greater the chance there is of reducing the spread of the cancerous tumor. If detected early, the 5-year survival for women with localized BC is 97% (American Cancer Society, 1990). According to the International Agency for Research on Cancer (IARC), high quality, mammography screening on an ongoing basis could reduce mortality by 25%. Screening and early detection of BC starts with a monthly breast self-examination (BSE) for women 20 years and older.

Canada recommends that all women 40 and older have an annual Clinical Breast Exam (CBE), with biennial mammography for all women 50 and older (Canadian Cancer Society, 2006). The Canadian cancer society recommends that all women 40 and older have an annual clinical breast exam (De Grace, O'Connor, Perrault, Aitken & Joannis, 1996). Clinical breast examination (CBE) is complementary to mammography and a yearly CBE is important, as 10% to 15% of breast cancer will not be seen on mammograms (Canadian Cancer Statistics, 2006). Early detection depends primarily on women's involvement and participation in BC screening. Individual knowledge, attitudes, and beliefs are seen as the basis for determining health-screening behaviors. The incidence of BC continues to rise over the last decade, with a slight decrease in mortality because of the use of mammography screening (Rawl, Champion & Menon, 2000).

The likelihood of early screening for BC depends on the women's understanding of the illness, belief in the examination and reduced barriers to its performance. Health beliefs may be affected by ethnicity, age or having a relative with BC. Studies in Western countries have shown that ethnic minority groups are more likely to be diagnosed with advanced stage disease and hence have higher mortality rates (Ghafoor, Jamal, Ward, Cokkinides, Smith & Thun, 2003). According to literature in the USA, the BC morbidity and mortality is higher among minority groups and they are less likely to participate in BC screening compared to white women, despite the fact that white women have a higher incidence of breast cancer (ACS, 2005).

There is a growth in the literature on ethnic groups' utilization of health services in the United States and United Kingdom. In Canada, this issue has to date received little

attention. Quan, Fong, De Coster, Wang, Musto, Noseworthy & Ghali (2006) analyzed the data from a Canadian community health survey in 2001. Quan and colleagues found that members of visible minorities are less likely to have had a Pap test or mammograms than white people. Under utilization of cancer screening tests may be related to the differences in referral patterns or beliefs about cancer across ethnicities (Quan et al., 2006).

Cancer is an important issue among studied ethnic groups. It is attributed to about one sixth of all deaths. A review of the literature shows that limited data are available regarding BC incidence in ethnic minorities (Raja-Jones, 1999). Several studies have suggested that the incidence of cancer among minority women is low. Raja-Jones (1999) attributed the low incidence rates to the low level of screening practice; they may have cancer but are not officially diagnosed with cancer because they were not screened. Moreover, Hoare (1996) mentioned that in a study done among women in the United Kingdom from the Indian sub continent, (the largest ethnic subgroup in the United Kingdom) incidence rates of BC is approximately half of that of the indigenous United Kingdom population and it is closer to the incidence rate of the country of origin. However, it was noted that the changes in lifestyle due to immigration can alter this rate (Kliwer & Smith, 1995; Hoare, 1996).

Several studies have examined women's knowledge, beliefs and attitudes about breast cancer and mammography screening. Although there has been a significant improvement in knowledge and encouragement to participate in screening, mammography remains underused by some women. For example, Maxwell, Banjec & Snider (2001) used the data from 1996-1997 National populations Health survey to describe patterns in mammography in Canadian women ages 50-69 years old. Among participants, 79.1% had never had a mammogram. This finding confirms less frequent use of mammogram in older aged women. Reasons for not having a mammogram include: residing in a rural area, being of an older age, having been born in Asia, and having no regular physician and no recent medical consultations.

Different studies on the impact of age and race on mammography practice are available. For example, a study by Rawl, Champion, Menon & Foster (2000)

investigated the impact of age and race on mammography practice among 648 African American and Caucasian women aged 50 or older. Researchers found that the most common reason for not having a mammogram was that the doctor did not inform them to do one or the women did not know where to go. On the other hand, the most common reason was embarrassment and at their age, they believed they did not need mammograms (Rawl et al, 2000). Increasingly a large body of the literature discusses old age as a reason for not having had a mammogram. Remennik (2006) mentioned that many studies in Israel and United States have shown that women older than 60 years of age are less likely to use screening. They believe that breast cancer after menopause is no longer of a health concern. Furthermore, older immigrant women usually have poor language skills. This may contribute to the lack of participation in BCS resulting in late BC diagnosis among older age women. Canadian cancer statistics reported that BC incidence and death rates increase with the age. For example, probability of developing cancer in next 10 years for age group 40-49 is 1.3% compared to 3.2% for age 70-79 (Canadian Cancer Statistics, 2006).

The use of mammography screening varies according to socio-demographic characteristics such as race and ethnicity. Swan, Breen, Coates, Rimer & Lee (2003), analyzed the data from the 2000 U.S. National Health interview survey and earlier surveys to notice trends in cancer screening practices. Their results showed that there is an increase in mammography use for immigrant women living in the United States for more than 10 years, reaching 32% compared to 17% for those who are new to the United States.

Rajaram & Rashidi (1999) reported religious and socio-cultural issues related to BC screening and health practices among Asian Islamic immigrants in the US. They discussed modesty and body covering as two factors that hinder these women's participation in screening. For example, agreeing to screening only if a female physician can perform the screening procedure. Another barrier is these women's beliefs about cancer and the social stigma associated with it. Rajaram & Rashidi stress that religious, cultural background and linguistic differences contribute to physician communication problems. They cited some references that indicate physicians are less likely to share

information with individuals whom they feel to be different from themselves in terms of social status, ethnicity, gender, and age. Physicians' recommendations are one of the most important motivations for mammography. The literature suggests that physician recommendation contributes to increased participation among women's screening. George (2000), in his integrative review on barriers to BC screening, pointed out that in 8 of the 13 studies examining mammography screening, lack of physician's recommendations is the major contributing factor for not having the screening. Moreover, in the same study, individual barriers such as knowledge and attitudes were shown as significant reasons for not having a mammogram. George (2000) mentions that women relate the necessity of mammography with personal or family history. Therefore, lack of communication between physician and patient would decrease the cancer-screening rate. Lower rates of screening among immigrants are common in the United States as well (Shirazi, Champeau & Talebi, 2006).

Rashidi and Rajaram (2000) studied breast self-examination behavior among 39 Middle Eastern Asian Islamic immigrant women in the US. Participants ranged in age from 20 to 48 years of age. A majority of them (85%) had heard of BSE, while 74% had not practiced BSE. Most of the women had never learned about BSE from a health care provider. Rashidi and her colleague point out that communication barrier between patients and physicians might affect the reduced spread of information by health providers to these women. Lack of knowledge of cultural and religious practices of Middle Eastern Asian Islamic women among health providers might also result in lack of effective communication.

The literature relates the low screening rate among immigrant women to the number of years in the host country, language skills, education level, age, lack of female physician, and negative relationships with health providers (Shirazi et al, 2000). Ahmed, McNally & Stewart (2002) reviewed published studies to examine barriers facing Hispanic women in using breast and cervical screening practices. The common factors were related to the fear of diagnosis of cervical cancer. Language difficulties also impeded delivery of medical care and hindered full communication with the health provider. In addition to these barriers, older people believed they did not need this test at

their age. According to Rajaram and Rashidi (1998), studies conducted among minority African American, Asian and Hispanic women demonstrated that these women thought that screening, such as mammograms, would cause cancer as screening looks for trouble and does not prevent it. Moreover, women of traditional ethnic groups rigorously maintained that modesty, which is highly valued, has a role to play. Women were not comfortable with talking about breast and sexual matters and thus avoided breast and pelvic examinations (Rajaram and Rashidi 1998). Understanding of these women's social, cultural and historical factors is crucial in understanding the barriers to utilization of BC screening among minority groups.

Increasingly, while a large body of the literature is available on breast cancer and screening among Korean, Mexican and Vietnamese immigrants in Western countries, very few studies are available for Arabic speaking immigrant women. Little research is available on BC incidence rate among Arabic women either in their homelands or as immigrants. Aziza and Cohen (2006) conducted a study in Israel and they found that the incidence of BC is considerably lower in Arab women than in Jewish women, yet the survival rates from BC are notably lower among Arab women. This attributes to late stage diagnoses of BC (Azaiza & Cohen 2006). Studies done on Middle Eastern and Asian born women living in Australia, found that this group utilizes fewer early detection practices than Western born women (Azaiza & Cohen 2006). The barriers were stemming from the belief that there is no cure for cancer, feeling of discomfort and the notion that screening is painful. Moreover, they noted that a physician's recommendation plays a vital role in motivating women to have early screening.

In many Arab countries, BC is the most common cancer in females. The incidence of BC in Arab women is lower in comparison to other populations. However, it is well known that Arab nations tend to develop BC at least a decade younger than their counterparts in Western countries. The median age of incidence of breast cancer is 46 years in Kuwait, Egypt and other Gulf countries (Motawy, El-Hattab, Fayag, Oteifa, Ali, George, Barghash, Bugallouf & Jabrallah, 2004). On the same note, Fakhro, Fateha, Al-Asheeri & Al-Erki (1999) studied patient characteristics among 93 Bahraini with breast

cancer who were discharged from the hospital. Thirty three percent of these patients were 40-49 years of age and 48.4% of women were below 50 years of age.

Soskolne, Marie and Manor (2006) also conducted a study in Israel. They examined factors related to screening mammography behavior among 510 Muslim Arab women aged 50 to 69. The women had poor knowledge about BC and mammography. Only 20% had had screening before. Soskolne and colleagues' findings are consistent with Bener, Honein, Carter, Da'ar, Miller, and Dunn's (2002) findings on the determinants of BC screening behavior among Arab women. Special factors that contributed to mammography screening among Muslim women were the age and level of education. Beliefs and recommendations were also important factors contributing to mammography screening among Muslim women. These included: age, lower education and lack of knowledge about BC and mammography as well as anxiety and fear leading to denial of susceptibility. The literature suggests that women from Middle Eastern Asian countries report a lower incidence of BC due to diagnosis in advanced stages and of late detection (Rashidi & Rajaram, 2000).

Bener, Alwash, Miller, Denic and Dunn (2001) explore the knowledge, attitudes and practices related to BC and BC screening among 175 Muslim women aged between 40-65 years old in the United Arab Emirates. Thirty-percent of women knew that family history was a risk factor. Thirty-eight percent of women had received BSE instruction and 7% lacked knowledge about BSE. However, only 13% actually practiced BSE. This shows the gap between knowledge, instruction and explanation for practice. Eighty percent of women agreed about the importance of Clinical Breast Examination but only 14 % had actually done it.

Petro-Nustas (2001) examined factors associated with their beliefs toward mammogram utilization for screening among Jordanian women. The research participants were 59 women aged between 18-45 years. Eighty-six percent had knowledge about breast tumors and only 49% had knowledge about mammograms. None of them had had mammography done before. Petro-Nustas found that participants' underutilization of mammograms is due to the deficiencies in the available services, as there are no screening programs in most Arab countries. Furthermore, he confirmed

cultural barriers such as modesty issues as well as breast cancer and social stigma related to it, which other researchers also found (Rajaram & Rashidi 1998; Azaiza & Cohen, 2006, Shirazi et al., 2006).

In summary, a review of the literature reveals that cultural attitudes, beliefs and knowledge about breast and cervical cancer screening influences how Arabic speaking women practice breast and cervical cancer screenings. According to the literature, factors that affect women's participation in breast or cervical cancer screening can be divided into three major groups. Socio-demographic factors include age, income, education and ethnicity. Psychological factors include beliefs, attitudes and knowledge of the practice, fear, embarrassment and feeling. Health care systems and other external factors include ability to access health services and physician recommendation. In their encounters with health care professionals, women, especially non-English speakers, were unable to obtain the services they needed because health care professionals often failed to understand that the position and condition in which women worked and lived could be a major deterrent to the appropriate management of illness. As a result, the current health care system is on the Western ideology of health and illness that frequently fails to accommodate the health care needs of clients of different ethno-cultural backgrounds (Weerasinghe & Mitchell, 2007). Therefore, health providers need to adapt their message about the importance of these forms of cancer to reflect the perceptions and beliefs of Arabic speaking women to achieve a universal use of preventive cancer screening. At the same time, adult educators can play an important role in educating immigrant women in cancer screening. An active awareness program that includes both formal as well as informal workshops on accessing health care, especially breast and cervical cancer screening, would reduce the overall cancer rate.

Chapter Three

Theoretical framework

The focus of my research in Adult Education is to explore the knowledge, attitudes, beliefs, perceptions and experiences of Arabic speaking women about breast and cervical cancer screening, and to bring these to the attention of educators and others interested in the findings of the study. Both Black feminist theory and critical social theory, both relevant to adult education form the theoretical frames for my research. Reflecting on women's narratives from the stance of feminist discourse is enlightening and educating. Freire acknowledged that society could give voice to the knowledge of oppressed peoples only by providing structures that allow them to speak for themselves (Freire, 1994). This serves the purpose of my study.

The field of Adult Education plays an important role in fostering learning which in turn empowers individuals. As Miles (1998) has noted, adult education is broadly contained in all professional fields. Its impact extends to all spheres of our lives whether social, economic, political or cultural levels of the community.

Adult education has contributed to empowerment of women by addressing issues of poverty, violence and health concerns in the lives of women. Moreover, adult education has responded to the social conditions of women's learning experience (Morrish & Buchanan, 2001). Education will only empower people if it enables them to act collectively based on their own relativity in order to change it. Empowering women to exercise their choices is not only valuable in it but is also the surest way to contribute to the overall development. Women's empowerment can be achieved by creating an environment that will allow women to participate in education programs that work effectively for social equality for women (Morrish & Buchanan, 2001). Heng (1995) notes that

[Women's] empowerment is a way of feeling, conceiving and relating with oneself and with the world...Empowerment has to occur at the individual, interpersonal and institutional levels, where the person develops a sense of herself as confident, effective and capable (personal power), an ability to effect others

(interpersonal power), and ability to work with others to take action (individually and collectively) to improve their lives and change social institutions (political power) (p. 79).

Critical social theory and empowerment education (Freire, 1994) provides an important perspective that directs this study through advancing the emancipator function of knowledge. For Freire, the educator's role is to help people become aware of the world around them. A critical social theory based in education highlights the relationship between social systems and people. Social systems and people and how they produce each other are ultimately how critical social theory can contribute to the emancipation of both. Wallerstein and Bernstein (1988) adapted Freire's ideas to health education and mention that empowerment education is an effective health education and prevention model. They linked empowerment to health and powerlessness to disease. Educators' participation in group action and dialogue efforts that are directed at community targets enhance a sense of control and a belief in one's ability to change one's own life.

Critical social theory influences personal as well as social choices and many of life's options influences social attitudes. Therefore, social attitudes may also control many options in women's health care. Closely related to critical social theory is feminist theory. To be a woman is to be gendered, that is to be a product of social and cultural beliefs and practices that surrounds our daily lives (Hayes & Flannery, 2000). Feminist theory understands reality from the perspective of women. It allows me to study, analyze, and explain social phenomena from a gender-based perspective. The feminist approach is considered in all phases of my research process from the selection of the topic, through choice of design, to data collection and analysis, and to the interpretation of the findings.

According to Bell Hooks, (2000) feminism became a means of understanding women's experience of discrimination and oppression that shapes our social status. In this way, feminism calls attention to the diversity of women centralising the experience of all women especially those who are less studied because of their social position (Hooks, 2000). Black feminism provides a conceptual framework to examine social phenomena from women's perspective. It pushes us to use the everyday experiences of

women as a source for research. Most importantly, “black feminism pushes [researchers] to analyse gender, ‘race’ and class relations as simultaneous forces, and to examine knowledge production from different social and political locations” (Anderson, 2002, p. 18). This theoretical perspective have directed me towards the exploration of how the social, cultural religious which are shaped by the conceptualisation of race and gender influence Arabic speaking women’s breast and cervical cancer screening practices. The use of the term Black in Black feminism is to designate people as marginal with minority status. Bell Hooks (2000) points out that a Black feminist perspective has an advantageous position to generate knowledge that fosters women’s empowerment and social justice. As Anderson (2002) stressed a feminist project is a project that places women’s experiences and thoughts at the center of the analysis. Through understanding and analyzing these marginalized women’s experience, knowledge generation will occur to empower them.

I recognized that the words “oppression” and “marginalization” are understood differently in different contexts. For the purpose of my study I am using the words as they relate to women’s cancer screening practices. I recognize that many Arabic-speaking women have wisdom related to other health issues and cannot be homogenized as a singularly “oppressed” or “marginalized” group.

Most of the published research on women’s learning focuses on the experience of white educated women. When women of color were included, mostly they were black leaving a lack of knowledge and attention about women of different races, cultures and ethnicities (Hayes & Flannery, 2000). Dealing with people from different ethnic backgrounds in a positive way remains a difficult issue for most adult educators; dealing with individuals from any minority group requires a full awareness of those individuals, their needs and their interpersonal motivations.

Cultural values, beliefs, structure of the family and community, environment and language need to be included in the inquiry to gain deeper understanding of the challenges for Arabic speaking women seeking breast or cervical cancer screening. This will assist in identifying disease prevention strategies among Arabic speaking immigrant women.

The fundamental focus of Black feminism is to listen to and value the voices of marginalized women voices that come from the margins. Following these perspective I have used Arabic speaking women's experiences as sources for investigating their screening practices. Starting from the Arabic speaking women's perspectives enables me to understand the process through which social and cultural relations have influenced their decisions about screening practices.

Chapter Four

Methodology

Study design:

This chapter will discuss the methodology used in this study. This discussion will include the description of the data collection methods, study population and data analysis. In addition, the procedure of contacting participants as well a discussion of ethical precautions and methodological challenge will be covered.

The purpose of my study is to investigate Arabic speaking immigrant women experiences. I wanted to capture my research participants' views as much as possible. A qualitative study is best to explore the perspective on breast and cervical cancer and screening of these diseases among Arabic speaking immigrant women in Halifax, N.S. The qualitative research approach provides detailed contextual information and can capture the complexity and meaning of this topic. I selected qualitative research because of the flexibility of structure it offers and how participants' thoughts, opinions and feelings are constantly acknowledged in the forefront (Denzin & Lincoln, 2005). Sherman and Webb (1988) stated that the key philosophical assumption of all types of qualitative research is that it is about individuals interacting with their social worlds that construct reality. Qualitative researchers are interested in understanding the meanings people have constructed, how they make sense of their world, and the experiences they have in the world (Sherman & Webb, 1988). Thus, due to the limited research about Arabic speaking immigrant women, a qualitative approach, with its exploratory, descriptive, and constructive nature, is ideal in this context. "Qualitative research, then, has the aim of understanding experience as nearly as possible as its participants feel it or live it" (Sherman & Webb, 1998, p.7).

The data collection method used in my study was quantitative surveys and semi-structured interviewing techniques. "Conventional social scientists often rely on survey or interview processes to build understandings of cultural groups. These researchers are likely to make inquires of a number of group members in a bid to understand their attitudes, beliefs, opinions, and/or behaviors" (O'Leary, 2004, p. 118). Semi-structured interviews helped me gather more focused information about themes related to the

research question. Moreover, I intentionally interviewed Arabic speaking women from different socio demographic backgrounds and age groups to explore diversity in experiences and opinions.

Survey:

The first step in data collection was survey administration. The survey questions were short and written in plain language so that research participants can complete the survey within approximately half an hour. O’Leary (2004) stresses that when the survey is too long it can be returned incomplete or filled in randomly. The survey questions are closed questions so the respondents choose from a range of predetermined responses. The survey offers anonymity and therefore confidentiality. The survey contains questions regarding Arabic speaking immigrant women's knowledge, beliefs and attitudes towards breast and cervical cancer and screening (appendix A part II & III). The questions also inquire how Arabic speaking immigrant women practice breast and cervical examinations and what prevents or motivate them to engage in preventive cancer screening practices. In addition, the quantitative survey includes items that address demographic data (see appendix A part I). Prior to the survey, a survey package that included a cover letter, an informed consent form and a questionnaire were hand-delivered to individual women. One hundred and five surveys were distributed. I attended all special and informal events in the Halifax regional municipality to recruit participants and administered the survey in person. Most surveys were distributed during women’s gatherings such as women circles, baby showers, meetings at the mosque or any informal women gatherings. In this the surveys was administered face –to –face, which provided the opportunity to clarify questions and at the same time to increase the response rates (O’Leary, 2004). Surveying a variety of groups and in multiple settings will increase the diversity of the women participants in terms of age, levels of educations, country of birth and family income.

In order to avoid the problem of missing data Knapp’s (1998) guidelines of dealing with missing data were followed. These guidelines included prevention, deletion, and estimation, working around it and studying it. In order to achieve this, prior to data

collection I clarified and explained all instructions about filling the survey to the women. Then a double check for missing data was done to each questionnaire immediately after the women has completed it. If any missing data were noted, I drew the women's attention to the incomplete question(s) and asked the women to answer the question(s) and determine the reason behind the leaving the question unanswered. Fortunately these steps were successful and I was able to catch up on most missing data. With all these precautions at the end all surveys with missing data were reported.

Semi- structured interviews:

Interviewing is a data gathering technique used in qualitative research when the goal is to collect detailed, person-centered information (O'Leary, 2004). In a study where different language and cultural perspectives are prevalent, conducting in-depth interview using the participants' first language enables the participants to describe their experiences using their own words (Anderson, 1986). My research involved interviewing five Arabic speaking immigrant women. Semi-structured interviews, with open-ended probing questions (see pp. 4-5), would encourage the participants to discuss their experiences with breast and cervical cancer and screening. My interview questions were clearly stated and were semi-structured according to a prepared protocol. This makes the process of hearing, adjusting, and linking ideas together based on the answers given easier. I asked my participants to add or clarify what they just said when necessary.

As can be deduced from its name, semi-structured interviews are "neither fully fixed nor fully free and are perhaps best seen as flexible" (O'Leary, 2004, p.164). Semi-structured interviews also helped me to collect more focused information about topics and themes related to the over arching research question. I interviewed individuals from different backgrounds and age groups, to explore a diversity of experiences and opinions. An informal interview facilitated the collection of information and ensured the success of the interview. Informal interviews are much like conversations in which questions are usually prepared ahead of time to move the interview in a desired direction, but participants typically elaborate on various points with encouragement and guidance from the interviewer. When the subject matter appear to be relevant and enlightening,

participants may continue talking on the same subject. An interview differs from a common conversation as it requires building rapport with the participants and above all, it has a specific yet an implicit research agenda (Fetterman, 1998). The participants were able to describe their experiences as openly as possible while still maintaining a research focus because dialogue between the participant and me was interactive reflective and open. Participants were encouraged, respected and listened to. Flexibility of the interview process was maintained through out the data collection so that women could feel comfortable in sharing their stories without any fear of judgment. This would generate 'rapport' and would create a more natural environment for open and honest communication. To ensure the success of the interview, the interviewer has to achieve a balance "between the warmth required to generate 'rapport' and the detachment necessary to see in the interviewee as an object" (Oakley, 1981, p.33). The interview was conducted in the language preferred by the participants, which was mainly Arabic and at a time and place that was convenient for them. Creating a positive and trusting environment by considering times and places comfortable for the participants helped to make the participants comfortable. I was also aware of the length of the interview, which was somewhere between one and two hours.

With the permission of participants, I audio tape recorded the interviews for data collection. Being fluent in Arabic gave me the ability not only to conduct interviews in Arabic but also to engage more directly with participants. This aided in the comfort level of the participants and eased the flow of discussion. In addition, I took field notes which was crucial for all interviews to summarize nonverbal communication. Body language is a signal to further explore the topic, change to another topic, or to end an interview (O'Leary, 2004). I locked all the transcripts and audio tapes in a filing cabinet in my home to protect the confidentiality of my participants. Moreover, all related documents of my participants' interviews will be destroyed after completing my thesis. Throughout the research process, pseudonyms and codes were used to identify the research participants. To preserve confidentiality and anonymity according to ethical guidelines no real names of participants were used in the thesis. Any identifier was removed and only I would have access to transcripts.

To ensure validity of the data, I met with each participant individually and they confirmed that the transcripts represented their words. This eliminated or minimized misunderstandings about any part of what the participants had to say (Borland, 1991). For the most part the participants approved of their transcripts and did not suggest any serious changes.

I also triangulated my data through my research methodology which consisted of the two methods (survey and semi-structured interview) in addition to my own self-reflections on my research. Thus this triangulating process supports the validity of the data.

Study population:

The participants included in this study were Arabic speaking immigrant women living in Halifax. The current Canadian guideline recommends the cervical cancer screening using the Pap smear test within three years of the initiation of sexual activity, and an annual mammography is recommended for women 40 years and older. In N.S the mammography is recommended for women aged 50 to 69 years. According to Arabic culture, women should start their sexual activity only after marriage. Based on these recommendations, women aged 20 years and older, who are married and have been in Canada for one year or more, would make up the study population. Keeping in mind the research focus, the study included only Arabic speaking immigrant women who are able to read and speak English and /or Arabic. Selection of research participants was not based on specific levels of education. Moreover, recruitment of research participants was done by networking within the Arabic speaking community. Personal contacts maximized women's confidence to speak about these sensitive health topics.

Being an Arab immigrant woman, living in Halifax, who may have similar experiences with breast and cervical screening, I have insights into the Arab culture and a general understanding of Arabic speaking immigrant women's experiences. Moreover, sharing a similar cultural background with the research participants encouraged them to feel more comfortable to share their experiences and be willing to participate in this research, which equipped me better to understand the behavior of the interviewees.

Challenges:

As with all forms of research, my research has involved methodological challenges that I had to resolve. One potential challenge I faced in my research was the topic itself because both breast and cervical cancer involve body sites that are considered very private. Moreover, cancer itself is a ‘taboo’ topic for these women and to discuss such things was a challenge. To overcome this, I collected data only during women’s gatherings so women could feel comfortable to discuss this hot topic. The research was a good chance for these Arabic speaking immigrant women to question their knowledge of cancer. The study created a supportive environment for Arabic speaking immigrant women to share information about breast and cervical cancer and screening.

I am also aware of the unequal power relation that exists between the researcher and the participants, which might result in the discomfort of the participants. Therefore, I made every effort to be respectful towards the women whom I interviewed. I had to be aware of the ways I interact with the women. O’Leary (2004) stresses:

Researchers need to recognize that power can influence the research process, and with power comes responsibility. Both the integrity of the knowledge produced and the well-being of the researched are dependent on the ethical negotiation of power and power relationships (p.43).

I discussed power issues with my participants explaining that as this research gives them the opportunity for their voices to be heard and at the same time they are the people who will decide the success or failure of the research. Conducting community-based research requires the researchers to give something back to the researched group, so that the findings from the research can change their position in the society (Castodal, 2004). With this in mind, I gave my participants a clear explanation of the multiple purposes of the research. I ensured them that there were no promises for positive change or huge shifts in their health, although I will take these findings to the health providers and I will disseminate my research findings to the Arabic speaking women and the community at large in community meetings.

Procedure:

Prior to commencement, this study was first submitted for a human ethics review at Mount Saint Vincent University Graduate Studies Committee. Through ethical conduct, participants will be protected. For example, women decided whether or not they wanted to be audio taped. Also pseudo names were used. Once I passed the ethics committee's approval, I used the snowball sampling method, (Bogdan & Bicklen, 1982), whereby a connection with one participant led to finding other interviewees. To recruit participants I attended informal gatherings to explain the purpose and significance of the research. I started contacting these participants by providing an information letter. The information letter included information about me and the purpose of the study. Prior to actual data collection, participants had to sign a consent form. The consent form and information letter were in both English and Arabic (appendix E, D & B, C respectively). I translated the survey questions, semi-structured interview questions, consent forms and information letters into Arabic to over come the language barriers.

Data Analysis:

The survey consists of multiple-choice questions, which will include variables such as beliefs, knowledge, attitudes, perceptions and their benefits and barriers to screening. For analysis, I used the Excel Open office. Descriptive statistical methods tables, graphs and charts were used to summarize all the variables. Analysis is through the traditional qualitative process, which includes transcribing the interviews, coding data to identify commonalities and variations, identifying common and variable patterns within each group and across groups and identifying themes, which link or explain the data (Patton, 1990). The data obtained from interviews were transcribed in the primary language of the participants and then translated into English, to ensure accuracy and the transcripts were rechecked against audiotapes. There was a second reader so that the quality of translation was guaranteed. The transcripts were reviewed and analyzed for common ideas or themes. Analyzing is an ongoing process that involves thorough reading, marking transcript margins, identifying, adding codes and categorizing themes.

The first step in my data analysis process was to transcribe the audiotapes and read through all of them and try to detect and make sense of various themes using a combination of reasoning, where theories are confirmed (O’Leary, 2004). I highlighted words and concepts that were related to themes in my literature. While looking for interconnections between various themes, I constantly tried to keep my research questions in mind (O’Leary, 2004). I analyzed the data according to its relevance, significance, and meaning in relation to the questions I posed for my research. Using interpretive analysis means that I had to focus on my findings and descriptions, including the search for contexts, underlying implications, patterns, and procedures. Interpretive analysis offered more in-depth qualitative conclusions by focusing on concerns, words, and ideas that relate to already classified patterns or themes (Aronson, 1994). In addition to the interpretive analysis, I also used the established literature on the topic to support my arguments and findings. Aronson (1994) mentioned that the interweaving of the literature with the findings gives the story that is built by the researcher a superior quality and worth.

Finally, I wrote up my findings, supporting them with direct quotes from participants, values from my surveys, as well as the relevant literature. Through thematic analysis I came up with the following themes:

- Worry and fear of the unknown
- Knowledge of breast and cervical cancer
- Screening behaviors
- Barriers to screening
- The health Care System
 - Doctors never told us
 - Shared responsibilities
 - A female doctor is better
 - First language physician
- Strategies to reach women
- Factors that influence decisions about screening practices.

I will discuss my research findings within these themes in the following chapter.

Chapter Five

Data Analysis & Discussion

The purpose of this study was to highlight the knowledge, beliefs, attitudes and perceptions of Arabic speaking immigrant women in Halifax towards breast and cervical cancer and screening. In this chapter I present my data analysis; I examine the themes arising from the interviews and the numerical values from the survey and discuss them with reference to the relevant literature.

Phase One

The first phase of the study included 105 face to face surveys. Through networking and the snow ball approach, Arabic speaking immigrant women aged 21 and older and who are married were asked to fill out a survey on a voluntary basis. A total of 105 surveys were distributed. There was a response rate of 95% (N = 100 out 105) of potential participants.

The survey contained questions about the respondent's knowledge of breast and cervical cancer risk factors and early detection as well as their beliefs and attitudes about breast and cervical cancer and screening. The survey questions also inquired about if and how they practice breast and cervical screening and what prevents or motivates these women to engage in preventive cancer practices. In additions, the survey included items that address demographic data. The survey consisted of multiple choice questions. Most of the surveys were done in Arabic, as it was preferable by the participants. Data analysis was performed on the different section of the survey using the Statistical Package for the Social Science (SPSS) 12.0 windows. Basic descriptive statistics and frequency calculations were performed on all variables considered in this study.

The demographic characteristics of the survey participants are presented in the following figures and tables which include country of birth, age group, education level and number of years in Canada, etc.

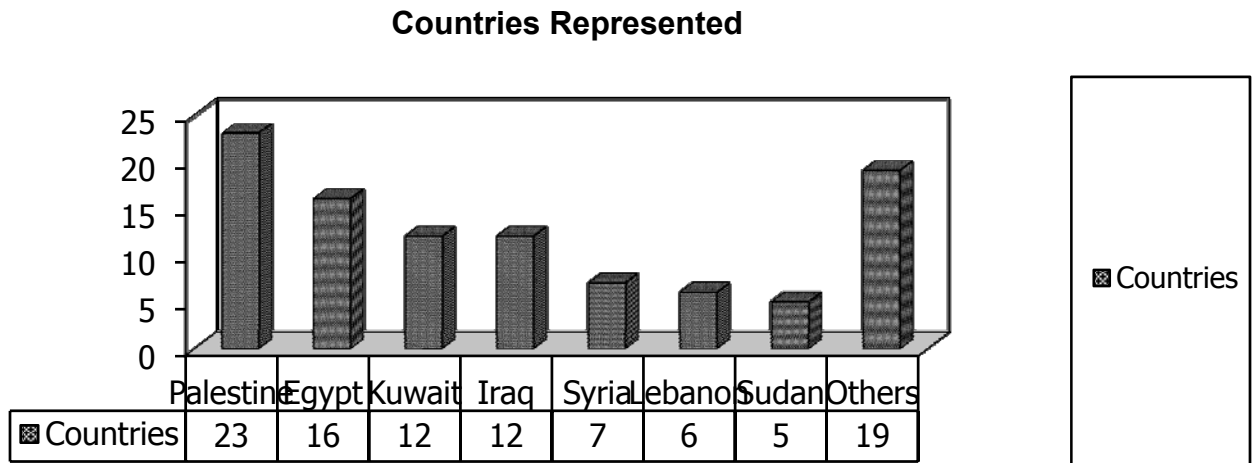


Fig. 1 Study Group by Country of Birth

With regard to the above data 100 respondents participated in the survey and were drawn from 18 different countries as follows: 23% of the respondents were from Palestine; 16% from Egypt; 12 from Kuwait; 12 from Iraq; 7% from Syria; 6% from Lebanon; 5% from Sudan and 19% from the remaining 11 countries.

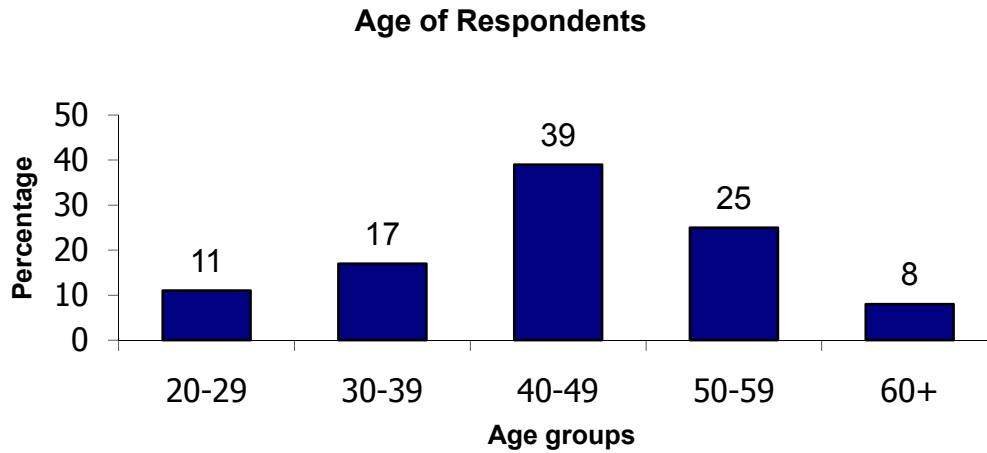


Fig. 2: Study Group by Age Categories

Study Group by Age of

Age Group	Number & Percentage %
20-29	11
30-39	17
40-49	39
50-59	25
60+	8

Table 2: The Country of Birth of the Study Sample

Country	Number & Percentages %
Palestine	23
Iraq	12
Jordan	3
Lebanon	6
Syria	7
Egypt	16
Kuwait	12
Saudi Arabia	3
United Arab Emirates	1
Sudan	5

Libya	3
Morocco	1
Tunisia	1
Yemen	3
Algeria	1
Oman	1
Somalia	1
Qatar	1

Table 3 Study Group Parental Status

Children	Number & Percentage %
No	6
Yes	94

Parental Status



Fig 3 A Pie Chart of the Parental Status of the Study Group

94% of those surveyed had children while 6% had no children.

Table 4 Educational Level of the Study Group

Education Level	Number & Percentage %
Less than high school diploma	10
High school diploma	31
Undergraduate degree	49
Graduate Degree	10

Table 5 Level of English Proficiency of the Study Group

Number of years in Canada	Number	Percentage %
1-3 years	22	22
3-5 years	11	11
>5 years	77	77
English proficiency	Number Reading	Number Speaking
None	2	4
Poor	8	9
So-So	33	36
Good	37	39
Fluent	20	12

Table 6: Marital Status, Motherhood, Menopause & Percentage of Participants who have a Female or Male Family Doctor

Martial Status	Number & Percentage%
Married	92
Separated	4
Widow	4

Age at first Child	Number & Percentage %
14-23	59

24-33	31
> 33	4

Age at last Child	Number & Percentage %
19-29	26
30-39	54
> 40	14

Menopause	Number & Percentage %
Yes	25
No	75

Family Doctor	Number & Percentage %
Male	20
Female	80

Phase Two

The second phase of the study included semi-structured interviews with 5 Arabic speaking immigrant women. Interviews were approximately one to two hours in length. The interviews were done in Arabic as this was the participants' choice. With permission of the five participants the interviews were audio taped. The audiotapes of all interviews were transcribed and translated

These five Arabic speaking women clearly do not represent all Arabic speaking women's views, however, each woman's perspectives offered valuable insights for my study. Moreover, I got the benefit from doing the survey in women's gatherings where I was able to discuss some of my interview questions with the women during these gathering. I found that despite the heterogeneity of my research participants their responses were quite homogeneous.

The participants are between the ages of 21 to 60 years, all are married and have been in Canada from 3 to 15 years. Participants' education levels were wide spread ranging from grade 7 to graduate level. Participants were from five different Arabic countries, as shown in the table below:

Table 7 Demographic Characteristics of the Interviewee

Name	Age group	Marital Status	Level of education	# of children	Years in Canada
Warda	20-30	Married	Grade 7	Two	Three
Lala	30-40	Married	Post Graduate Degree	Three	Three
Zozo	40-50	Married	High School Diploma	Five	Five
Nena	50-60	Married	Graduate degree	Three	Ten
Bebe	60-about	Married	Graduate degree	four	Fourteen

The interviews were analyzed through a traditional qualitative process. The analysis includes, coding the data to identify commonalities and variations, and then identifying themes which link or explain the data. Thorough reading and re-reading of the transcripts allowed me to identify code and categorize themes. I used interpretive analysis to analyze the data I had collected according to its relevance, significance and meaning in relation to my research questions. I also used the established literature on the topic to support my arguments and findings.

“Worry and fear of the unknown”

During the administration of the surveys whenever the women took the survey to fill it out and/or upon hearing or reading the word ‘Breast or Cervical Cancer’ they repeated the words “Ya Lateef, Ya Lateef,” which has one of the names for God and means ‘God be kind to me and prevent this danger from happening to me’. It could also be used as a prayer.

For these women (as most of Arabic women) breast and cervical cancer mean to them fear, worry or a monster. For example, when asked her views on the topic of cancer Warda said:

“Fear umm. I don’t know, actually it’s just fear.” Zozo has the same comment of worry and fear. She explained,

[Silent... breathing...] It is something that gives you an uncomfortable feeling and when you think about it you fear from the topic itself. It is a kind of fear and worry. [Long silence] I remember my friend when she did mastectomy all her life has changed. You can’t imagine the tragedy she lives in.

Nena has the same feeling and she said:

Oh... A lot of worry fear and discomfort as this is the disease of the era. Oh it’s the fear from the unknown.

Bebe similarly emphasized this fear,

You know it’s worry and fear from the unknown; really it is fear, a lot of fear.

Lala characterized this in a sinister way. She explain,

I am shocked when I hear this topic. Same like a monster that can attack me at any moment. I would like to be careful of this monster [... pause...] Sometimes I would like to forget this terrible topic. Pray God protect us.

The women’s feelings about breast and cervical cancer, are related to the fact that these cancers affect parts of a woman’s body that are private which represent her feminine identity as a woman. When I asked these women which type of cancer they felt is more serious for them, breast or cervical cancer, they each have different responses which related to how the consequences of treatment of the two forms of cancer were deemed visible or hidden. For example, Nena, after a long silence, answered:

I think... breast cancer is more serious. Yes, it is more serious as it can spread quickly but for the cervical they can just take the uterus out [hysterectomy] and no one would notice. Umm, you know if they did mastectomy everyone would know and notice the difference which means my feminine out-look will be different.

Zozo agreed with Nena.

If I had breast cancer, God please don't affect me, this will affect my feeling as it will change my out-look, but for cervical no one would notice anything. It is something you cannot see.

Bebe brought up an interesting point which agrees and clashes with Zozo and Nena.

Bebe explains:

Breast cancer is more serious. It can spread to all parts of the body which makes it the worst. For cervical only we can remove the uterus or even ovaries and that's it. Oh... regarding out-look, women can wear special kind of bra... but you know from psychological point she will be sad as when even she looks at herself she will be upset.

Warda and Lala brought an interesting point which clashes with Zozo, Bebe and Nena's comments. Lala said:

As a woman, umm... I feel if a woman has cervical cancer she would not be able to give birth like the "dead tree," you understand me? She is unproductive and not effective in the society. Breast cancer may affect women's shape and her feminist out look but this can be solved. I mean by wearing certain kinds of bra, and she can still give birth so it is not that serious as cervical cancer.

On the same vein Warda said:

You can't imagine a woman with no uterus, which means she can't have kids. Cervical cancer is more serious and dangerous.

The women's response about which is more serious, breast or cervical cancer seem related to their age. On one hand the women who are older than 40 generally think that breast cancer is more serious because it may lead to a mastectomy which is a visible consequence compared with cervical cancer which may lead to the uterus being removed, an "invisible" consequence. On the other hand, those who are younger find it more serious to have cervical cancer as it will affect their ability to give birth which then may affect their marital relationships.

This concern as expressed above by Warda and Lala reinforces that motherhood, namely giving birth, is a critical determinant to a woman's stability in a marriage relationship. The culture of motherhood constitutes an important avenue for women's

participation in Arabic society. The bride's woman's status in her husband's household remains unstable until she gives birth to her first baby and proves that she is fertile. Infertility within the context of marriage is viewed as a mark of shame rather than a medical condition (Farsoun, Khoury & Underwood, 1996.)

Knowledge of breast and cervical cancer

Lack of knowledge about breast and cervical cancer and screening is very clear among Arabic women. Even though they may be aware of the screening they may not necessarily have information as to why it is needed or the risk factors, etc. Lack of knowledge appeared to be closely related to the limited awareness and conversation among many Arabic women regarding these issues.

Bebe related to this to the level of education and says:

There is not enough information about the disease. Yeah, yeah I think there is a relationship between the level of education and your knowledge about the disease. You understand, that educated women can search to know everything, she can look up on internet or in magazine but for uneducated it is a challenge.

Warda agrees with Bebe:

Education is very important because women with a higher level of education will go for screening. I think I never go for screening because of my education level issues [pause] maybe.

On the other hand, Lala has a different point of view:

Education is not always a reason to force women to go for screening. For example, I am well educated but I never did try screening. "Awareness" is important. It is the number one reason to go for screening.

Nena supports Lala and says:

Your knowledge is the most important factor. Some women are educated. For example I finished my undergraduate in math but I don't have enough information about this disease and I think this is the case for most women. Oh yes, awareness about the disease, cause and the importance of screening [are important].

Zozo agrees with the idea of education and awareness and she explains:

Education is important and it plays an important role in doing screening but most important is awareness and information about the disease. This forces you to go for screening and these women will hope for a cure if she is diagnosed with it.

The literature showed that there is a consistency between higher levels of education and going for screening (Arevian et al, 1997; Soskolone et al, 2006). In my findings education is not always a reason for getting screened, as it is clear from the survey 49% of women had an undergraduate degree. Awareness of the need for screening is more important for these women. My participants indicate clearly that having a higher level of education does not necessarily mean a higher level of knowledge and information about cancer in general and about breast and cervical cancers specifically.

Knowledge of breast and cervical cancer screening

The participants indicate that they have very little knowledge and understanding of breast and cervical cancer and that their access to this knowledge is limited. Lack of knowledge is closely connected to limited conversations among Arabic women about these issues. One participant, Warda, states

I hadn't heard anything. Nobody talks about this. Women don't tell each other. I am not aware of what the cervix is or where it is in my body.

Moreover, Bebe, who had undergraduate degree said,

I don't think I have enough information. What all I know is that it is a cancer that can not be treated easily [pause]. I heard sometimes eating canned food or any food, a meat, which is treated with chemicals, will increase your chance of getting cancer. I remembered there are some factors that increase your chance of getting cancer but I don't know what these factors are... really we have no information.

From the survey 24% of women felt that the screening procedure such as a mammogram only increased one's chance of getting breast cancer. This is consistent with other findings (e.g. Rajarm & Rashidi, 1998).

Also Nena and Zozo added the same information,

"We all know that a small lump will appear and it is not inherited."

Nena explains:

Women may know some information about breast cancer but cervical cancer is a “closed door topic” for Arabic women. The only thing that they know is removing the uterus after having cancer. Yeah, yeah this all we know as Arabic women.

From these interviews it seems that due to a level of ignorance of facts and the lack of understanding the women’s concerns remain focused on the worst–case scenarios such as surgery rather than on preventative measures and non-surgical treatments. Knowledge and lack of understanding about the disease or the importance of screening is common in the literature on Arabic speaking women (e.g. Matuk, 1996; Lesjak et al 1997; Maaita & Barkat, 2002).

The following table shows the level of participants’ breast cancer general knowledge.

Table 8 Level of Participants’ Breast Cancer General Knowledge

Questions	% answered I don’t know	% answered correctly
The constant irritation of a tight bra over time can cause breast cancer.	56	26
One out of every eight women in Canada will get breast cancer some time during her life.	58	36
In some women being overweight increases the risk of developing breast cancer.	36	31
Women who bear their first child after the age of 30 are more likely to develop breast cancer than women who bear their first child before the age of 30.	47	28
Women with no known risk factors for breast cancer rarely get breast cancer.	39	31
Some types of fibrocystic breast cancer, non cancerous breast lumps, increase a women’s risk of breast cancer.	32	52
Women in Canada have a higher risk of breast cancer than women in Arabic countries.	35	36
Most breast lumps are cancerous.	17	77
Breast cancer is more common in a 65-years old woman than a 40-year-old woman.	30	17
Mammography is recommended yearly for women over 40 years old.	8	81

From the survey it is clear that women had poor knowledge about BC and mammography. This finding is consistent with Soskolone, Marie and Manor (2006) who conducted their study in Israel among Muslim Arab Women.

When women asked how most breast lumps are found, 23% of participants answered by the women themselves whereas 58% believed that most lumps are found by mammogram and only 19% thought that lumps are found by physicians during clinical breast examinations. When the women were asked about doing clinical breast examination, only 40 out of 100 have done it before.

Most Breast Lumps are Found by-:

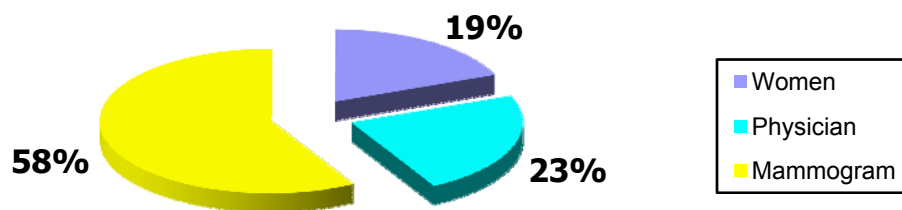


Fig 4. Participants' Responses to How Most Breast Lumps are found

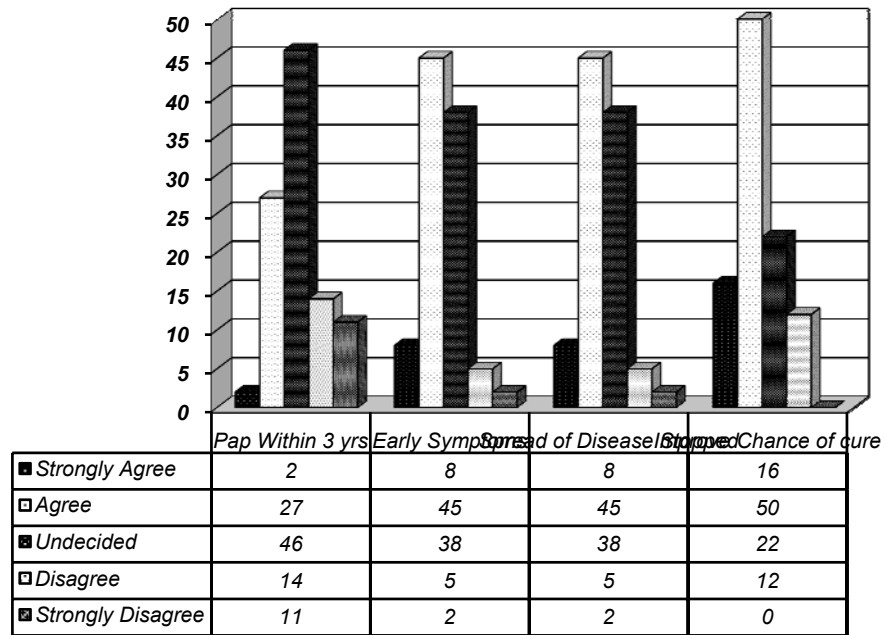
Most participants, 73%, believed that regular breast screening makes a great difference in the chance of curing breast cancer. Only 5% thought that it would make no difference. Moreover, 81% of participants correctly identified that mammogram is recommended yearly for women over forty years old. A total of 87% agreed that mammography can detect lumps that cannot be felt.

Regarding breast self-examination, half of the women had done it before but not on a regular basis. Moreover, no one had taught them how to do it and they depended only on the information from brochures or from friends, which as mentioned previously is not talked about frequently between women. This shows the gap between knowledge instruction and explanation for practice. This is consistent with the findings of Bener et al

(2001) who studied the knowledge, attitudes and practices of Muslim women in the United Arab Emirates related to breast self-examination.

On the other hand, regarding knowledge about cervical cancer only 48% of participants think that there is some chance of treatment if women had cervical cancer and only 44% think that there is chance of recovery. Women knowledge about early detection of cervical cancer is fair about 50% of participants strongly agree that Pap test can provide early detection, lead to stop or spreading of the disease and improve chances of being cured of cervical cancer. The following diagrams show women knowledge on cervical cancer and the screening.

Respondents' Knowledge of Cervical Cancer
Fig 5: Question 8,9,10 and 11



The Questions as follows:

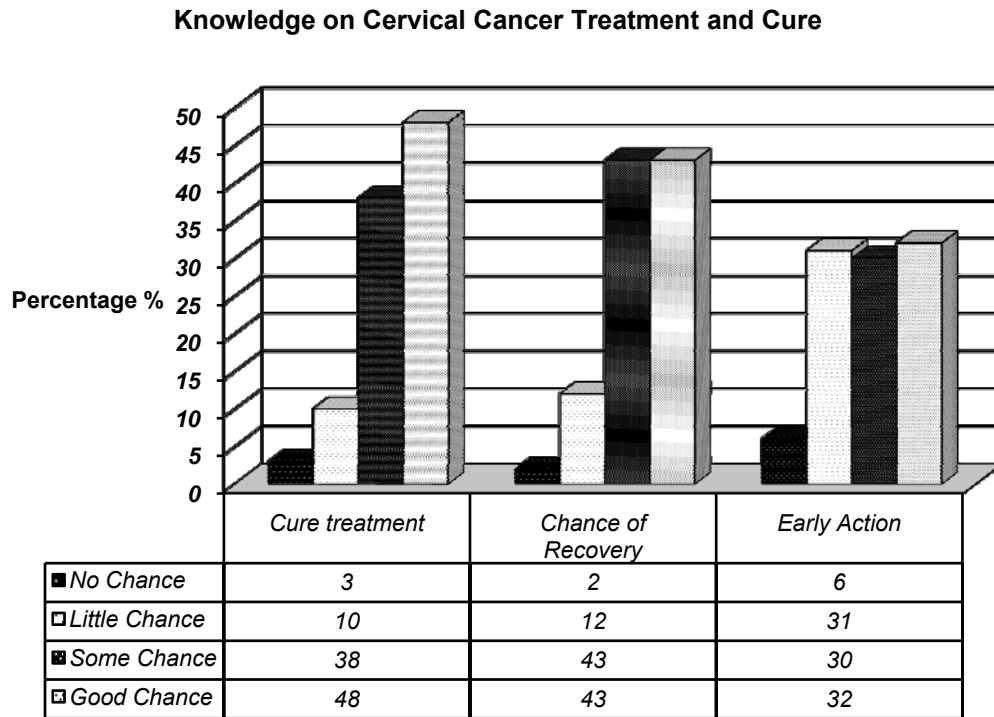
Q8 A Pap smear, a test in which cells are scraped from the cervix, is recommended within three years of the initiation of sexually activity.

Q9. Having a Pap smear test can provide early detection of cancer. (i.e. before showing symptoms)

Q10.Through early detection, using a Pap smear test, the spread of the disease can be stopped.

Q11. Do you agree that early detection would improve one's chances for being cured of cervical cancer?

Fig 6
Question 4, 6 and 7



The Questions are as follows:

Q4. If a woman develops cervical cancer, is it usually too late to get treatment to cure it, or do you think she still has a chance to do something about it?

Q6. Do you think a woman who is diagnosed with cervical cancer has a chance of recovering from it?

Q7. Do you think there is an action women can take to early-detect cervical cancer?

Screening Behaviour

The participants were asked if they had ever had a mammogram or Pap test and how long it had been since they have had their last screening. With regard to the mammogram, 67 out of 100 had never had a mammogram. It is very interesting to note that of the total participants; roughly 64% of women were 40 years and above thus eligible for an annual mammogram according to Nova Scotia health guidelines. When asked how long it had been since they had had their last mammogram, the majority had a mammogram within the last two years, as illustrated in the following table and graph.

Table 9 Participants' Last Mammogram

When was your last Mammogram?	Number & Percentage %
Less than six months	4
6 moths- a year	9
1 year- 2 years	11
More than 2 years	9

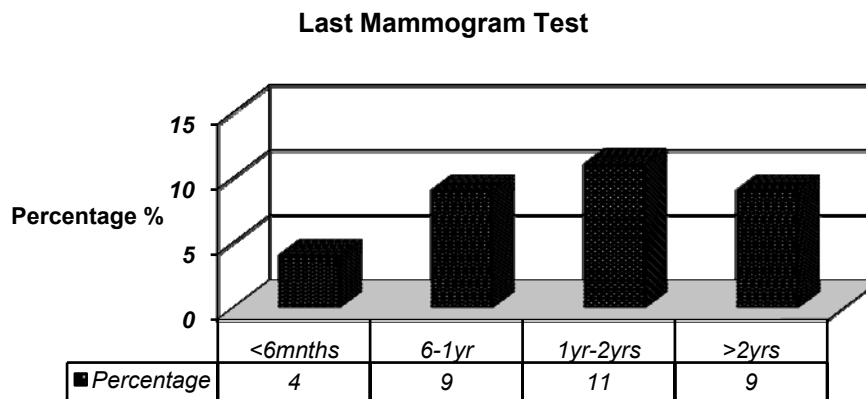


Fig 7 Participants' Last Mammogram

On the other hand regarding cervical cancer screening, more than 50% of the participants had a Pap test. When asked the reason for not having the test 21% answered that they do not feel it is necessary. This study points out that these Arabic speaking immigrant women did not have Pap test either because of a lack of understanding about its importance or the lack of recommendation by a physician to have such tests done. This finding is congruent with Matuk (1996) who examined the newcomer women's Pap smear test screening practice using the data from Newcomers Health Survey in Windsor, Ontario in 1991.

This shows that these women have poor knowledge about the importance of screening, as illustrated in the following tables

Table 10 Participants' Response to Their Cervical Cancer Screening Practices

Ever had a Pap test?	Number& Percentage %
Yes	51
No	49

Reason for having no Pap test	Number & Percentage %
Never heard of it	9
Do not fell necessary	21
Scared of process	12
Not permitted because of culture	0
Other	6

Table 11 Participants' Last Pap test

When was the last Pap test?	Number& Percentage %
Less than six months	9
6 moths- a year	14
1 year- 2 years	15
More than 2 years	14

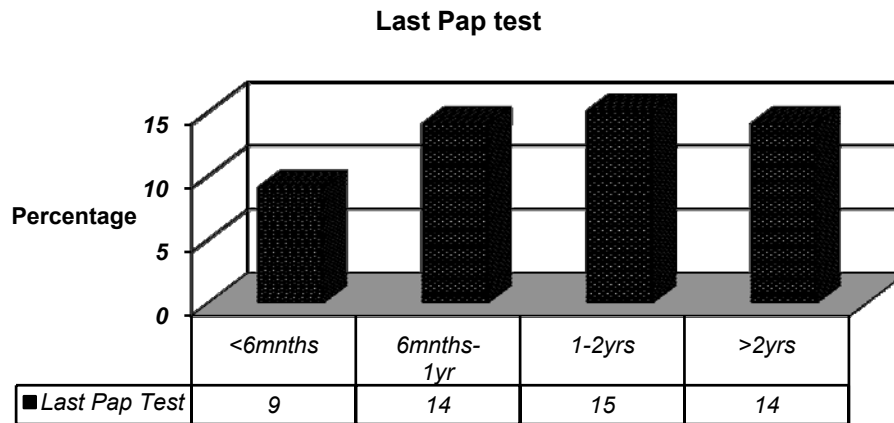


Fig 8 Participants' Last Pap test

Table 12: Recommendation for Pap test by physician and feelings about the Pap test

Recommendation for Pap test by physician?	Number & Percentage %
Yes	74
No	26

How do you feel about the Pap test?	Number & Percentage %
Comfortable	8
Necessary/Important	71
Afraid of it	15

Barriers to screening

In my survey I included items to measure respondents' emotional, physical or structural concerns responsible for negative outcomes related to screening behaviours. The barriers-response options ranged from "strongly agree" to "strongly disagree." The respondent could score on scale of one to five in which one is "strongly agree," two is "disagree," three is "undecided," four is "agree," and five is "strongly disagree." The findings are summarized in the following diagram.

The questions were as follows:

Q20. I am afraid to have a mammogram because I might find out something is wrong.

Q21. I am afraid to have a mammogram because I do not understand what the mammogram procedure involves.

Q22. I do not know how to go about getting a mammogram.

Q23. Having a mammogram is too embarrassing procedure.

Q24. Having a mammogram takes too much time.

Q25. Having a mammogram is too painful.

Q26. Having a mammogram exposes me to unnecessary radiation.

Q27. I have no time to schedule a mammogram.

Q28. I have other problems that are more important.

Barriers to Mammogram Test

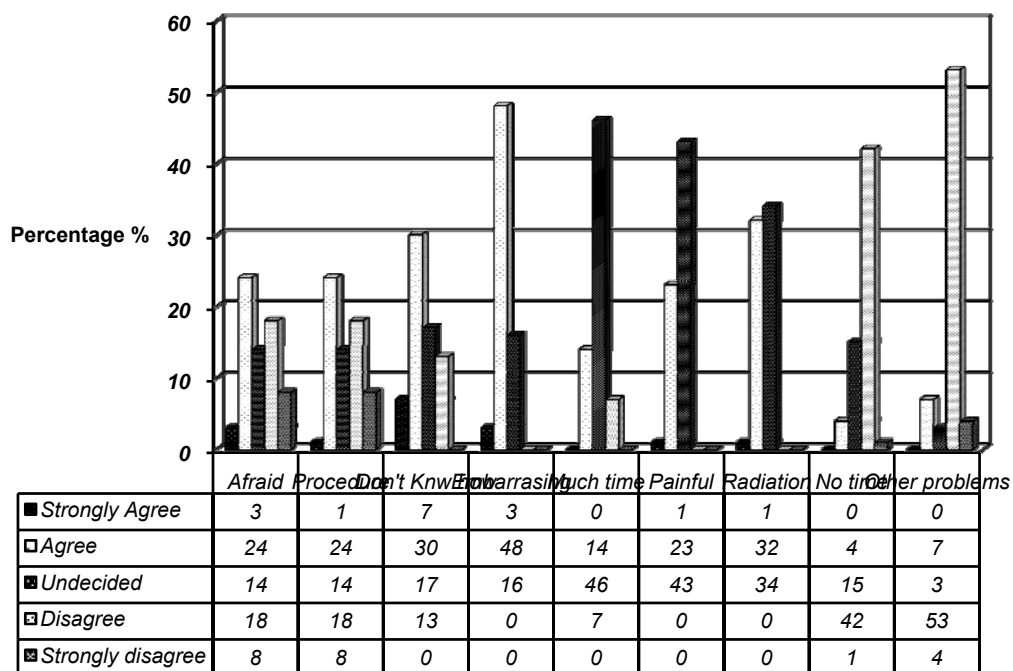


Fig 9 Participants’ Attitudes regarding Barriers to Mammography

Feelings of fear, pain and exposure to unnecessary radiation are common attitude barriers among women who practiced the screening before. On the other hand, those who had never had it said they did not know how to go about getting mammogram or afraid to find out something is wrong were the main barriers. These findings are similar to Azaiza & Cohen (2006).

This view of being exposed to unnecessary radiation is also clear in the survey where 32% of participants have the same opinion. This finding is consistent with Aziza and Cohen (2004) and Otero-Sabagal, Owens, Canchola, Golding, Tabnak and Fox (2004) who find that a barrier to screening is the concern that x-rays may be harmful and hazardous to health. Otero-Sabagal et al’s research participants were from five racial/ethnic groups in California.

On investigating which barriers affect the past cervical screening experience of the respondents using the same scale, embarrassment, and fear that the test will show abnormal cells were the most significant barriers. These results are in agreement with the results of Thomas, Saleem and Abrham (2005).The following diagram illustrates these findings.

Question-: 12, 13, 14, 15 and 16

Q12. I have no time to schedule for a Pap test

Q13. I think having a Pap smear will interfere with my comfort

Q14. Having a Pap smear is an embarrassing procedure

Q15. Having regular Pap tests for check-up will take a lot of my time

Q16. I am afraid to have a Pap test because it will show abnormal cells

Barriers to Pap Test

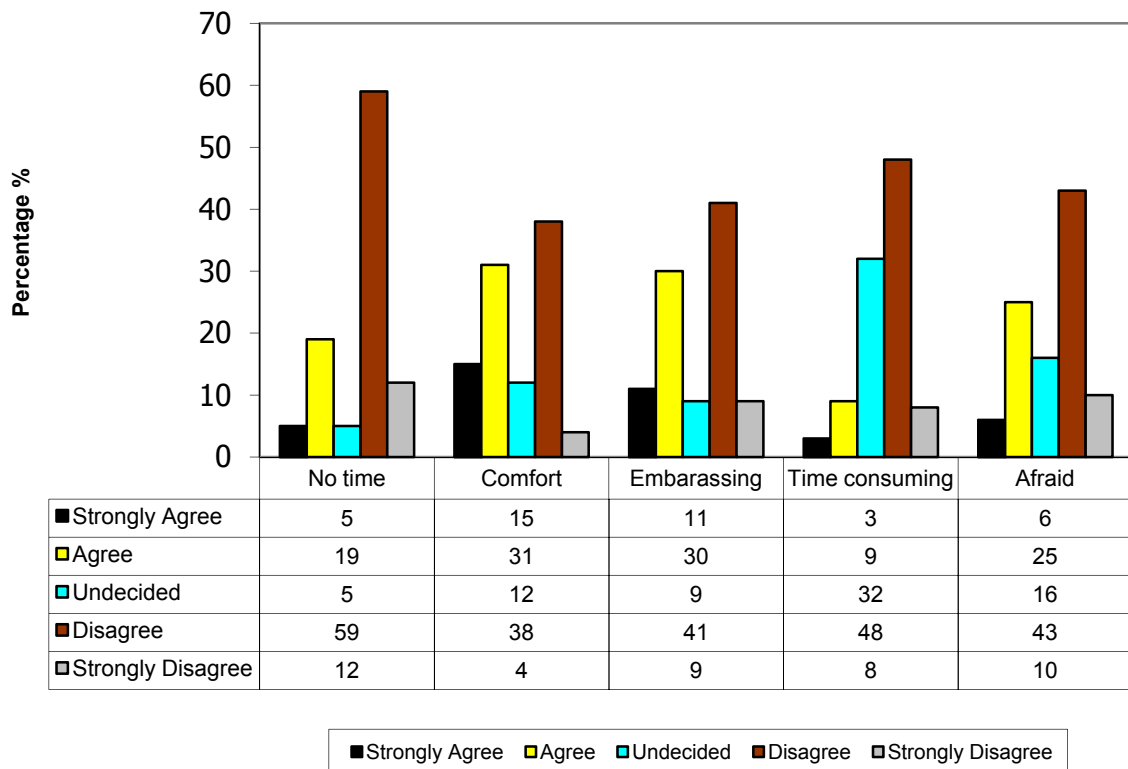


Fig 10 Participants' Attitudes regarding Barriers to Pap test

Although higher levels of education was cited by Arevian et al (1997),and Soskolone et al (2006) as making a difference to the knowledge of breast and cervical cancer and screening, this may not always be the case, as Lala explains,

I am well educated with a graduate degree but still I didn't know information about these things. It is important to note that even though they may be highly educated they may not necessarily have accurate information or understanding about breast or cervical cancer.

Umm... it is a kind of fibroses or tumor that if not treated will end up in removing uterus or breast.... But really these all I know...

According to the survey around 59% of the participants are highly educated and have completed their undergraduate or graduate studies which support Lala's views about the relationship between education and good knowledge about breast and cervical cancer and screenings.

Through my interviews it is clear that many of the women were very interested in this topic. All participants expressed opinions that women need to increase their awareness and knowledge about breast and cervical cancer and screening of these cancers. They expressed their desire to get informed of the risk factors, stages of the disease, and procedures, as well as treatments and screening.

The fatalistic view of cancer is often augmented by the frightening prospect of mutilation of the body as its treatment. According to Remennick (2006) fear of and lack of knowledge about cancer treatment is common in many low resource countries or in cases where this is the only option for treatment. In the same vein Bener et al (2002) mentioned that misconceptions about treatment may have discouraged women from screening and treatments.

Health care system

The health care system in itself presents a number of challenges for Arabic women to obtain screening. These include the gender of the physician, lack of care providers' recommendations to their patients to get screening and language, as well as confidentiality and trust issues.

“Doctors never told us”

My participants indicated they are not made aware of breast and cervical cancer and the importance of screening for these cancers. Participants feel their family doctors are not providing them with vital information or telling them to do cancer screening procedures. When I asked her about participating in screening, Zozo notes:

We go to the doctors for different problems but one seldom told us to come for Pap test or recommend a mammogram for us.

She adds,

I have been here for 5 years and I am 45 but my family doctor never talked with me about mammogram, Clinical Breast Examination and or Breast Self Examination. If he asked me to do it and gave me the request like the one for blood test I will go immediately.

This is the same idea that Lala insisted the family doctor never say anything. She adds,

I don't like this terrible topic, do you understand me? I don't like even thinking about it... Umm, I have kids and I do breast feeding so I don't need these kinds of screenings. [Anyway] ,even the family doctor never told about me about screening or any related tests.

Doctors' recommendations play an important role for women to go for screening. Physicians are reportedly not informing Arabic women about screening and its importance. According to my survey 90% of women had never had doctor recommendations for mammogram. This is not an uncommon barrier to screening. The literature reports this as the main reason women don't obtain screening (Matuk 1996; Rawl et al 2000; Quan et al, 2006). Specifically George (2000), in his integrative reviews on barriers to B.C screening pointed out that in 8 out of 13 studies lack of physicians' recommendation is the major barrier for not having screening. This is consistent with (Azaiza & Cohen, 2006; Shirazi et al, 2006; Soskolone, 2006) who found that the most powerful factor related to screening was getting a recommendation from health care providers.

Bebe who has been in Canada for several years has never gone for a mammogram. She explains:

I have been here for 14 years and I am 60 years old, I had never had a mammogram or CBE. You know, the family doctor never talked about these with me.

I asked her if she had ever had Pap test. She replied:

Yes, I go for Pap test yearly as I have problem so yearly they take sample, but I never heard of breast screening.

In the survey there was a question after the recommendation question asking about the reason for their physician's recommendations. Most of the participants mentioned that it should be changed to reason for screening as they never had recommendation.

On the other hand, Nena has a different point of view. She says,

I do Pap test regularly but for mammogram I went once but I stopped, you know nobody told me or even the doctor asked me to go for it. [Pause...] I will tell you, I heard that x-rays and radiations from mammograms increase the chance of getting breast cancer [so] for this reason I do not like to go.

Warda mentions that:

No, I have never thought about doing these screenings and even my family doctor never recommended it for me, may be because I am still young, [laugh].

Maha: But you have kids?

Yes, I have been married for 5 years and I am only 22, so I am young.

In the survey 6% of the respondents related the reason for not having a Pap test to the fact that they are younger even though they are married for a couple of years or more and they were older than 22 years. This shows the poor knowledge regarding screening practice among my survey respondents and interviewees.

Family doctors should be aware of the necessity of encouraging women to go for screening and the need to increase their patients' awareness about breast cancer and cervical cancer. Throughout my interviews all women agreed that they will seek help from family doctors as they trust the information that they are provided with.

Shared Responsibilities

According to the interviews with my research participants it was clear that both the women and the health care providers have shared responsibilities. Women are responsible for seeking health care including breast and cervical cancer screening. Doctors are also responsible for giving advice and encouragement for women to seek health care and to remind them and talk to them about these cancer screening tests.

Zozo reinforces this point,

Yes, it is up to us, but the family doctor is responsible too. The family doctors have to pay attention to their patients and send them to these examinations. If the doctors don't pay attention and don't tell the women then the women wouldn't know. It is very important to encourage the Arabic women and to tell them what to do.

However, some women might not want to talk about or perform breast and cervical examinations. This is consistent with what Lala feels, which she asserts is all the more reason for the doctor to insist on cancer screenings, especially with their patients who are Arabic speaking women.

The Arabic women are very hesitant to go for these kinds of examinations. If the doctors don't insist to have it done, they would not have it done. So the truth is with these kinds of examinations, the doctors need to encourage the women and tell them what to do. The doctors have to tell the women about it because many women, like me would not know where to go for screening or who to talk to. So we need doctors' help.

Motivating women to take care of their health is a shared responsibility, a collaborative process that would only work if women and their physicians are willing to take part. Bebe explains this by saying:

The mentality of the Arabic women is that, they don't want to go for these kinds of examinations. They are very hesitant, embarrassed and afraid of the results after examination. When it comes to breast and cervical examination, I think that the family doctor should push more and motivate the Arabic women to go for these tests.

The low participation in preventive cancer screening by Arabic women is related in part to their lack of awareness of the cancers, the preventive methods, the treatment options, etc. The health care providers can play an important role by reminding women to go for screening as well as providing them educational material about breast and cervical screening. Nena supported this point by saying:

Breast and cervical cancer and screening are one of the closed topics among Arabic women. Low awareness about this disease and fear from them lead to lower participation, in screening for example, many women, and I am one of them, to have no knowledge and information about this terrible disease. There comes the role of family doctors by recommending screening for these Arabic women, and talk with them about the breast and cervical cancer it self.

Traditional thinking in the faith and the position of the doctors play a big role in women's uneasiness with these examinations. Warda feels that women's embarrassment can be overcome if the family doctors take initiative to encourage the women to have breast and cervical examinations. She explains:

I can't ask my doctor about these things. I will wait for the doctor to take the initiative of that.

“A female doctor is better”

The women in my study perceived the gender of the health care provider to be a critical issue. Most women preferred a female health care provider to address women's health issues. The survey shows that 80% of the participant had a female doctor. Even if women have a male doctor they prefer to go to a female physician for women issues. Most participants felt more comfortable with a female provider.

Zozo explain this,

Female issues are completely different. If I have a fever, no problem to see a male doctor.

Zozo goes on to say that embarrassment and modesty issues were often concerns for screening if the physician is a male. Another participant, Lala, comments,

If I went for screening and a male provider is there, I will not go for it, like forget it. Yeah, yeah, you can't ask these sensitive questions to a male.

For these women shame and modesty is worse than the disease and death. Arabic women prefer not to go or visit women's health clinics unless they are staffed by women (Remennick, 2006; Bener et al, 2006). Nena and Bebe have the same idea about the importance of a female doctor or health provider especially with this issue. Nena's comment is:

You can't expose yourself to foreign men, Oh yes this is very clear in our religion and culture as long as there are female provider why do I need to do this? Yes I can't imagine myself like this in front of a man other than my husband.

Warda added to this important comment:

I can ask her any question and she can encourage me as a woman to go for screening. In most cases, the female health care provider has been found to be the preferred source for information about breast and cervical cancer screening because women feel more comfortable in asking questions.

Thus the female providers have a vital role in increasing women's awareness of early detection and providing adequate information about screening. The issue of modesty is highly valued and since the women were not comfortable with talking about breasts or sexual matters they may avoid screening. This is finding reinforced in other studies (e.g. Rajarm & Rashidi, 1998, 1998; Matin & LeBaron, 2004). The presence of the female doctor can play an important role in increasing women's awareness of early detection and providing adequate information about these issues.

First language of physicians

Language is a concern for many women, but participants' views differ on which physician is preferred, one who speaks English as a first language or one who speaks Arabic as a first language. In some cases a physician from outside the Arabic speaking community is better, because of issues of trust and confidentiality. One participant, Warda says:

I prefer an outsider physician. The Arabic community is a small and close where everyone knows one another. For me language is a barrier but interpreters are good in these cases. I think the interpreter is aware of privacy and confidentiality issues.

Warda continues:

I would prefer Canadian one because I will not be embarrassed to discuss with her this sensitive issue. Moreover, I may need to tell her some private information and the Arabic doctor I could see her in any Arabic event or gathering but the Canadian I will never see her again and she will never know my husband. [Pause] I am afraid that the Arabic doctor would talk about my situation with others even not on purpose.

On the same vein another participant has a different idea. Nena explains:

My English is not good and many women even may not be able to speak English at all or not well enough to use a mainstream physician without an interpreter. [But] using an interpreter for such private health concern is difficult.

Bebe's idea clashes with Nena's comment as she says:

The Arabic doctor is the best, because of the language but she should be honest and respect privacy and confidentiality of the patients, I can discuss every single issue with her easily. The Canadian doctor tries to understand my broken English. I don't prefer interpreters as I feel that they are not well trained to convey complete messages.

Even with the difficulties of language women were not necessarily comfortable to see an Arabic speaking physician. Issues of trust, confidentiality are cited as barriers to seeing first language (Arabic) physicians. Zozo has concerns about interpreter. She remarks,

Language is very important. If you do not know the language, you can't understand what is going on. In addition, if you do not know the language you need interpreter and this issue is very private and confidential and I do not know if the interpret would respect this or not and the next day all the community know everything.

She says she would prefer an Arabic female doctor and continued saying:

If she is not going to talk about this to our community then I would prefer the Arabic doctor because it is easy to explain everything in my language.

Lala's view agrees with Zozo's and Bebe's about preferring a female Arabic speaking doctor, she explains:

It's not easy to find a female Arabic doctor; I think there are only two physicians who are serving this large Arabic group. Female Arabic physician is a desire as she knows my culture and language... but where is she?

Lipsom & Omidian (1997, cited in MacKinnon & Howard, 2000) mention that inadequate English interferes with identifying appropriate sources for care and understanding verbal and written instruction. Interpreters are not always available and sometimes women are expected to find their own which is discouraging. Finding someone who has the time and skills is difficult and we cannot forget the privacy issues (Mackinnon & Howard, 2000). Moreover, Mackinnon and Howard (2000) mention that interpreters do not necessarily act as clarifier if the patient does not understand but as a cultural broker if a cultural issue blocks communication between patients and health providers.

Otero- Sabgal et al (2004) stress that to provide better service for immigrant and non-English speaking communities, the health care services must include interpretation services and multicultural staff. In addition, training staff to be culturally sensitive to patients' needs, as well as providing educational material that are culturally appropriate in their language are also required.

Strategies to reach women

Arabic women prefer not to go for screening for different reasons. These include fears about the test results, lack of awareness and language barrier. The challenges of providing culturally appropriate and accessible service to Arabic speaking immigrant women are numerous. Participants mentioned a variety of different ways and strategies to reach Arabic women so as to increase their participation in screening. Warda explains:

Request from family doctor is the main thing that forces Arabic women to go for screening. The family doctor can ask women to do it and then can make workshops to increase the awareness of these women at the community site or at clinic. At these workshops they can give women information about prevention and treatment. The more you know mean you will go for screening.

Zozo agrees with Warda when she says:

It is important to make intensive awareness because it will increase women care about screening as the disease spread and everyday you hear some one has this disease, God protect us. So women should think seriously about screening. Fear from the disease may force women to do screening. Educational programs, information regarding prevention, treatment and symptoms all these will force me to go for screening. I think awareness is not enough .The family doctors' clinic it has a very important role in increasing women awareness about screening also if there is a nurse at family doctor clinic who can teach us about BSE.

She adds:

The family doctor asks me to do the test in the same way as he/she asks for blood test. For example if he ask me and gave me the request this will force me to do the test.

Bebe agrees with them and she also focused on a very important point: about communicating with the Arabic speaking community and education through informal means.

Word – of mouth, in the Arabic community if you tell one person, everybody will be informed. Yes even if one lady has all the information, she will explain and inform a few more then all the community can learn. Moreover, the most important thing to increase women awareness and participation in screening is by affording “First language resource material”. Yes the written materials were necessary especially in Arabic language. Also this information should be placed at doctor’s office.

Word of mouth is found to be an effective communication approach for many ethnic communities, who rely on the experience of others (Kar, Rina & Shana, 2001, cited in Poureslami, David, Rootman, Nicol & Balka, 2007).

Indeed, in my study many women expressed an easiness to know more about breast and cervical cancer and screening, and their desire for knowledge and actions that would increase the ways in which information is disseminated and thereby increase the practices of women’s cancer screening. Nena agrees with them adding,

For example having conferences and workshops to increase the awareness will encourage women to go for screening. Oh, yes information about the number of

cases and the cure specially information regarding risk factors and health in general. I think it is important to tell about the spread of the disease. In addition, to reduce the long time between the tests, and care about follow up. For example after I did the mammogram in two years in a row no body called me and I did not care about going. Also the places where you go for screening should be in different parts in Halifax to make it easier for women.

Lala stresses the importance of raising awareness and says:

Yes, awareness is very important so women can care about screening. For example I have a graduate degree but I don't think I am aware enough about this disease. We need information about the percentages of cancer cases and the cured ones, and how it is related to culture and religion do you understand me? [Pause]... I want to say for example in our country we never heard that a lot of women diagnosed with breast or cervical cancer like here. So if they told us that cancer is related to the environment, food or anything else this may encourage me to go for screening. I want to add something. If I have information about risk factors I may go for screening because all I know it is related to I giving birth and marriage.

From the survey various methods were recommended by participants to reach women in the Arabic community with information related to this topic. The best approaches were health education in the community, in the clinic site and the TV, as shown in the following diagrams. The question in the survey was: What do you think the best approaches to communicate information about breast and cervical cancer and screening services to people with a background like yours? Write a number beside each one in order of most important (1) to least important (7).

- TV
- Radio
- Magazine
- Internet
- E-mail

- Health education in clinic site
- Health education in your community

Best Approach to communicate information on breast and cervical cancer

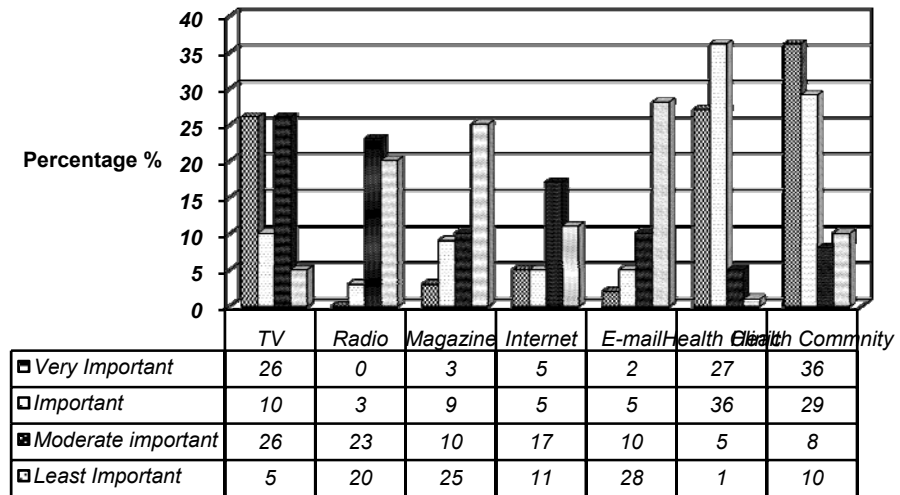
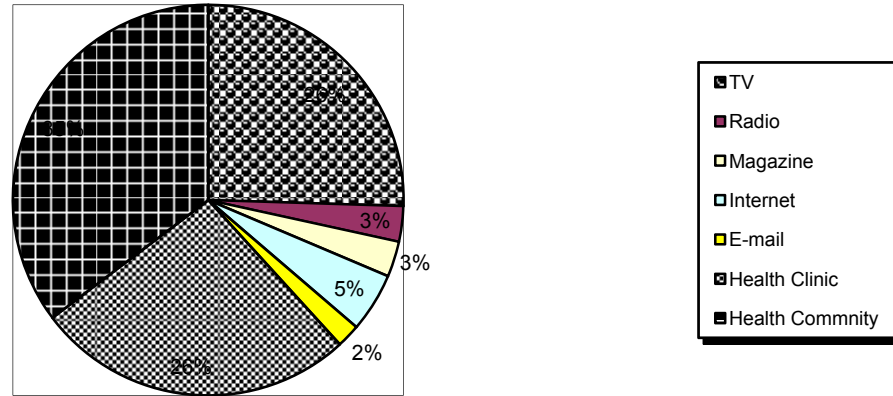


Fig11 Participants' response to best approach to communicate information on breast and cervical cancer

Fig 12 A Pie Chart for Best Approach

Best Approach for Information on Breast and Cervical cancer



There is a hunger for knowledge among women in this community and a need to have safe and comfortable environments to discuss these types of issues. Word of mouth and information networking by using peers either volunteer or paid can be an effective way for reaching women with important health information.

Poureslami et al (2007) suggest that easy access to information is possible through means of culturally relevant videos. These videos can be made in the language of targeted group using community members as actors. Trusted, well educated individuals would be helpful for dissemination of health information. Moreover, Remennick (2006) mentions that training community outreach workers- lay women who could spread the message of screening and educate other women about cancer. In addition, Holt, Kyles, Wiehagen & Casey (2003) mention an important way of providing health information for African American women. Holt and his colleagues point out that spirituality/ religiosity play an important role in the lives and cultures of African American women so educating authority religious figures about breast cancer and the benefits of early detection can help in encouraging these women to go for screening.

“No need to open the closed door”

Arabic women believe that as long as they have no symptoms it is not necessary and sometimes inappropriate to seek medical assistance and go for screening. This lack of awareness about cancer prevention is the main reason for a low participation rate in screening. Arabic women tend to ignore themselves and put her needs behind the needs of others. Family particularly children and husbands and community events all come first then her needs tend to come last. As Brook(2000) mentioned it is no secret that women often place the needs of others before their own.

Lala comments:

For many years, women in my country survived without these test. If I am sick or have a problem then I can go to see the doctor. So I am fine. Why I go to search for a problem?

Warda’s comments are consistent with those of Lala’s:

My body is perfect and I don’t complain from anything .Why I go to open this closed doors?

Zozo’s story about her friend supports this view of a “closed door”. After a long silence, she says,

You know my friend had nothing and she was good. She went to do some tests and she is diagnosed with this terrible disease... [Crying]... her whole life changed now when you see her you can’t recognize her. Yes, yes it is better not to open this door.

Partly due to the fear of mutilation of the body, many women are terrified by cancer treatments which are kind of endless suffering. This fear is more common among those who have observed others close to them being treated with surgery, radiation therapy & chemotherapy which have serious adverse effects such as edema, nausea, hair loss, weakness and weight loss (Remennick, 2006).

Bebe has a different point of view which clashes with the others:

I know fear from this terrible disease prevent[s] women from going for screening but we know that prevention is better than treatment and it is easy to do a lot of things at the beginning. So women should be encouraged to go for screening to check her body.

Nena's comment is interesting. She explains:

For Arabic women cancer is the "death sentence" which prevents them from going for screening. Women are worried about the results which make them say no need to go and open this closed door. They usually say; if I have something bad it will appear why do I go and search for the problem?

These women view cancer testing as looking for trouble. This is similar to finding by (Rajarm & Rashidi, 1998; Remennick, 2006). The fears from the disease and lack of knowledge are the main reasons why these women prefer to keep the door closed. This self neglect does not necessarily reflect ignorance, as many women are aware of breast cancer risks, rather it reflects social disadvantage augmented by negative emotional reactions to cancer.

Factors that influence decisions about screening practices

Cultural Factors

Different factors influence Arabic women's decisions about going or not going for screening and thus are related to the delay in seeking help for breast and cervical screening. These factors could be related to cultural factors or other factors such as a lack of knowledge, fear and social influence as well as the language deficiencies. Understanding factors related to delay in seeking help among Arabic women would help in developing programs that would increase screening behaviour among Arabic women. According to Bebe,

Health is important, culture has no effect.

Lala's remarks are consistent with Bebe's, as she explains,

I think cultural factor would play an important role for older women like my mother's age. For this new generation they do not care about these issues.

For Warda it is different. She states,

My role in the family and responsibilities to my family make me hesitant and try to forget about screening. I am afraid if something bad in result this will affect my family and even my relationship with my husband will be affected.

Zozo agrees with Warda by saying,

My responsibility to my family that I play an important role and my husband is not here with us what I do if I diagnosed with this terrible disease? [Pause]. Our whole life will be different so it is better not to open this door. Traditionally, if my husband family knew that I have this scary disease our relationship would be affected. I think if a man is young his family would force him to marry another woman to have children but he can keep his older wife but this depends mainly on his character. Moreover, women in our culture do not like to go for screening so women would not talk about her and this disease in any single occasion. It is the first sign of death.

In the Arabic culture women's social status is totally dependent on their roles as wives, mothers and housekeepers and their importance in society comes from their ability to provide service to others. As Remennick (2006) mentions serious disease and cancer may prevent women from performing these roles and therefore they would become more dependent on others for help and care. This means they need to depend on men, who often are unable or unwilling to be depended on for playing these roles; therefore they may look for another wife.

Social Factors

As mentioned above whenever my research participants took the survey to fill it out and/or if they heard or read the phrase "breast or cervical cancer" they repeated "Ya Lateef, Ya Lateef." which has one of the names for God and means 'God be kind to me and prevent this danger from happening to me'. It could also be used as a prayer.

My participants' misunderstandings about cancer lead to lack of motivation to go for screening and this is explained by these women in the interviews.

Bebe:

Fear and worry [come] from the disease [as] it is the disease with no cure - "the disease of death". Moreover, screening will discover and show the appearance of this terrible disease and this will end in a tragedy in the family, when you hear the word "cancer" you say "God protect us".

Lala agrees with Bebe and says:

The most important factor you know when we hear "this terrible thing" we usually get scared. Yeah, I remember this idiom, "The one who is afraid from the

monster can see it” As we get scared from the disease we try to avoid this [Pause] please no need to open this closed door.

Warda agrees with them as it's the first sign of death and their fear from the results, she explains:

This disease has no cure it is the first sign of death. We usually prefer not to go for screening as we are afraid from the results.

Zozo explains this participation of cancer as shameful in her remarks:

These misunderstandings about cancer as taboo with no cure prevent us to go for this kind of tests. Why would I go to hear such bad things and go for the non ending circle of chemotherapy? I don't need to know this bad thing. I know a friend of mine she refused to tell anyone that she has breast cancer. She did not want to admit that she had the disease. She said people will start to look at her differently.

This fatalist view of cancer is similar to the findings of a study by Thomas et al (2005) among Black minority groups who associate cancer with death.

Religious Factors

Arabic women believe in fatalism what is called in Arabic “Al Qada'a wa Al-Qader.” This means no one has control over disease/life or death; however one should take care of one's body. Bebe explain this:

Yes, we believe that we will get what ever God wrote for us you know this wisdom “what is written on the forehead your eyes will see it” but we have to remember that God created the disease and who associate cancer with death helped people to discover the treatment for it [So] we have to be careful before we got the disease.

She adds,

According to religion women has to [ask to be excused] from her husband before she goes any where. That means she has to tell him and get his permission before she goes for screening, and he is not going to refuse for her to go for screening.

The comments of another participant, Lala was consistent with what Bebe mentioned. She explains:

We believe in “Al Qada’a’ wa Al- Qadar” but our religion asked us to look for the causes. You know if we follow our religion it will be great. According to our religion we have to care about causes and reasons. Therefore, it is a kind of awareness and culture which affect us not religion. Umm...I will tell you , in our religion women can’t go anywhere without getting permission from her husband so some women prefer not to go for screening as they are afraid from the “result”.

She continues:

Wait, wait I will explain more, women think if she wants to take the permission to open this closed door, and she may be diagnosed with cancer. Then her husband could marry another woman. You know polygamy is allowed in our religion [Laugh]. For example if she had breast cancer and did mastectomy he will say I need a woman who has breasts. Or, if she had cervical cancer and they removed her uterus he will say I need kids. This could be a reason for him to marry another woman, so why would these women bring problems to themselves?

This is consistent with findings of Smith et al (2001) who analyzed the barriers to cancer screening and one of these barriers was the decision making process. Smith et al note that this is common for all cultures studied.

Warda adds another point:

Yes, I believe that everything is from God but our religions ask us to go for treatment and prevention. Modesty is an issue and it is sometimes the reason for not going for screening. For example if I went for screening and I found that a male is going to do it I will go back with out doing screening.

Zozo supports Warda’s idea and says:

Yes, a female doctor is important to do the test. I can’t expose my body to a foreign man, you know modesty issue. To go for the test I have to take permission from my husband from a religious point of view. The main reason that would influence my decision is if there is no woman to do the test

Nena agrees with both Warda and Zozo:

Yes, modesty is an issue but I think most of nurses who do mammogram are women. I believe in God and I know that if I am going to get something there is no

worry I will get it... but we have to go for screening as kind of protection. Umm... you know this idiom "prevention is better than treatment." Yes, I have to tell my husband that I am going for the test, not take permission to go.

This fatalistic attitude towards cancer is common in Middle Eastern cultures as noted in a study done by Arevian, Nouredine & Kabakian (2007). Arevian and colleagues studied attitudes of Lebanese /American women towards cervical cancer screening. Arevian et al mentioned that one of the major barriers for these women not to undergo screening is their fatalistic attitudes.

Language Factors

The inability to communicate in English creates often hinder accessing health care and in particular preventive health care. Limited language skills come with other problems such as finding a trusted translator for such private issues. Bebe makes this concern very clear when she says,

Language is a major barrier for women to go for screening or look for information. Even interpreters sometimes are not qualified for the job.

Lala considers language as a minor factor and says:

Yes, language is a factor. If that woman has awareness she will go and find some one to translate for her. So language is a minor factor if we have awareness.

For Warda interpreters can help her with the language. She elaborates,

Language is a barrier but interpreters are good in these cases. Finding a translator is difficult, not only should this but the interpreter be aware of privacy and confidentiality issues.

Nena agrees with Warda:

Sometimes communications is a problem and may feel uncomfortable with the presence of the interpreter. But what I can do if I can't communicate?... Umm... the interpreter should respect the privacy of the patient.

Zozo expressed a concern regarding the presence of interpreters:

Language is very important. If you do not know the language, you can't understand what is going on. So if the brochure is in Arabic this is very good. In addition, if you do not know the language you need interpretation and this issue is

very private and confidential and I do not know if the interpreter would respect this or not and the next day all the community know everything.

Most of the information on breast and cervical cancer and their screening programs is written in English, which many of the Arabic women in my study cannot understand. Thus limited language skills coupled with low funding for translator services is a direct barrier to accessing health care service, in particular breast and cervical cancer screening programs for these immigrant women. Language as a barrier related to screening and understanding of the complex referral system was identified in this study. This echoes the findings in earlier research that report lower screening rates due to language difficulties (Ahmed et al, 2002; Woloshin et al 1999; Jacobs et al, 2005; Remennik, 2006).

Chapter Six

Conclusion and Recommendations

Through my Adult education program I have come to understand that adult education is a chance for people to improve their situation in life, whether on a personal, career-related or social level or all three simultaneously. As an adult learner and educator who is inspired by Freire's ideas of raising consciousness and education for emancipation and empowerment of oppressed people I became interested in this topic as I was determined to find ways to empower a specific group of immigrant women and give them the chance so their voices can be heard. Through my study I explored the knowledge, beliefs, attitudes and perceptions of Arabic speaking immigrant women living in Halifax, N.S toward breast and cervical cancer and screening. In this chapter I will focus the discussion on issues related to my research purpose. I will discuss the contextual factors influence Arabic speaking women decision making regarding breast and cervical cancer screening. In addition I will elaborate on some of the challenges and barriers that prevent Arabic speaking women in accessing the available health resource in particular screening. In doing so, my aims are to illustrate clearly the key factors that affect Arabic speaking women's decisions to engage in breast and cervical cancer screening and to make clear where the problems lie. To support the women's health care practices and participation in cancer preventive programs, I will recommend strategies to remove identified barriers.

Based on the findings of this research I conclude that the women's decision to engage in preventative breast and cervical cancer screening is influenced by many factors. The factors that determine if and how Arabic speaking women practice screening are cultural, social, religious, as well as their level of health knowledge and English language skills.

The first stage of decision making is the participants' understanding that there is a risk to their health and well-being if they do not detect cancer cells in the early stages. In general there are no physical symptoms of breast and cervical cancer in their early stages (Canadian Cancer Statistics, 2006). Thus providing clear and accessible information about breast and cervical cancer, its prevention and need for early detection through screening would impact women's recognition of these potential health threats by

increasing their awareness, which in turn, might increase their willingness and motivation to go for screening.

Any breast or cervical cancer public awareness program must reinforce the perceptions that lead to good screening practices and alter those that discourage a lack of such practice. For example, the realistic fears and concerns about cancer expressed by these women should be recognized and brought into discussion in a non threatening and supportive manner to encourage women to go for screening. Health promotion messages must be tailored to the strong faith of these women and should support the Arabic culture and the religious concepts that God wishes people to take responsibility for themselves. In Arabic countries we have a long tradition of personal transformation that come primarily through church and mosque (Barakat, 1993). Spiritually and religiosity play important roles in the lives and cultures of my research participants. Educating relevant religious and cultural authorities who advise women on moral matters can play an important role in delivering information to Arabic speaking women about breast and cancer and the benefits of early detection. Remennick (2006) mentioned that studies have shown network of church activists has encouraged older African American women to go for a mammogram. Within a spiritual framework with the participation of an African American church a booklet on early detection was developed.

Providing simple straight forward information can encourage women to go for screening, such as information about the ability of the screening to detect abnormalities and the wide success of treatment for the early stages of breast and cervical cancer where early detection can increase the chance of cure to 95% (Canadian Cancer Statistics, 2006). Educational material should also include not only information about cancer testing, but also about breast and cervical cancer itself, its treatment and the success rate of these treatments. These include contemporary cancer therapies, especially breast conserving surgery in the case of a positive result. Additionally, it is imperative that screenings be done with the consideration of the women's cultural backgrounds so that a female doctor will do the screening, and if the woman needs interpretation a female Arabic speaking interpreter can be available and that their confidentiality and privacy be discussed and ensured. Information such as this may encourage Arabic speaking women

to go for screening. The provision of comfortable, supportive settings for screening would also be helpful.

Lack of health information and promotional materials about cancer screening in Arabic and other languages and in appropriate formats that is culturally acceptable is another significant factor. In addition, the information in some of the materials is not sufficient or does not answer the concerns of immigrant women, as Nena explains;

My English level is good so I can read the brochures but it does not give me all the information I need. For example, I want to know if I have this disease (Ya Lateef) how the treatment is going to be and is there a chance for cure.

She adds:

I need to know how my cultural background is going to be respected during screening and all other processes.

The participants insist that the brochures should be in Arabic and in a simple language with some pictures or illustrations to make things more clear.

Health care providers need to be not only aware that there are cultural differences, but they also need to educate themselves as to what these differences are. There is a pressing need to develop culturally competence education programs for health care providers so they can deliver optimal care to all patients and enhance immigrant women's access to health (Kramer & Balteman 1999 and Ferran, Tracy, Grany & Kramer). The pre-migration experience of immigrant women can be addressed in this health education programs (Weerasinghe & Mitchell 2007). This will enhance the relationship between health care providers and clients leading to more access to health care.

The Arabic speaking women in my study often cannot accurately access the available resources. Many experience difficulty because of language barriers, inaccessible health information, unfamiliarity with the health care system and a lack of understanding of the health services available for them. Although there are health programs available, these programs do not provide services in such a way that can be easily accessed by Arabic speaking women. For example one of the participants Warda expressed a lack of knowledge about how to gain access to screening. She says:

There is lots of help and things available but we don't know about it, like screening, because you have to remember where we are coming from, where preventive care as screening is only requested under certain conditions.

As Miles (1998) has noted, women's empowerment requires a general shift towards life-centered values and social organization, at the same time, this shift requires the empowerment of women. Empowerment has to occur at the individual level where person develop a sense of herself as confident and effective to improve their lives and bring social change. Spencer (1998) mentioned that in the words of Lindeman, adult education is social, not just social in its process but social in its purpose. This could be done by educating women about how to navigate the complete health system and how to benefit from the available service. I think if health educators try to teach and address women individually which involve awareness or conceptual understanding of self. As Scott (1998) mentioned Freire shows us that changing individual has massive connotation for social change. This change will have implication on the future generation which will result in making screening as a normal behavior.

For Arabic speaking women there are number of barriers to accessing information about breast and cervical cancer and screening. One of the barriers is that many of the women have other priorities in their lives and so their preventive health is way down on their list of priorities. As Brooks (2000) mentioned it is no secret that women often place the needs of others before their own. Arabic speaking women put their children's needs on the top of their list of health priorities. If her kids are sick she will run to the doctor but she will rarely think to go for herself in case she cannot perform her household duties. It is important for health care providers to recognize that this practice should not be viewed as the women's lack of interest or sense of self, but rather such an approach may be strengthening and may be a strong foundation from which to approach a somewhat hostile world. Therefore, physicians could get the advantages of having these mothers coming to their office with their children and at those times remind them to come back for their screening or Pap tests. In addition, women who visit hospitals with their children health care providers can do the same thing or at the very least give them brochures about cancer screening.

As Bell Hooks (2000) suggests:

Feminist activists need to affirm the importance of family as a kinship structure that can sustain and nourish people; to graphically address links between sexist oppression and family disintegration; and to give examples, both actual and visionary, of the way family life is and can be when unjust authoritarian rule is replaced with an ethic of communalism, shared responsibility, and mutuality. The movement to end sexist oppression is the only social-change movement that will strengthen and sustain family life in all households. (p.40)

The rules and roles accompanying gendered power relations are deeply established in our cultures that are not questioned by people. As Bierema (2003) mentioned many women and men never experience this level of awareness instead functions in state of gender unconsciousness where they neither question the status nor work to change it.

Child care is an issue for women and Arabic speaking immigrant women are not different, so to have an information program that would allow women to attend information sessions and have their children in child care would encourage women to attend. One of my plans is to hold informal information sessions. These sessions could be held at different places and times. The sessions could be held at churches, mosques or other community centers. In these sessions we will organize safe play and entertainment for kids so women could attend and kids would have fun at the same time. Moreover, the session could be done in a way that health providers with the assistance of interpreters could do the sessions. I think if there is a drop in child care for a woman who has to go for medical appointments would be great, for example Young Men's Christian Association (YMCA) and other community organizations could help.

The most notable barrier was that these women are not receiving information about breast and cervical cancer and screening from their primary health care providers which is one of their main sources of health information. Participants also indicated that they would undergo screening if they received recommendations to do so from their family physicians. In addition, it would be great if posters in Arabic and English were available at physicians' offices and hospitals to encourage and remind women about early detections.

Adult education has evolved through efforts to assist people in their search for better quality of life. One of the basic concepts of andragogy is that adults learn differently

than children, they are more self directed with specific learning goals (MacKeracher, 2004). I agree with Elias and Merriam (1980) who identified that one of the philosophies of adult education is to raise consciousness and bring about change. The Women's Institute, National Farmer's Radio Forum, Antigonish Movement and the literacy basic education programs in Tanzania are all examples of education for social change (Spencer, 1998).

In this study, Arabic speaking immigrant women's lived experiences were emphasized as the most important component of analysis. My aim is not only to generate more accurate information of women's breast and cervical cancer and screening experiences, but also to improve their screening practices. Based on my research with Arabic speaking immigrant women I make the following recommendations.

Recommendations:

Based on my findings, breast and cervical cancer is a stigma in which Arabic culture found it hard to contact Arabic speaking women to talk to someone about her concerns. Therefore, a hot line or an automatic computerized answering machine which allows women to push a number on the phone to get various recorded messages, so women can ask questions without dealing with the person directly. The family physician can strongly recommend each of his/her female patients to have screening. Family physicians could send letters to remind women to have these tests done annually. This letter can be in both Arabic and English to address the language barriers.

There was a keen desire expressed by all the women to learn more about breast and cervical cancer and screening and obtain more information. They suggested education out-reach sessions at community sites or at clinics as a very good way for women to receive this information. To increase community awareness about the disease, both non-formal (i.e. Workshops, information sessions, distribution of pamphlets) and informal (i.e. word of mouth, discussions with peers) routes should be taken. I think to deliver an effective community awareness screening programs is by training community outreach workers laywomen from the same communities, who could spread the messages of breast and cervical screening and educate women in its basics. The laywomen can use social network to women in different events, assist Arabic speaking women in their social networks with resources and information regarding screening and early detection

information. Efforts involving lay outreach workers for AIDS and tuberculosis have similarly proved to be very successful among ethnic minorities in the United States as mentioned by Remennick (2006).

Providing readily available simple straight forward information can also decrease barriers and clarify any misconceptions about breast and cervical cancer screening. Health promotion and disease prevention strategies should focus on how to remove structural barriers that affect immigrant women's health care practice, for example limited program out reach and inadequate referrals and language barriers.

Adult learning theory is about acknowledging learners' past experiences and validating all types of learning and as adult educators we strive to nourish the love of learning in our students whether in a formal, non formal or informal context (Mackeracher, 2004). The learning environment is important for women. As adult learner, they prefer collaborative, cooperative and respectful environment. Women learn through connection to others as most women experience this through mother hood (Mackeracher, 2004). Educator must find comprehensive solutions in order to address the specific problems faced by this group. One such solution could be to have a female health educator come to the women's circle to teach these women techniques of BSE including practice on breast models, the importance of doing screening and counseling on cancer prevention habits. The women's circle or gathering is something similar to study a circle which is an idea of learning together in a circle which is an ancient tradition in many cultures (Andrews, 2002). Usually starts with a religious lesson and after that many issues related to daily life are discussed as well as the programs offered at library or any other places.

Women's circles or gathering is something similar to study circles which are an idea of learning together in a circle which is an ancient tradition in many cultures (Andrews, 2002). The structure of the circle is always fosters collaboration, inclusion, respect and participation. Study circles are not difficult to adapt various topics and diverse interest of participants. In this gathering, women get together and share their stories and worries about the future it is a place where they feel united (Zaman, 1999).

Another idea is to have classes at Metropolis Immigrant Service Association (MISA) or YMCA in Halifax where they can have women conversation groups and the

best way is to include talking about these issues in ESL classes. For example, they could have different topic to talk about each week, they could divide the classroom into two groups of there were men to be more effective. This type of education could include use of Arabic language videotapes tailored to address specific fears Arabic speaking women might have about breast and cervical cancer and screening and misconceptions about prognosis. Drama and story telling could be incorporated as in the Arabic culture drama plays an important role in making a change of the lives of many women (Huraiz, 1991). For example media initiative to promote breast and cervical cancer screening among Vietnamese-American women in Alameda and Santa Clara Counties in northern California was used (Jenkins et al., 1999). In addition, a folder with all information regarding the importance of early detection, risks of cancer and frequently asked questions and answers could be given to each woman at the end of the session.

I feel that it is critical that educational strategies must ensure women receive this medical information and are exposed to education on cancer screening but men also must receive education on these important issues because they are also affected. It is important to increase men's awareness, not only because they play an important role in decision-making within the family, they are also affected by cancer whether it is the women/girls in their family who may develop cancer or whether it is the men themselves who may develop cancer.

One of the pedagogical teaching strategies that are recommended to foster an inclusive lifelong learning practices are using media literacy (Brigham, 2008). For example, in creating awareness of aging and ageism learning through media was one of the strategies used by educators (Barnett, 2006 cited in Brigham, 2008). Learning through media includes magazines, movies, television programs and internet as source of information the assist educating to create awareness of screening.

I think one of the educational tools that I am going to use is one of my research tools used in this study – the survey. When women filled out the survey they were so eager to know the answers for each question. Therefore, the survey can be used as educational tool to increase women's knowledge about breast and cervical cancer screening. This can be done at the information sessions with the help of a trained health care provider.

These health promotion and disease prevention strategies should place emphasis on the importance of women looking after their health not only family members as Nena suggests:

The doctors have to say why it is important to prevent the disease. They have to explain to women that even though looking after children and husband is important, mammograms and Pap tests are important too. These tests will help women live longer.

The participants' discourses regarding strategies to promote breast and cervical cancer screening among Arabic speaking women emphasized that both they themselves and their doctors have the responsibility to promote and practice cancer screening. The participants also want doctors to be more active in the promotion of these practices. They want doctors not simply to tell them to go for screening but to explain more about what breast and cervical cancer are, and why it is important to go for screening. In general, the women participants have a positive view regarding the Canadian institutions and governments, although they would like to see more support for recruitment and training for interpreters in medical terminology.

I think that health care providers should recognize that women of different ethno-cultural backgrounds are active clients of health care. They should recognize that women's health care decisions are influenced not only by their cultural knowledge and values but also by their socially constructed positions such as their race, gender and class. Health care providers need to recognize that what is considered as a reasonable act by them might be contrary to what is expected by Arabic speaking immigrant women. In providing health care to immigrant women the health care providers need to change their view of health care responsibility which might increase the accessibility to health and health care by the marginalized population. Arabic speaking immigrant women are a population of increasing number and importance, and future research should be done further to understand how to best address their health status. According to a 2001 census it was estimated that approximately 1,465 Arab/Middle Eastern women were residing in Halifax, making the second highest visible female minority in Nova Scotia after the Black population (Statistics Canada 2001 b).

Further, without having the stories of Arabic speaking immigrant women, the health system relies upon knowledge that may not adequately reflect the cultural determinants important to the health of this population. Understanding the core knowledge and values of others may change the way in which health care is provided (Weerasinghe & Mitchell, 2007). It is critical that health care providers hear the stories of Arabic speaking women, and that can be achieved through cultural competence educational programs. Having the marginalized women finding voices and telling their stories is the core center of Black Feminism (Hooks, 2000).

The promotion of breast cancer and cervical cancer screening among Arabic Canadian women should be aimed at several levels of intervention. Thus, my recommendations for future research include: (a) a wider population-based survey to assess the current status of Arabic Canadian women's breast and cervical cancer screening practices, and to investigate the factors that affect Arabic women's cancer screening practices; (b) the development and implementation of a health promotion and disease prevention program that incorporates the findings of this study into its promotional strategies; and (c) investigate into Arabic speaking women's relationships with physicians and the improvement of physician-patient relationships which are essential to successful promotional strategies for Arabic women; (d) investigate Arabic speaking men's health concerns, specifically their knowledge, beliefs and attitudes towards cancer that often affects men such as prostate cancer; and (e) investigate Arabic speaking men's experiences with women in their families who have cancer.

In summary I assert that Arabic-speaking women's breast and cervical cancer screening practices can be improved with the provision of effective high quality health care that is culturally appropriate and acceptable to immigrant women and with health care providers' understanding of Arabic women's lived experiences. Increasing accessibility to these cancer preventive programs demands that health care policy makers increase institutional funding to support programs that provide services to immigrant women.

It is essential for health educators who work with the Arabic speaking population to understand as much about Arabic culture and health beliefs as possible so that a safe and satisfying use of available resource can result. Furthermore, assisting Arabic

speaking immigrant women to better understand their health and increase their awareness can result in improved usage of preventive methods.

Epilogue

As I reflected back on the experience of conducting this research and writing this thesis I have several final points to make. The first point is that I have come to recognize the ways I have changed as a lifelong learner since I joined the Masters of Education program at Mount Saint Vincent University. My journey began when we planned to immigrate to Canada, where I was looking forward to doing a Doctoral Degree. I thought that it would be easy to do this with all my educational and teaching experience. Unfortunately, it was not easy to get to that step. I was asked to do many courses as a non degree student before doing a PhD. I started to search for a suitable program to study, it was then I found about the Adult Education program.

At the beginning it was very hard for me to deviate from Science to the Humanities, but I said to myself I had to continue for the sake of my purpose which at the time was to get a certificate from a Canadian Institution so I can get a job. Later on, the program inspired me to change my perspective and broaden my knowledge. I soon came to understand that the purpose of adult education is multifaceted. Now my goal as an adult educator is to help people and empower individuals towards social change.

As an adult educator I noticed that I triggered initiation of education in the minds of these women when I distributed the survey. They started to discuss and tell stories related to their experiences, knowledge, beliefs and perceptions towards breast and cervical cancer and screening. Later when I interviewed the women during my second phase of data collection, I noticed that they were asking for more information and demonstrating a willingness to learn. I think what this study did is like throwing a stone in a pond, it had a ripple effect, which makes me happy and gives me this enthusiasm to disseminate my findings, such as through information sessions in the Arabic speaking community to increase the awareness of Arabic speaking women towards breast and cervical cancer and screening.

The second point I would like to make is to provide suggestions for other researchers doing cross-cultural research. The complexity of the researcher's subjectivity as an insider / outsider is blurred. For me, although I am from the Arabic community, I can be considered an insider. At the same time moving to another culture and being

exposed to the mainstream “Canadian” culture give me the ability to see and discuss things differently so I can be labeled as an outsider. I think this requires awareness of how the researcher is perceived by the participants. Moreover, the researcher’s insights and reflections are important assets at all stages of the research which contribute to triangulation of data.

Another suggestion for researchers doing cross-cultural research is with regard to “Back Translation” (Brislin, 1970) which might be of value to researcher doing their data collection in one language and writing up the research in another language. Back translation means to retranslate the transcripts back to the original language used in the interview to compare the key aspects and to ensure that one gets the same information. This process contributes to validity of the data.

Finally, I recognize that while cancer is a taboo topic, attitudes are changing towards it all over the world. As the number of cancer cases are increasing in the Arabic world screening practices are also on the increase, although the procedures are usually expensive and are not covered by national medical insurance in Arab countries.

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Appendix A: Survey questions

Part I: Demographic questions

Please check the box that is relevant to you

1. What is your marital status?

- married separate divorced
 single widowed

2. Birth date : _____

3. Do you have any children? no yes

If you answered yes to question 3, please answer questions 4, 5 and 6 and continue answering the rest of the questions.

If you answered no, please go to question 7

4. How many? _____

5. How old were you when you had your first child? _____

6. How old were you when your last child was born? _____

7. In what country were you born? _____

8. In what year did you immigrate to Canada? _____

9. What language(s) do you speak most often at home? _____

10. Are you at presently: Employed Unemployed Retired
 Fulltime homemaker

11. What is your occupation? _____

12. Is your spouse/partner working outside the home? yes (full time)

yes (part time) no not applicable

13. What is the highest level of education you have obtained?

less than high school diploma high school diploma
 undergraduate degree graduate degree

14. What is your annual family income?

under \$20,000 under \$40,000 under \$60,000

15. Have you reached menopause? yes no

16. English proficiency:-

	Speaking	Reading
None:	_____	_____
Poor:	_____	_____
So-so:	_____	_____
Not bad:	_____	_____
Fluent:	_____	_____

17. What is the gender of your regular doctor?

male doctor female doctor

Part II : Breast cancer

Below you will find a series of questions. Please select one of the following responses, which best reflect your own personal opinion about each question.

1. The constant irritation of a tight bra over time can cause breast cancer.
 true false don't know
2. One out of every eight women in the Canada will get breast cancer some time during her life.
 true false don't know
3. In some women, being overweight increases the risk of developing breast cancer.
 true false don't know
4. A women who bears her first child after the age of 30 is more likely to develop breast cancer than a women are who bears her first child before the age of 30.
 true false don't know
5. Women with no known risk factors for breast cancer rarely get breast cancer.
 true false don't know
6. Some types of fibrocystic breast disease, non-cancerous breast lumps, increase a women's risk of breast cancer.

true false don't know

7. Women in Canada have a higher risk of breast cancer than women in Arabic countries.

true false don't know

8. Most breast lumps are cancerous.

true false don't know

9. Most breast lumps are found by

women physician mammogram

10. How much difference does regular breast cancer screening make in the chance of curing breast cancer?

a great deal some difference no difference

11. Breast cancer is more common in a 65-year-old woman than a 40 year old woman.

true false don't know

12. Mammography is recommended yearly for women over 40 years old.

true false don't know

13. Mammography can detect lumps that cannot be felt.

true false don't know

14. If I get a mammogram and nothing is found, I will not worry as much about breast cancer.

strongly agree agree undecided disagree strongly disagree

15. Having a mammogram will help me find breast lumps easily.

strongly agree agree undecided disagree strongly disagree

16. If I find lumps through my routine mammogram, my treatment for breast cancer may not be as bad as those who do not do regular mammogram.

strongly agree agree undecided disagree strongly disagree

17. Having a mammogram is the best way for me to find a very small lump in my breast.

strongly agree agree undecided disagree strongly disagree

18. Having a mammogram will decrease my chances of dying from breast cancer.

strongly agree agree undecided disagree strongly disagree

disagree

19. I have had a mammogram, an x-ray of each breast, to look for breast cancer.

yes

no

If you answered no to question 19, please answer questions 20 to 29 and continue to the rest of the questions.

If you answered yes, please go to question 30.

20. I am afraid to have a mammogram because I might find out something is wrong.

strongly agree

agree

undecided

disagree

strongly

disagree

21. I am afraid to have a mammogram because I do not understand what the mammogram procedure involves.

strongly agree

agree

undecided

disagree

strongly

disagree

22. I do not know how to go about getting a mammogram

strongly agree

agree

undecided

disagree

strongly

disagree

23. Having a mammogram is too embarrassing procedure.

strongly agree

agree

undecided

disagree

strongly

disagree

24. Having a mammogram takes too much time.

strongly agree

agree

undecided

disagree

strongly

disagree

25. Having a mammogram is too painful.

strongly agree

agree

undecided

disagree

strongly

disagree

26. Having a mammogram exposes me to unnecessary radiation.

strongly agree

agree

undecided

disagree

strongly

disagree

27. I have no time to schedule a mammogram.

strongly agree

agree

undecided

disagree

strongly

disagree

28. I have other problems that are more important.

strongly agree

agree

undecided

disagree

strongly

disagree

29. I have had a recommendation from my family doctor to get mammography.

yes

no

30a. If yes, the last time was

Less than six months ago

Six months to less than one year ago

One year to less than two years ago

Two years or more ago

30b. The reason why I had a mammogram was because of:

routine check up follow-up to problem other

31. Have you ever did BSE?

Yes No

32. Would you ever say you pravitice BSE?

Every 3 months monthly sometimes

33. Have you ever had CBE? (doctor or nurse examines the breast for unusual lumps through touch)

Yes No

Part III: Cervical Cancer

Below you will find a series of questions. Please select one of the following response, which best reflect your own personal opinion about each question.

1. I worry about getting cervical cancer.

never rarely occasionally fairly a lot

2. I believe the chance of me getting cervical cancer is.

no chance little chance some chance good chance

3. Do you think that according to your family history, you are more likely to get cervical cancer than most women are your age?

no chance little chance some chance good

4. If a woman develops cervical cancer, is it usually too late to get treatment to cure it, or do you think she still has a chance to do something about it?

no chance little chance some chance good chance

5. Being diagnosed with cervical cancer would have an effect on my sexual activity.

strongly agree agree undecided disagree strongly disagree

6. Do you think a woman who is diagnosed with cervical cancer has a chance of recovering from it?

no chance little chance some chance good chance

7. Do you think there is an action women can take to early-detect cervical cancer?

do not feel necessary

scarred of the procedure

not permitted according to the religion/culture

other (specify) _____

18b. If yes , when was your last Pap smear test

Less than six months ago

Six months to less than one year ago

One year to less than two years ago

Two years or more ago

19. I have had a recommendation from my family doctor to get a Pap test

yes

no

20. The reason (s) why I had a Pap test was because:

routine check up

follow-up to problem

other

21. How do you feel about having a Pap test?

comfortable

necessary/important

afraid

22. What do you think the best approaches to communicate information about breast and cervical

cancer and screening services to people with a background like yours? Write a number beside each one in order of most important (1) to least important (7).

• TV

• Radio

• Magazine

• Internet

• E-mail

• Health education in clinic site

- Health education in your community

Appendix A*

أسئلة عامة الجزء الأول

الرجاء وضع علامة أمام الاجابة المناسبة أدناه :-

1- الحالة الاجتماعية

- متزوجة منفصلة مطلقة
 أعزب أرملة

2- تاريخ الميلاد _____

- 3- هل لديك أطفال؟ نعم لا

إذا كانت اجابتك نعم للسؤال رقم 3 فضلا اجيبي على الاسئلة التالية
إذا كانت اجابتك لا فضلا اذهبي مباشرة لرقم 7

4- عدد الاطفال _____

5- كم كان عمرك عندما انجبت الطفل الاول؟ _____

6- كم كان عمرك عندما انجبت الطفل الاخير؟ _____

7- مكان الميلاد؟ _____

8- السنة التي هاجرتي فيها الى كندا؟ _____

9- ماهي اللغة المستخدمة ا في المنزل؟ _____

10- هل انت الان

- اعمل لا اعمل على المعاش ربة منزل

11- المهنة _____

- 12- هل الزوج يعمل؟ نعم لا

13- المستوى التعليمي .

اقل من الثانوية العامة الثانوية العامة

تعليم جامعي تعليم ما فوق الجامعي

14 الدخل الثانوي للأسرة: أقل من 20,000 دولار أقل من 40,000 دولار أقل من 60,000 دولار

15- هل وصلت الى سن اليأس؟ نعم لا

16 إتقان اللغة الانجليزية

المحادثة	القراءة
لا يوجد _____	لا يوجد _____
ضعيف _____	ضعيف _____
متوسط _____	متوسط _____
جيد _____	جيد _____
بطاقة _____	بطاقة _____

17 هل لديك طبيب عائلة؟ نعم لا

طبيب طبية

الجزء الثاني سرطان الثدي

لديك مجموعه من الاسئلة الرجاء اختيار الذي يمثل رأيك الشخصي لكل سؤال

1- الالم الذي يسببه لبس الصدرية الضيقه يؤدي الى سرطان الثدي

لا أعرف خطأ صح

2- نسبة الاصابة بسرطان الثدي لدي النساء في كندا واحدة في كل 8 سيدات

لا أعرف خطأ صح

3- زيادة الوزن لدي المرأة يزيد من معدل الاصابة بسرطان الثدي

لا أعرف خطأ صح

4- السيدة التي تنجب الطفل الاول بعد الثلاثين اكثر عرضة للسرطان من التي تنجب قبل الثلاثين

لا أعرف خطأ صح

5- النساء اللاتي لا تتوفر لديهن العوامل التي تزيد من احتمال زيادة نسبة الاصابه بسرطان الثدي نادرا ما يصابها السرطان

لا أعرف خطأ صح

6- إصابة المرأة ببعض الأورام الليفية الحميدة تزيد من احتمال تعرضها لسرطان الثدي

أعرف خطأ صح

7- النساء في كندا اكثر عرضة للاصابه بسرطان الثدي من النساء في الدول العربيه

أعرف خطأ صح

8- معظم الكتل في الصدر هي أورام سرطانيه

أعرف خطأ صح

9- معظم الكتل الصدريه يتم اكتشافها بواسطه

الطبيب النساء فحص الثدي بالأشعة

10- أجراء الفحص الدائم لسرطان الثدي يزيد من نسبة نجاح العلاج التام

يزيد النسبة بعض الشيء لا يؤثر

11- سرطان الثدي اكثر شيوعا لدي النساء ذات 65 عاما عنه لدي النساء ذات ال 40 عاما

لا أعرف خطأ صح

12- يوصي بأجراء الفحص الصدري بالأشعة سنويا للنساء فوق الأربعين

لا أعرف خطأ صح

13- بالأشعه يمكن اكتشاف الكتل التي لا يمكن اكتشافها بالفحص اليدوي

لا أعرف خطأ صح

14- إذا قمت بفحص الصدر بالأشعة ولم يوجد شئ لن اقلق من سرطان الثدي

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

15- القيام بالفحص بالأشعة يساعد في اكتشاف الكتل الصدريه بسهوله

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

16- اذا حدث و اكتشفت وجود كتل خلال القيام بالفحص الروتيني بالأشعة فان فرصه علاجي من سرطان الثدي ستكون أفضل من الذين لا يقومون بالفحص الدوري

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

17- أجراء الفحص بالأشعة للصدر هو افضل وسيله لاكتشاف الكتل الصدريه

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

18- الفحص بالأشعة للصدر يخفض من احتمال الوفاة بسرطان الثدي

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

19- سبق لي القيام بعمل فحص بالأشعة لكل ثدي علي حده للكشف عن سرطان الثدي

نعم لا

اذا كانت اجابتك لا للسؤال 19 الرجاء الاجابه على جميع الاسئله التاليه
اذا كانت اجابتك نعم للسؤال 19 الرجاء الذهاب مباشرة الى السؤال رقم 30

20- اشعر بالخوف من القيام بالفحص بالأشعة للصدر لانني أخشي أن تكون هناك مشكلة ما

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

21- أخشي من أجراء فحص الصدر بالأشعة ذلك لانني لأعلم ماهي خطوات أجراء هذا الفحص

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

22- انا لا اعرف الخطوات الواجب أتباعها للقيام بالفحص للصدر بالأشعة

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

23- أجراء الاشعه للصدر عمليه محرجه

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

24- أجراء الاشعه للصدر تستغرق وقت طويل

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

25- أجراء الكشف بالاشعه للصدر مؤلمه جدا

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

26- أجراء الكشف بالاشعة للصدر يعرضني لمخاطر أشعة أخرى

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

27- ليس لدي الوقت الكافي لتحديد مواعيد لاجراء اشعه للصدر

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

28- لدي من المشاكل ما هو اهم من عمل فحص للصدر بالاشعه

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

29- الطبيب نصحني بأجراء فحص للصدر بالاشعه

نعم لا

30أ) اذا كانت الاجابه بنعم متى كانت اخر مره قمت فيها بالفحص

اقل من سنه اشهر أكثر من سنه أشهر

ما بين سنه الي سنتين أكثر من سنتين

30. ب) سبب توصية الطبيب بأجراء الفحص للصدر هو

الفحص الروتيني متابعة لمشكلة معينة أسباب أخرى

الجزء الثالث

سرطان الرحم

من الأسئلة المذكورة أدناه الرجاء اختيار الاجابة التي تعكس رأيك الشخصي لكل سؤال

1- الاصابة بسرطان الرحم يشكل لدي هاجس

أبدا نادرا أحيانا بشدة

2- أعتقد أن فرصة اصابتي بسرطان الرحم هي

لا يوجد قليلة بعض الشيء كبيرة

3- هل تعتقدن أنه بسبب تاريخ الأسرة فإن احتمال الاصابة بسرطان الرحم لديك أكثر من معظم النساء في عمرك

لا يوجد قليلة بعض الشيء كبيرة

4- هل تعتقدن أنه في حالة أصابة المرأة بسرطان الرحم ليس هناك وسيلة للعلاج أم مازال هناك فرصة لعمل شيء

لا يوجد قليلة بعض الشيء كبيرة

5- كوني مصابة بسرطان الرحم فأن هذا يؤثر على قدرتي الجنسية؟

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

6- هل تعتقدن أن المرأة المصابة بسرطان الرحم لديها الفرصة للشفاء؟

لا يوجد فرصة فرصتها قليلة بعض الشيء فرصتها كبيرة

7- هل تعتقدن أن هناك اجراء يمكن للمرأة اتخاذه للاكتشاف المبكر لسرطان الرحم؟

يوجد قليلة بعض الشيء كبيرة

8- الفحص للرحم (Pap test) الذي يتم فيه أخذ بعض الخلايا من عنق الرحم مطلوب خلال 3-سنوات من بدايه العلاقه الجنسيه.

لا اوافق بشدة لا اوافق لا اعرف اوافق اوافق بشدة

9- القيام بالفحص لعنق الرحم يساعد على الكشف المبكر لسرطان الرحم قبل ظهور الاعراض

أوافق بشدة لا أوافق لا أعرف أوافق لا أوافق بشدة

10- إجراء الفحص المبكر باستعمال فحص عنق الرحم يوقف انتشار المرض

أوافق بشدة لا أوافق لا أعرف أوافق لا أوافق بشدة

11- هل توافقين على ان الفحص المبكر يحسن من فرصه الشفاء من سرطان الرحم

أوافق بشدة لا أوافق لا أعرف أوافق لا أوافق بشدة

12- ليس لدي الوقت الكافي لعمل مواعيد لفحص سرطان الرحم

أوافق بشدة لا أوافق لا أعرف أوافق لا أوافق بشدة

13- القيام بالفحص لسرطان الرحم يؤدي الي الشعور بعدم الارتياح

أوافق بشدة لا أوافق لا أعرف أوافق لا أوافق بشدة

14- القيام بالفحص لسرطان الرحم عمليه محرجه

أوافق بشدة لا أوافق لا أعرف أوافق لا أوافق بشدة

15- القيام بفحص سرطان الرحم يستغرق وقت طويل

أوافق بشدة لا أوافق لا أعرف أوافق لا أوافق بشدة

16- اخاف من القيام بفحص لسرطان الرحم لانه ربما يظهر بعض الخلايا الغير طبيعيه

أوافق بشدة لا أوافق لا أعرف أوافق لا أوافق بشدة

17- هل قمت بعمل فحص لسرطان الرحم

نعم لا

18- اذا كانت الاجابه لا (السبب هو)

لم اسمع به من قبل

لا اعتقد انه ضروري

اخاف من الطريقه التي يتم بها الفحص

ليس مسموح لي بسبب العادات/الديانه

اسباب اخرى اذكرها

18 ب) اذا كانت الاجابه نعم متى كانت اخر مره قمت بها بالفحص لسرطان الرحم

اقل من سته اشهر

من ستة أشهر الى سنة

من سنة الى سنتين

سنتين او اكثر

19- طلب منى طبيبي بالفحص لسرطان الرحم

نعم لا

20- السبب (الاسباب) للقيام بالفحص لسرطان الرحم هو

الفحص الدوري

المتابعه لمشكله معينه

اسباب اخري.

21- ماهو تقييمك لاجراء فحص سرطان الرحم

مريح مهم وضروري مزعج

22. ما هي الوسيله المناسبه في رايك لتوصيل معلومات عن سرطان الثدي و الرحم وطرق اجراء الفحص المبكر لهما للنساء من هم من نفس الخلفيه الثقافيه- اكتبى الرقم بجانب كل وسيله حسب الاهمية حيث واحد مهم جدا الى 7 اقل اهميه

التلفاز

الراديو

المجلات

الانترنت

الايميل

التثقيف الصحي في المركز الصحيه

التثقيف الصحي في المنطقه

Appendix B

Information letter for the survey

November 13, 2007

Dear Participant:

My name is Maha Abdelrahman Amin, and I am a graduate student in the Masters of Education Program in the Faculty of Education at Mount Saint Vincent University.

I invite you to participate in a research project, which I am conducting for writing a thesis to complete my Master of Arts in Education. My research thesis title will be “Knowledge, Beliefs, Attitudes, and Perceptions about Breast and Cervical Cancer Screening among Arabic speaking immigrant women in Halifax, Nova Scotia”.

My research project will focus on Arabic speaking immigrant women’s experiences with breast and cervical cancer screening. I will survey Arabic speaking women who are married and have been in Canada for at least one year. The purpose of my research is to shed light on the participation, accessibility, and suitability of the current breast and cervical cancer screening guidelines and practices for Arabic speaking women in Halifax, NS. The information gained from this study will be useful for health educators, and health care providers in developing specific clinical strategies and education programs to promote breast and cervical cancer screening for Arabic speaking immigrant women.

Your participation will involve filling in a survey that will take about 30-40 minutes of your time. The survey questions are about breast and cervical cancer knowledge, attitudes, beliefs and perceptions. There are no right or wrong answers and your response will be anonymous. You do not need to write your real name on the survey, as I will use codes or numbers.

To preserve confidentiality and anonymity according to ethics guidelines no real names of participants will be used in reporting of the survey data and in the thesis. All surveys will be stored in file cabinet in my home. After I complete this thesis, I will destroy them by shredding all the surveys.

Participation in this study is voluntary, and your refusal to participate will in no way affect you. You can withdraw from the research at any time, for any reason without penalty and any of your contributions can be withdrawn too, if you wish. Your

participation is important to the success of this study. If you agree to participate, please read the attached consent form and sign your name.

I intend to write a thesis and I may present the study at conferences, and possibly publish a paper in an academic journal. If you are interested, I can provide you with a copy of a summary of my thesis, which I can send to you by email, and / or I can lend you a copy of the whole thesis.

Thank you for expressing interest in this project. If you have questions about how this research is being conducted, you can contact the Chair of the University research Ethics Board (UREB) c/o MSVU Research Office, who is not directly involved with this study, at 457-6350. My phone number is [REDACTED], and e-mail address is [REDACTED]. My professor and thesis supervisor is Dr. Sue Brigham. She can also address any concern or question you have about this research. She can be contacted at 457-6733 or by e-mail at: susan.brigham@msvu.ca.

I look forward to seeing you soon!

Sincerely,

Maha Abdelrahman Amin

Graduate Student

Appendix B*

ورقه تعريف عن الاستبيان

عزيزتي المشاركة:

انا اسمي مها عبد الرحمن امين طالبة دراسات عليا بقسم التعليم بكلية التعليم بجامعة ماونت سانت فنسنت ادعوك للمشاركة في هذا البحث الذي اقوم به لنيل درجه الماجستير في التربيه عنوان الرساله هو مدى معلومات و اعتقادات و سلوك و ادراك المرأه العربيه المهاجره بهاليفاكس عن سرطان و الرحم و سرطان الثدي و الفحوصات لهما . هذا البحث سيركز على تجربه المهاجرات العربيات مع فحوصات و تشخيصات سرطان الرحم و الثدي. سوف اقوم بالاستبيان مع النساء العربيات المتزوجات والاتي لهن بكندا مده لا تقل عن عام. الهدف من هذا البحث هو القاء الضوء على مشاركته و سهوله و ملائمه الفحوصات الموجوده حاليا للنساء العربيات بهاليفاكس. المعلومات التي ستستوفر من هذه الدراسه ستساعد العاملين و الدراسين في الحقل الطبي لتطوير الاستراتيجيات و البرامج التعليميه لتطوير فحوصات سرطان الثدي و الرحم لهذه الفئه.

الاسئله في هذا الاستبيان عن معلومات و سلوك و اعتقادات و ادراك النساء العربيات. مشاركتكي سوف تشمل تعبئه استبيان يستغرق حوالي 30 الى 40 دقيقه و هذا الاستبيان يتعلق بمعلوماتك و اعتقادك و ادراك لسرطان الرحم و الثدي. ليس هناك اجابه صحيحه او خاطئه ان مشاركتك في هذا البحث سوف تحفظ بسريه تامه علاوة على ذلك ليس هناك ما يدعو لكتابه اسمك في هذا الاستبيان علما بانه سيتم استخدام كود خاص لكل مشترك كما انه يحق للمشارك رفض الاجابه على اي اسئله لا يريد الاجابه عليه. للحفاظ على الخصوصية وفقا لاختلاقيات البحث العلمي لن يتم ذكر اسم اي مشترك في اي تقارير ناتجة عن هذا البحث. سوف يتم حفظ هذه الاستبيانات بطريقه شخصية و سوف يتم التخلص منها بمجرد الانتهاء من البحث. المشاركة في هذه الدراسه طوعيه و رفضك للمشاركة لن ياتر عليك بأي شكل. يمكن لاي مشترك الانسحاب من هذا الاستبيان في اي وقت دون ابداء الاسباب و بدون اي مسؤوليه و يحق للمتطوع سحب اي مشاركات سبق المساهمه بها.

مشاركتك هامه جدا لنجاح هذه الدراسه و في حاله موافقتك على المساهمه الرجاء قرأه النماذج المرفقه و التوقيع عليها.

لاي اسباب اذا حدث لكي اي تأثير نفسي نتيجة للمشاركة في هذا البحث يمكن تحويلك اي اي اخصائية تتحدث العربيه و سوف امدك بالاسم و رقم الهاتف. ارغب في كتابه البحث و قد اقوم بتقديم هذه الدراسه في مؤتمرات و كذلك هناك احتمال لنشر هذه الدراسه في مجلات علميه في حاله رغبتك في الحصول على نسخه من هذا البحث يمكن ارساله لك عن طريق البريد الالكتروني او يمكن اعارتكم نسخه من البحث الكامل .

نشكركم على الموافقه في المشاركة في هذا البحث و اذا كانت لديكم اي استفسار عن هذا البحث يمكن الاتصال على اداره البحث العلمي بالجامعه على ما بناهم ليس لديهم صله مباشره بهذه الدراسه على هاتف رقم 4576350 او الاتصال على هاتف المنزل رقم 4536212 او مخاطبتي على البريد الالكتروني

او الاتصال على الدكتور المشرفه على الرساله هي الدكتور سوزان بيجهام على هاتف رقم 4576733 او عن طريق البريد الالكتروني

susam.brigham@msvu.ca

نامل بمشاركتكم

مقدمه مها عبدالرحمن امين
طالبه دراسات عليا

Appendix C

Information letter for Interviews

November 13, 2007

Dear Participant:

My name is Maha Abdelrahman Amin, and I am a graduate student in the Masters of Education Program in the Faculty of Education at Mount Saint Vincent University.

I invite you to participate in a research project. I am conducting this research for my Master thesis of Arts in Education. My research project title will be “Knowledge, Beliefs, Attitudes, and Perceptions about Breast and Cervical Cancer Screening among Arabic speaking immigrant women in Halifax, Nova Scotia.”

My research project will focus on Arabic speaking immigrant women’s experiences with breast and cervical cancer screening. Arabic speaking immigrant women who are married and have been in Canada for at least one year will be included in the study. The purpose of my research is to shed light on the participation, accessibility, and suitability of the current breast and cervical cancer screening guidelines and practices in NS. The information gained from this study can be useful for health educators along with health care providers in developing specific clinical strategies and education programs to promote screening for Arabic speaking immigrant women.

I will interview you individually; the interview will take about one to two hours. The interview will be done in a place that works well for both of us. In the interview, you can use English or Arabic language, as I am fluent in both languages.

I will write notes during the interview, and if it is okay with you, I will also audiotape the interview. You may ask at any time during the interview that the audiotaping be turned off. All the audio tapes, notes, and transcripts will be stored in a file cabinet in my home and I will destroy all audio tapes, notes, and transcripts after I finish this study. To preserve confidentiality and anonymity you can choose pseudonyms. Throughout the research process, I will use pseudonyms and codes to identify participants. To preserve confidentiality and anonymity, according to ethics guidelines, no real names of participants will be used in the thesis. Any identifier will be removed and only I will have access to transcripts. I will use these pseudonyms for the final report, publications and presentations of the research information.

If you decide not to continue your involvement in the research at any time, for any reason, you may discontinue without penalty and any of your contributions can be withdrawn too, if you wish.

I intend to write a thesis and I may present the study at conference, and possibly publish a paper in an academic journal. If you are interested, I can provide you with a copy of a summary of my thesis, which I can send to you by email, and if I interested I can lend you a copy of the whole thesis.

Thank you for expressing interest in this project. If I have questions about how this research is being conducted, I can contact the Chair of the University research Ethics Board (UREB) c/o MSVU Research Office, who is not directly involved with this study, by calling 457-6350. My phone number is [REDACTED], and my e-mail address is

[REDACTED] My professor and thesis supervisor is Dr. Sue Brigham. She can also address any concern or questions you have about this research. She can be contacted at 457-6733 or by e-mail at: susan.brigham@msvu.ca.

I look forward to seeing you soon!

Sincerely,

Maha Abdelrahman Amin

Appendix C*

ورقة تعريف عن المقابلة الشخصية

عزيزتى المشاركة

انا اسمي مها عبد الرحمن امين طالبة دراسات عليا بقسم التعليم بكلية التعليم بجامعة ماونت سانت فنسنت ادعوك للمشاركة في هذا البحث الذى اقوم به لنيل درجة الماجستير في التربيه عنوان الرساله هو مدى معلومات و اعتقادات و سلوك و ادراك المرأه العربيه المهاجره بهاليفاكس عن سرطان و الرحم و سرطان الثدي و الفحوصات لهما . هذا البحث سيركز على تجربه المهاجرات العربيات مع فحوصات و تشخيصات سرطان الرحم و الثدي. سوف اجري مقابلات شخصية مع النساء العربيات المتزوجات والاتي لهن بكندا مده لا تقل عن عام. الهدف من هذا البحث هو القاء الضوء على مشاركته و سهوله و ملائمه الفحوصات الموجوده حاليا للنساء العربيات بهاليفاكس. المعلومات التى ستستوفر من هذه الدراسه ستساعد العاملين و الدراسين في الحقل الطبي لتطوير الاستراتيجيات و البرامج التعليميه لتطوير فحوصات سرطان الثدي و الرحم لهذه الفئه.

المقابلة الشخصية سوف تكون فردية و تسغرق حوالى ساعة الى ساعتين ز المقابلة تتم فى المكان و الوقت المناسب لك و للباحثة. أثناء المقابلة يمكنك إستعمال اللغة العربية أو الإنجليزية حيث اننى متمكنة من الإثنين. يحق للمشتركة رفض الإجابة على أسئلة لاتريد الإجابة عليها.

سوف يتم كتابة بعض الملاحظات أثناء المقابلة إذا لم يكن لديك مانع. كما سيتم تسجيل المقابلة بعد موافقتك يمكنك طلب وقف التسجيل فى أى لحظة اثناء المقابلة. ان مشاركتك في هذا البحث سوف تحفظ بسريه تامه علاوة على ذلك ذلك سوف يطلب منك إختيار اسم مستعار و هذا الاسم ليس إسمك الحقيقى و سوف يستخدم فى رسالة البحث و اى منشورات أخرى. للحفاظ على الخصوصية وفقا لاختلاقيات البحث العلمي لن يتم ذكر اسم اي مشترك في اي تقارير ناتجة عن هذا البحث. سوف يتم حفظ هذه الاستبيانات بطريقة شخصية و سوف يتم التخلص منها بمجرد الانتهاء من البحث.

المشاركه في هذه الدراسه طوعيه و رفضك للمشاركة لن يأتز عليكى بأي شكل. يمكن لاي مشترك الانسحاب من هذا المقابلة في اي وقت دون ابداء الاسباب و بدون اي مسئوليه و يحق للمتطوع سحب اي مشاركات سبق المساهمه بها. مشاركتك هامه جدا لنجاح هذه الدراسه و في حاله موافقتك على المساهمه الرجاء قرأة النماذج المرفقه و التوقيع عليها.

لاي اسباب اذا حدث لكي اي تأثير نفسي نتيجة للمشاركة في هذا البحث يمكن تحويلك اي اي اخصائية تتحدث العربية و سوف امدك بالاسم و رقم الهاتف.

ارغب في كتابه البحث و قد اقوم بتقديم هذه الدراسه في مؤتمرات و كذلك هناك احتمال لنشر هذه الدراسه في مجلات علميه في حاله رغبتك في الحصول على نسخه من هذا البحث يمكن ارساله لك عن طريق البريد الالكتروني او يمكن اعارتك نسخه من البحث الكامل .

نشكركم على الموافقه في المشاركه في هذا البحث و اذا كانت لديكم اي استفسار عن هذا البحث يمكن الاتصال على ادارة البحث العلمي بالجامعه على ما بناهم ليس لديهم صلح مباشرة بهذه الدراسه على هاتف رقم 4576350 او الاتصال على هاتف المنزل رقم 4536212 او مخاطبتي على البريد الالكتروني

او الاتصال على الدكتور المشرفه على الرساله هي الدكتور سوزان بيجهام على هاتف رقم 4576733 او عن طريق البريد الالكتروني

susam.brigham@msvu.ca

نامل بمشاركتكم

مقدمه مها عبدالرحمن امين
طالبة دراسات عليا

Appendix D

Informed Consent Form for Survey

I have read the information letter about Maha Abdelrahman Amin’s research project, “Knowledge, beliefs, attitudes and perceptions about breast and cervical cancer screening among Arabic speaking immigrant women in Halifax, Nova Scotia.” dated November 2007. I agree to take part in her study. My participation will help her understand knowledge, beliefs, attitudes and perceptions of Arabic speaking immigrant women and their experiences about breast and cervical cancer screening in Halifax.

I understand that Maha will not use my real name or any identifying information about me. I understand that my participation will require filling out a questionnaire. It will take about 20-40 minutes. I also understand that I have the right to ask any questions about the study. I will participate without payment.

I know that I can withdraw from the research at any time, for any reason, without penalty. I know that if I have questions about how this research is being conducted, I can contact the Chair of the University research Ethics Board (UREB) c/o MSVU Research Office, who is not directly involved with this study, at the telephone number 457-6350. In addition, I can raise further questions or concerns with Maha Abdelrahman Amin, whose phone number is (██████████), or by e-mailing her at: ██████████. I can contact Maha Abdelrahman Amin’s professor and thesis supervisor, Dr. Sue Brigham, by telephone (457-6733) or by e-mail at susan.brigham@msvu.ca now or at any point during the research.

In addition, if I am interested, Maha will provide me with a copy of a summary of her thesis, which she can send to me by email, and if I am interested she can lend me a copy of the whole thesis.

I understand that all information Maha obtains from me will be confidential, and that data collected may be used in publications in academic journals or in presentations at conferences related to breast and cervical cancer and screening.

Signature of participant

Date

Maha Abdelrahman Amin, Graduate student (researcher)

Signature _____

Appendix D*

اقرار بالموافقة على المشاركة فى الاستبيان

اقر بانني اطلعت على المعلومات المتعلقة ببحث طالبة مها عبد الرحمن امين و هو بعنوان معلومات و معتقدات و سلوك و ادراك النساء العربيات المهاجرات الى هاليفاكس عن سرطان الرحم و الثدي و الفحوصات الخاصة بهما. اوافق على المشاركة في هذا البحث. حيث مشاركتي ستساعد على فهم المعلومات و المعتقدات و سلوك و ادراك النساء العربيات المهاجرات و تجربتهم مع فحوصات سرطان الثدي و الرحم. اقر بمعرفتي التامة بان مشاركتي سوف تشمل علي تعبئه استبيان يستغرق من 30 الى 40 دقيقة ولدي الحق في الاستفسار عن فحوي هذه الدراسة التي اساهم فيها بدون مقابل مادي. علما بان الباحثه لن تستخدم اسمي الحقيقي أو أي معلومات تدل علي شخصيتي او مساهمتي.

كذلك اقر بعلمي التام بانه في حالة حدوث اي تاثيرات نفسية بسبب مشاركتي في هذا البحث سوف تقوم الباحثه مها عبد الرحمن بتوفير اسم ورقم هاتف لأخصائيه نفسيه تتحدث العربيه لمعالجه هذه التأثيرات. علما بانني لذي الحق في رفض الاجابه على اي اسئله لا اريد الاجابه عليها كما انه يحق لي الانسحاب من الدراسه في اي وقت و بدون ابداء الاسباب و بدون اي غرامه.

اقر بعلمي انه يحق لي الرجوع الى مجلس اخلاقيات البحث العلمي. على هاتف رقم 6350-457- في الجامعه للاستفسار عن اي اسئله متعلقه بهذا البحث كذلك علمي بان المجلس المذكور ليس له صلح مباشره بموضوع البحث. بالاضافه الى انه يحق لي الاتصال مباشره بالباحثه مها للاستفسار عن اي اسئله على هاتفها رقم 6212-453 أو عن طريق البريد الالكتروني على العنوان

كذلك يحق لي الاتصال مباشرة على الدكتور سوزان بريجهام المشرفه علي البحث الآن او في اي وقت خلال فتره البحث علي الهاتف رقم 4574733 أو على البريد الإلكتروني

suzan.brigham@msvu.ca

تعهدت الطالبة مها بالاضافه لما سبق بتوفير ملخص للبحث في حاله رغبتني في الاطلاع عليه وكذلك يمكن ارسال نسخه من البحث بواسطه البريد الالكتروني كما يحق لي استعاره نسخه كامله من البحث كما اعلم بان الباحثه سوف تحتفظ بسريه المعلومات و البيانات المجمعه. علما بأنه قد يتم نشرها- في مجلات ودوريات علميه- او المشاركة بها في مؤتمرات لها علاقه بسرطان الثدي و الرحم وطريقه الفحص

توقيع المشترك

التاريخ

مها عبد الرحمن امين طالبة دراسات عمليه و الباحثه

التوقيع

Appendix E

Informed Consent Form for Interviews

I have read the information letter about Maha Abdelrahman Amin's research project,

“Knowledge, beliefs, attitudes and perceptions about breast and cervical cancer screening among Arabic speaking immigrant women in Halifax, Nova Scotia.”, dated, October, 1st. I agree to take part in her study. I understand that my participation will help her to better understand knowledge, beliefs, attitude and perceptions of Arabic speaking immigrant women and our experiences about breast and cervical cancer screening in Halifax.

I understand that I will be interviewed individually. The interview will take approximately one to two hours, at a place and time that will be convenient for both of us. I will be interviewed without payment. I can use either Arabic and / or English when I am interviewed, if I wish. I understand that some notes will be taken during the interview and the interview will be audio tape-recorded. The audio tapes and notes will be translated into English and transcribed. All the audio tapes, notes and transcripts will be stored by Maha in a locked filing cabinet in her home. After completion of this thesis, she will destroy the audio tapes, notes, and transcripts.

I will be asked to choose a pseudonym for assuring confidentiality in reporting the research. These pseudonyms will be used in any resulting publications or presentations.

I know that I can withdraw from the research at any time, for any reason without penalty. I know that if I have questions about how this research is being conducted, I can contact the Chair of the University research Ethics Board (UREB) c/o MSVU Research Office, who is not directly involved with this study, at the telephone number 457-6350. In addition, I can raise further questions or concerns with Maha Abdelrahman Amin, whose phone number is [REDACTED], or by e-mailing her at [REDACTED]. I can contact Maha Abdelrahman Amin's professor and thesis supervisor, Dr. Sue Brigham, by telephone (457-6733) or by e-mail at susan.brigham@msvu.ca now or at any point during the research.

In addition, if I am interested, Maha will provide me with a copy of a summary of her thesis, which she can send to me by email, and if I am interested she can lend me a copy of the whole thesis.

I understand that all information Maha obtains from me will be confidential, and that data collected may be used in publications in academic journals or in presentations at conferences related to breast and cervical cancer and screening.

Signature of participant

Date

Maha Abdelrahman Amin, Graduate student (researcher)

Signature _____

Appendix E*

اقرار بالموافقة على المشاركة فى المقابلة الشخصية

اقر بانني اطلعت على المعلومات المتعلقة ببحث طالبة مها عبد الرحمن امين و هو بعنوان معلومات و معتقدات و سلوك و ادراك النساء العربيات المهاجرات الى هاليفاكس عن سرطان الرحم و الثدي و الفحوصات الخاصة بهما بتاريخ. وافق على المشاركة في هذا البحث. حيث مشاركتي ستساعد على فهم المعلومات و المعتقدات و سلوك و ادراك النساء العربيات المهاجرات و تجربتهم مع فحوصات سرطان الثدي و الرحم. استوعب بان المقابلة الشخصية تسكون فرديه هذه المقابلة ستستغرق حوالي ساعه الى ساعتين وستتم في مكان ووقت مناسب لي و للباحث. ستتم مقابلتي بدون مقابل مادي. كما انه يمكن استخدام اللغة العربية او الانجليزيه اثناء المقابلة اعلم بانه سيتم تدوين بعض البيانات اثناء هذه المقابلة كما سيتم تسجيل هذه المقابلة. سوف يتم ترجمه التسجيل و البيانات المدونه الى الانجليزيه حتى يتم نسخها. جميع التسجيلات و البيانات المدونه و النسخ المنقوله سيتم حفظها بدولاب مفلق بمنزل الباحث. بعد الانتهاء من الرساله سوف يتم تلف جميع التسجيلات و البيانات المنسوخة. سوف يطلب مني اختيار اسم مستعار لضمان السريه عند تدوين البحث و هذا الاسم المستعار و ليس اسمي الحقيقي سوف يستخدم في رساله البحث و اي منشورات اخري.

كذلك اقر بعلمي التام بانه في حالة حدوث اي تأثيرات نفسية بسبب مشاركتي في هذا البحث سوف تقوم الباحثة مها عبد الرحمن بتوفير اسم ورقم هاتف لأخصائيه نفسيه تتحدث العربية لمعالجه هذه التأثيرات. علما بانني لدي الحق في رفض الاجابه على اي اسئله لا اريد الاجابه عليها كما انه يحق لي الانسحاب من الدراسه في اي وقت و بدون ابداء الاسباب و بدون اي غرامه. اقر بعلمي انه يحق لي الرجوع الى مجلس اخلاقيات البحث العلمي. على هاتف رقم 6350-457- في الجامعه للاستفسار عن اي اسئله متعلقه بهذا البحث كذلك علمي بان المجلس المذكور ليس له صله مباشره بموضوع البحث. بالاضافه الى انه يحق لي الاتصال مباشره بالباحثه مها للاستفسار عن اي اسئله على هاتفها رقم 6212-453 أو عن طريق البريد الالكتروني على العنوان

كذلك يحق لي الاتصال مباشره على الدكتور سوزان بريجهام المشرفه علي البحث الآن او في اي وقت خلال فتره البحث علي الهاتف رقم 4574733 أو على البريد الإلكتروني suzan.brigham@msvu.ca

تعهدت الطالبة مها بالاضافه لما سبق بتوفير ملخص للبحث في حاله رغبتني في الاطلاع عليه وكذلك يمكن ارسال نسخه من البحث بواسطه البريد الالكتروني كما يحق لي استعاره نسخه كامله من البحث كما اعلم بان الباحثة سوف تحتفظ بسريه المعلومات و البيانات المجمعه. علما بأنه قد يتم نشرها- في مجلات و دوريات علميه- او المشاركة بها في مؤتمرات لها علاقه بسرطان الثدي و الرحم وطريقه الفحص

توقيع المشترك

التاريخ

مها عبد الرحمن امين طالبة دراسات عمليه و الباحثة

التوقيع