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Lifelong Learning for Lifelong Health:

Arabic-Speaking Immigrant Women's Attitudes and Knowledge of Breast and Cervical Cancer and Cancer Screening Practices in Halifax, NS

Maha Abdelrahman Amin, YMCA

Susan M. Brigham, Mount Saint Vincent University

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Maha Abdelrahman Amin, YMCA

Susan M. Brigham, MSVU

Abstract/Résumé:
This study is based on surveys with 100 Arabic-speaking immigrant women in Halifax and in-depth interviews with five of those women. The purpose of the study is to explore the participants' attitudes toward, understandings, knowledge, beliefs, attitudes, and perceptions of, and experiences with breast and cervical cancer screening and to examine the role of adult education in improving their access to information about screening. Our findings show that this heterogeneous group of women faces a number of complex barriers to accessing adequate health information, such as language barriers, the health care system's insensitivity to certain ethno-cultural practices, concerns about confidentiality issues, and lack of physicians' recommendations to undergo screening.

Keywords/Mots-clefs:
Immigrant women; Arabic; health; breast and cervical cancer; cancer screening; adult education; lifelong learning

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Introduction

This report is based on research with a specific group of adults. Specifically, our research participants were 100 Arabic-speaking immigrant women in Halifax, Nova Scotia, who, through surveys and, for five of them, in-depth interviews, shared their attitudes toward, understandings, knowledge, beliefs, and perceptions about, and experiences with breast and cervical cancer screening practices. This research also explored the critical role of adult education in improving access to information about these practices.

Adult education plays a critical role in all professional fields (Miles, 1998), and its impact extends to all parts of our social, economic, and political lives. A vital purpose of adult education is to raise learners' consciousness about critical social issues and to empower them with new knowledge to help improve the quality of life of individuals and communities. Empowerment in adult education, particularly for women, involves

> 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 affect others (interpersonal power), and an ability to work with others to take action (individually and collectively) to improve their lives and change social institutions (political power). (Heng, 1995, p. 79)

Empowering education provides important perspectives that directed this study. According to Freire (1994), the educator's role is to help learners become critically aware of the world around them. Critical pedagogy based on democratic critical consciousness-raising helps end a culture of silence. Critical pedagogy also leads to praxis that challenges power/knowledge regimes and social injustices. Adapting Freire's ideas of education to health education, Wallerstein and Bernstein (1988) declared that empowering education offers an effective disease prevention model. Participation in dialogue and group action to address societal concerns, such as health concerns, enhances a sense of control and belief in our ability to change our lives for the better.

Research on breast and cervical cancer in, and screening practices of, Arabic- speaking immigrant women is very limited, especially in Nova Scotia. Yet Arabic is the most common allophone language in Nova Scotia (Nova Scotia, 2002). In the Halifax Regional Municipality (HRM), Arabic is the third most commonly used language, following English and French (Halifax Quick Facts, 2007-08, p. 1). In Canada, the Arabic-speaking immigrant population has increased significantly over the last two decades (Citizenship and Immigration Canada, 2006). "Canadians of Arab origin make up one of the largest non-European ethnic groups in Canada. In

2001, almost 350,000 people of Arab origin[1] lived in Canada, representing 1.2% of the total Canadian population" (Lindsay, 2007, p. 9). In Atlantic Canada, since the mid-1990s, Arabic speaking countries such as "Saudi Arabia, Kuwait, Egypt, Iraq, Lebanon and United Arab Emirates have become major source countries, a trend that is expected to continue in future" (Akbari & Sun, 2006, p. 129). In Nova Scotia, Arabic-speaking immigrants account for 11.6 % of the total visible minority population (Statistics Canada, 2003). Given these statistics, it is vital that the health needs and concerns of the Arabic-speaking population be addressed. This study is the first to examine a specific health issue--breast and cervical cancer and screening practices--for this growing ethnic group in Halifax.

In the sections below, we describe our research participants and the methodology. We then briefly discuss our theoretical framework, Black feminism, and review some of the pertinent literature. Finally, under Research Implications (p. 16), we offer recommendations for health care providers and community groups.

Participants

The women who participated in this study are aged 20 years and older and have been in Canada for one year or more. Of them, 92% are married, 4% are widowed and 4% are separated. Further, 94% are mothers. All participants speak and read Arabic (many also speak and read English). Participants are from 18 different countries: 23% from Palestine, 16% from Egypt, 12% from Kuwait, 12% from Iraq, 7% from Syria; 6% from Lebanon, 5% from Sudan, and 19% from 11 other Arab countries: Algeria, Jordan, Libya, Morocco, Oman, Qatar, Saudi Arabia, Somalia, Tunisia, United Arab Emirates, and Yemen. The five women interviewed had also completed the survey. With regard to the participants' highest level of education, most (59%) have university education (49% have an undergraduate degree and 10% have a graduate degree). Among the others, 10% have less than a high school diploma, and 31% have a high school diploma.

Methodology

For this study, we drew on mixed methods. The data collection methods included a survey and semi-structured interviews. The survey was in Arabic and contained 47 questions (17 demographic questions, on such topics as age, marital and parental status, level of education, and country of birth, and 30 questions about Arabic-speaking women's knowledge and beliefs about and attitudes towards breast and cervical cancer and screening. A total of 100 surveys were completed. Five survey respondents also were interviewed in a semi-structured interview involving open-ended questions in the Arabic language. Each interview took between one and two hours and was tape recorded. The data therefore include the 100 surveys and the transcripts of the five interviews, which were translated into English. Data were summarized in tables and charts. Analysis of the interview transcripts involved coding the transcripts to identify commonalities and variations, as well as themes that link or explain the data (Patton, 1990). The research focus, methodology and data analysis were influenced by Black feminism, which is briefly discussed in the next section.

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[1] According to Lindsay (2001, p. 9) this "denotes people who reported Arab (or an origin that originates in the region commonly referred to as the Arab world), either alone or in combination with other ethnic origins in response to the question on ethnic origin in the 2001 Census or 2002 Ethnic Diversity Survey".

Theoretical framework

Black feminism provided the theoretical framework for this study. A feminist perspective examines social phenomena from women's perspectives and strives to understand women's experiences of discrimination and oppression that shape our social status. Black feminism from a Canadian perspective provides "an organizing framework which demystifies white Canadian gendered racial domination, creates a transformative space, and becomes a bridging discourse which lays the foundation for global connections and political projects to link us with black women universally" (Massaquoi, 2007, p. 81). "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). The Black feminist theoretical framework embraces the heterogeneous collectivity of women's identities and resists the homogeneous racist and rigid colonial constructs of, for example, 'immigrant women', 'women of colour' and 'women from the Third World' (Timothy, 2007, p. 164). In our study, the research participants share a language (Arabic), and all are immigrants to Canada, yet they are a heterogeneous group. As stated above, the women vary in terms of age, race, culture (including religion), ethnicity, class, level of education and country of origin. Using this theoretical perspective, we centre on the women's perspectives to explore a range of factors that impact on this heterogeneous group's knowledge of breast and cervical cancer and screening. The next section situates this research in the literature.

Review of the literature

Women of all races and ethnicities are at risk for breast cancer and cervical cancer because both types of cancer are a major public health issue around the world. Cervical cancer accounts for 15% of female cancers and is more common in developing, than in developed, countries. Breast cancer is the most invasive and life threatening type of cancer for women all over the world and represents 10% of the cancers globally (Parkin et al., 2005). Cervical cancer is the 11th most common cancer diagnosed among Canadian women and the 13th cause of mortality, whereas breast cancer is the second leading cause of cancer deaths in women (Canadian Cancer Society, 2006). Although effective preventive strategies for breast and cervical cancer have yet to be developed, early detection practices can reduce the impact of the disease and allow for a greater range of treatment options (American Cancer Society, 2005). Screening can detect early lesions (Elkind et al., 1988, cited in Maaita and Barakat, 2002), and early detection helps to reduce the mortality from these cancers. Early detection of cervical cancer increases the five-year survival rates to 90%. Further, the Papanicolaou smear (commonly called the Pap test) contributes to a decreasing rate of cervical cancer incidences and mortality rates (Canadian Cancer Society, 2006). Yet many women still go unscreened even where screening is freely available (Goel, 1994; Grunfeld, 1997; Remennick, 2006).

While a body of literature is available on breast and cervical cancer and screening among Korean, Mexican, and Vietnamese immigrants in Western countries, including Canada, few studies are available specifically on Arabic-speaking immigrant women. Research on various groups of immigrant women in North America indicates that their decision to be screened for breast and cervical cancer depends on their knowledge of and beliefs, perceptions and attitudes about, cancer (Goel, 1994; Shirazi et al., 2006). Immigrant women who do not speak English and

women of low socioeconomic status are likely to be under-screened or never screened for breast and cervical cancer (Grunfeld, 1997; Jacobs et al., 2005; Quan et al., 2006; Woloshin et al., 1997). In the United States, primary deterrents are cost and lack of insurance (Otero-Sabagal., Owens, Canchola, Golding, Tabnak & Fox, 2004). Other factors contributing to immigrant women's lack of screening include lack of time due to multiple responsibilities, such as employment and family, but also employment stress and a lack of social support (MacKinnon & Howard, 2000), which may result in women seeking help only when a health problem occurs and they need treatment. Additional factors related to low screening rates among immigrant women are education level, language issues, lack of access to female physicians, negative relationships with health providers, and fear of diagnosis, as well as religion and cultural beliefs,[2] in addition to a lack of understanding of the importance of screening or the lack of recommendation for screening by a medical practitioner (Ahmed et al., 2002; George, 2000; Matin & Le Baron, 2004; Meleis, Lipson, Muecek & Smith, 1998 ; Shirazi et al., 2000; Thomas et al., 2005).

Studies done to examine the knowledge about, attitudes toward, barriers to, and practices for cervical and breast cancer screening in Arabic countries showed that fear, embarrassment, cultural barriers related to modesty issues, social stigma and the belief that screening is unnecessary are the most common barriers (Azaiza & Cohen, 2006; Bener et al., 2001; Bakheit & Bu Haroon, 2004; Maaita & Barakat, 2002; Motawy et al., 2004; Shirazi et al., 2006). In Arab countries, population-based cervical or breast cancer screening programs are generally not carried out, and screening is conducted only in secondary health care settings, either at patients' request or if a physician decides it is required for a particular patient (Maaita & Barakat, 2002; Petro-Nustas, 2001). The median age of incidence of breast cancer in Arabic countries is 46 years (Fakhro et al., 1999; Motawy et al., 2004). Having provided a brief overview of the literature pertaining to our study, we now present some of our main findings.

Findings

The data point to several key findings, which we summarize below. First, we report on respondents' attitudes toward and perceptions about breast and cervical cancer and screening within the category *Fear and lack of information.* Next, we look at general knowledge of breast and cervical cancer and then report on respondents' screening behaviours. Further, to understand the complexity of respondents' attitudes toward and perceptions about breast and cervical cancer and screening, we highlight the narratives of the interviewees, which fall into two main categories: *1) Women's identity and their role and place in the family,* and *2) The characteristics of the family physician,* in which the women refer to female and "outsider" (non-Arabic speaking) physicians.

I. Attitudes and perceptions of breast and cervical cancer and screening

Fear and lack of information

During the administration of the surveys, the first words many women repeated were "Ya Lateef, Ya Lateef," which can be taken to mean 'God be kind to me and prevent this disease from happening to me'. For the participants, the mention of breast and cervical cancer means fear and worry, as this participant stated:

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[2] For example, immigrant women may encounter a clash between their ethno-cultural beliefs and the Canadian health care system (Ferran & Tracy, Gany & Kramer , 1999; Weerasinghe & Mitchell, 2007).

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? (Nena[3])

Participants consistently characterized cancer in a sinister way. For example, Lala explained her fear this way:

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.

Participants indicated that they have very little access to knowledge of breast and cervical cancer, a lack of knowledge closely connected to limited conversations among Arabic women about these issues and the fear and worry. One participant, Warda, stated

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 has an undergraduate degree, asserted

I don't think I have enough information. What all I know is that it is a cancer that cannot 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 remember there are some factors that increase your chance of getting cancer but I don't know what these factors are… really I have no information.

A concern about unnecessary exposure to radiation during screening was expressed by 32% of survey respondents. This finding is consistent with those of Aziza and Cohen (2004) and Otero-Sabagal et al (2004), who found that a barrier to screening is the concern that x-rays may be harmful and hazardous to one's health.

Also common among research participants was the fear of the worst case scenario, such as surgery, rather than of preventive measures and non-surgical treatments. Nena explained:

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.

II. General knowledge of Breast and Cervical Cancer

Breast Cancer

The following table shows the level of participants' general knowledge of breast cancer:

Table 1. Survey Participants' General Knowledge of Breast Cancer

Questions	% answered I don't know	% answered correctly
The constant irritation of a right bra over time	56	26

[3] Not her real name. All participants' names are pseudonyms.

can cause breast caner.		
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

The survey results show a general lack of access to information about breast cancer (with the exception of three responses in which the participants scored above the 50th percentile). This finding is reflected in findings in the literature on Arabic-speaking women (e.g., Matuk, 1996; Lesjak., et al 1997; Maaita & Barakat , 2002; Soskolone, Marie & Manor, 2006). Yet our survey results also show that 73% believed that regular breast screening makes a great difference in the chance of arresting the growth of breast cancer. Only 5% thought that it would make no difference. Moreover, 81% of participants correctly identified that a mammogram is recommended yearly in Canada for women over 40 years old. A total of 87% agreed that mammography can detect lumps that cannot be felt.

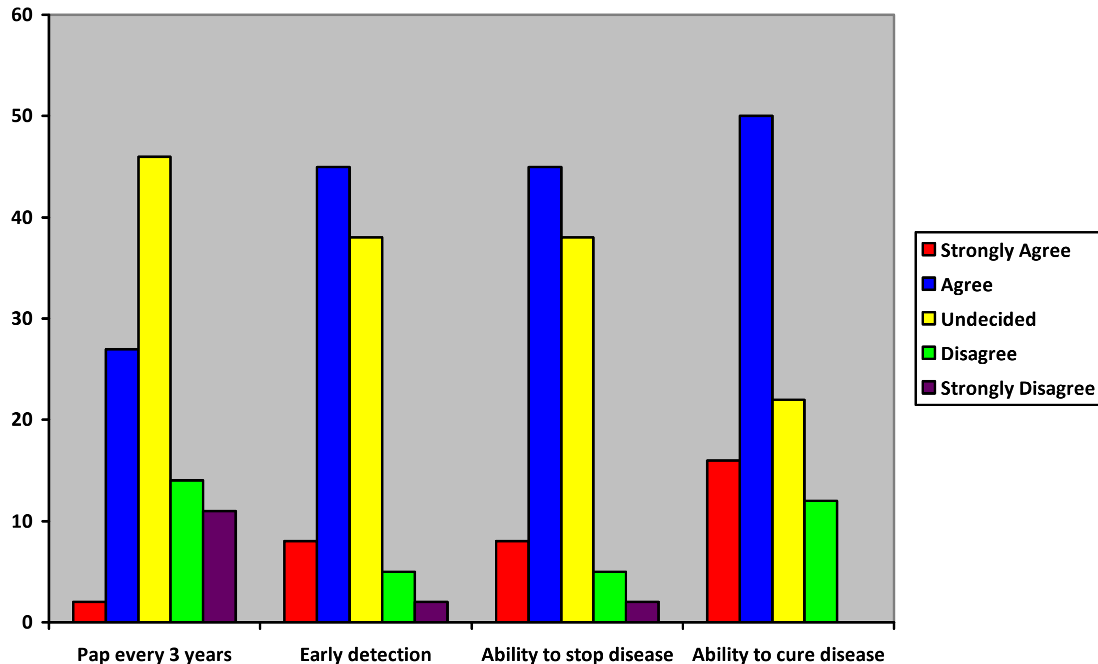
Regarding breast self-examination, half the women had done it before but not on a regular basis. Moreover, no one had taught them how to do it, and they depended completely on the information from brochures or from friends, even though, as mentioned previously, breast self-examination is not a frequent discussion topic among women. This shows the gap between knowledge instruction and explanation for practice and is consistent with the findings of Bener et al. (2001), who studied the attitudes toward and knowledge and practices of Muslim women in the United Arab Emirates related to breast self-examination.

Cervical Cancer

Regarding knowledge about cervical cancer, 48% of participants think there is some chance of treatment for women with cervical cancer, and 44% think there is chance of recovery. With regard to the women's knowledge about early detection of cervical cancer, about 50% of participants strongly agree that a Pap test can result in early detection, which could lead to arresting the spread of the disease and improving chances of survival from cervical cancer. The

following figure (Figure 1) shows the survey participants' knowledge of cervical cancer and the screening.

Figure 1. Survey Participants' Knowledge of Cervical Cancer Treatment Options and Survival Rates



III. Screening Behaviour

Participants were asked if they had ever had a Pap test (to screen for cervical cancer) or mammogram (to screen for breast cancer) and how long it had been since their last screening. Regarding cervical cancer screening, 49% of participants had not had a Pap test. When asked why, 21% answered that they did not feel it was necessary, 12% were scared of the process, and 9% had never heard of this test. Of those who had had the test, 74% stated that their physician recommended they have it. Respondents who had had a Pap test indicated when they had last had it done. The results of this question appear in table 2:

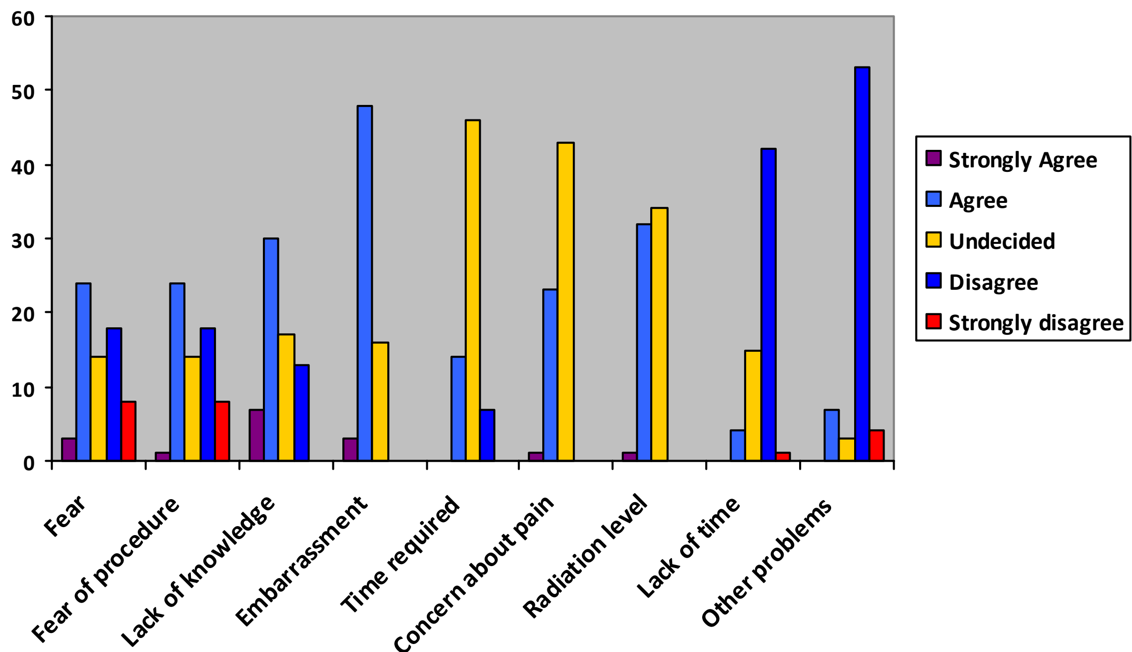
Table 2. Survey Participants' Most Recent Pap Test

	Percentage
Within the last 6 months	9
6 months to a year ago	14
1 to 2 years ago	15
More than 2 years ago	14

With regard to the mammogram, 67 out of the 100 women had never had a mammogram. It is interesting to note, therefore, that of the total participants, roughly 64% of women were 40 years and older, thus eligible for an annual mammogram, according to Nova Scotia health guidelines. Figure 2 (below) shows the responses to the following statements about mammograms:

a. I am afraid to have a mammogram because I may find out something is wrong
b. I am afraid to have a mammogram because I do not understand what the mammogram procedure involves
c. I do not know how to go about getting a mammogram
d. I do not have a mammogram because the procedure is embarrassing
e. I do not have a mammogram because it takes too much time
f. I do not have a mammogram because it is too painful
g. I do not have a mammogram because it exposes me to unnecessary radiation
h. I do not have a mammogram because I have no time to schedule an appointment
i. I do not have a mammogram because there are other problems more important to deal with

Figure 2. Survey Participants' Responses to Questions about Barriers to Having a Mammogram



Of those who did have a mammogram, most stated they had had it within the last two years.

Looking more in depth at the complexity of reasons for not having cancer screening, the narratives of the interviewees revealed two main themes: *a) Women's identity and their role and place in the family, and b) The characteristics of the physician.*

IV. Narratives about cancer screening

a) *Women's identity and their role and place in the family*

In general, the women viewed cancer testing as 'looking for trouble'. This is similar to the findings of Rajaram and Rashidi (1998) and Remennick (2006). The fatalistic view of cancer is often augmented by the frightening prospect of the body being altered during treatment. According to Remennick (2006), fear of, and lack of knowledge about, cancer treatment is common in many low resource countries or in cases in which surgery is the only treatment option. These misconceptions about treatment may discourage women from being screened and having treatments (Bener et al., 2001). Zozo, for example, referred to her friend's treatment, which involved an 'inevitable' surgical removal of her breasts, reinforcing Zozo's fear:

> *[Breast cancer]is something that gives you an uncomfortable feeling and when you think about it you fear from the topic itself. … [Long silence] I remember my friend when she did mastectomy all her life has changed. You can't imagine the tragedy she lives in.*

Bebe, too, related her concern about 'mutilation' of a woman's body as part of cancer treatment:

> *You know polygamy is allowed in our religion [laughs]. For example if [a woman] had breast cancer and did mastectomy [a husband] 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?*

Like Bebe, other participants referred to polygamy[4] as a practice that influences their decision not to participate in breast and cervical cancer screening. Warda explained:

> *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 is [the] result this will affect my family and even my relationship with my husband will be affected.*

Zozo agreed with Warda by saying

> *My responsibility [is] to my family… I play an important role and my husband is not here with us [so] what I do if I[am] 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.*

A key barrier identified by research participants is the concern about how cancer treatments may impact on their identity and their role and place in the family. Participants underscored that their social status very much depends on their roles as wives and mothers, and their importance in society comes from the ability to provide service to others. As Remennick (2006) mentioned, serious disease and cancer may prevent women from performing these roles, and therefore they would become more dependent on others for help and care. Some research participants, such as Bebe, quoted above, suggested that men are often unable or unwilling to be depended on for playing these roles; therefore, they may look for another wife.

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[4] Polygamy is banned in Canada (Section 293 of the Criminal Code of Canada). Offenders can face a five-year prison term. However, research participants are aware of, or involved in, polygamous relationships in Canada in which the husband's other wives reside outside of Canada.

Additionally, the women explained that it is common practice that women will ask permission from their husbands or other family member when leaving their home, which involves explaining the reason for going out. Having to explain the screening can be potentially embarrassing and worrying for some families. The women suggest that a simple requisition form, similar to a blood test requisition form, which is sometimes a standard follow-up to a physical check-up, would alleviate this concern and need for explanation.

The women stated that their fears about breast and cervical cancer are compounded by the fact that cancer affects parts of a woman's body that are deemed private and that represent her identity as a woman. For example, in general, motherhood constitutes an important role for women in Arabic society. The bride's status in her husband's household remains unstable until she gives birth to her first baby, which is evidence of her fertility; infertility is viewed as a mark of shame rather than a medical condition (Farsoun, Khoury & Underwood, 1996). Lala and Nena explained that the visibility of the treatment influences their views on cancer and cancer treatments:

> *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 outlook but this can be solved by wearing certain kinds of bra, and she can still give birth so breast cancer is not as serious as cervical cancer.* (Lala)

> *I think… breast cancer is more serious as it can spread quickly but for the cervical cancer [doctors] can just take the uterus out [hysterectomy] and no one would notice [but] if they did mastectomy everyone would know and notice the difference which means my feminine identity will be different. (*Nena)

The women's discussion about which is more serious, breast or cervical cancer, appears to be related, in part, to their age. For example, the women older than 40 generally felt 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. Those younger than 40 find it more serious to have cervical cancer as it will affect their ability to give birth, which may affect their marital relationships.

b. *The characteristics of the family physician*

"A female doctor is better."

Research participants perceived the gender of the health care provider as a critical concern. The survey shows that 80% of participants had a female physician. Even if women have a male physician, they prefer to go to a female physician for "women's health issues".

Zozo said that embarrassment and modesty issues are often concerns for screening if the physician is a male. Lala, commented, "If I went for screening and a male provider is there, I will not go for it; like forget it". Nena commented,

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 providers why do I need to do this? Yes, I can't imagine myself like this in front of a man other than my husband.

For a few of these women shame and lack of modesty in front of a man other than her husband are worse than the disease and death. Generally, many Arabic women prefer not to visit women's health clinics unless they are staffed by women (Remennick, 2006; Bener et al., 2006). Further, the women who had had a mammogram commented that having to change into a hospital gown and then walk through and wait in an area where men are permitted is an unacceptable situation.

About the importance of a female heath care provider, Warda added,

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, female health care providers have a vital role in increasing women's awareness of the value of early detection and providing adequate information about screening. The issue of modesty is highly valued, and since the women were not comfortable talking about breasts or sexual matters, they may avoid screening. This finding is reinforced in other studies (e.g., those of Rajaram & Rashidi, 1998, 1999; Matin & LeBaron, 2004).

"Outsider" (non-Arabic) 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 and who would therefore be a part of the "Arabic-speaking community" in Halifax. According to the participants, in some cases a physician from outside the Arabic-speaking community is better because of issues of trust and confidentiality. One participant, Warda, said

I prefer an outsider [outside of the Arabic community] physician. The Arabic community is 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 continued:

I would prefer Canadian physician 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.

Lala, Zozo and Bebe were firm in their preference for a female Arabic-speaking doctor. Lala, however, explained,

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

With regard to the issues of confidentiality, several research participants highlighted the crucial role of the (cultural health) interpreter. For example, Nena explained:

> *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.*

And Bebe stated,

> *While] 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.*

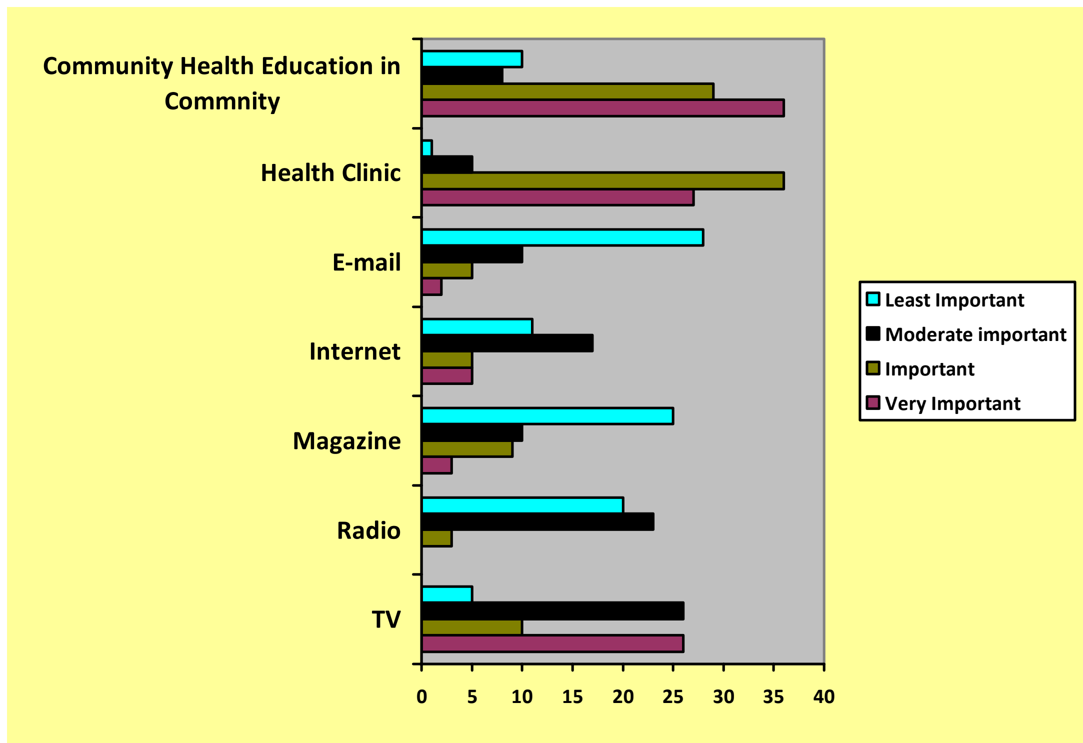
Lipsom and Omidian (1997, cited in MacKinnon & Howard, 2000) state that lack of English proficiency interferes with identifying appropriate sources for care and understanding verbal and written instruction. However, interpreters are not always available, and sometimes women are expected to find their own. Finding someone who has the time and skills can be challenging, and privacy issues contribute to those challenges (MacKinnon & Howard, 2000). Moreover, MacKinnon and Howard (2000) noted that interpreters do not necessarily act as a clarifier if the patient does not understand the health care provider's information or questions but acts as a cultural broker if a cultural issue blocks communication between patients and health providers.

Research Implications

Our findings show that the participants are learning about cancer through informal means but lack access to adequate current information about breast and cervical cancer and screening. This heterogeneous group of Arabic-speaking women faces a number of complex barriers to accessing adequate health information, and several factors determine if, when, and how Arabic-speaking women access cancer screening. Such barriers include lack of accessible information, language barriers (i.e., not enough health care providers who speak Arabic or insufficient interpretation services), a health care system's insensitivity to certain cultural practices (i.e., no assurance that technicians who perform mammography will be female or that waiting areas are for women only), concerns about confidentiality issues, and a lack of physicians' directives or encouragement to undergo screening (such as mammograms).

The women in our research indicated that despite their fears, they have a keen interest in learning more about breast and cervical cancer and cancer screening methods. Survey results show that the top three preferred ways of getting access to such information are 1) from health education within their community that is for women only, 2) through health clinics, and 3) from a television campaign. Figure 3 (below) compares research participants' suggestions for communicating information on breast and cervical cancer.

Figure 3. Comparison of Arabic-Speaking Women's Preferred Sources of Information about Breast and Cervical Cancer



Implications for health care systems and health care providers.
Our findings point to several implications for health care systems. In the immediate term, readily available interpretation services and more diverse health care staff are required (Otero-Sabagal et al., 2004). In general, the health care system should provide a broader range of educational resources and develop an innovative health care campaign aimed at informing Arabic-speaking women about breast and cervical cancer and screening. Such educational materials and/or a campaign must a) be offered in the Arabic language; b) recognize the role of spirituality and religiosity in the lives of many women; c) be culturally sensitive and responsive to patients' backgrounds, experiences and needs; d) address uncertainties, including the concern about physicians' confidentiality; and e) lead to further discussions among women and health care professionals.

A key overarching question this research underscores, which requires health care providers' immediate and serious contemplation, is the following: *In what ways can health care systems support inclusive, feminist, anti-racist, and anti-oppressive practices?* To work toward answering this question, health care providers need to create opportunities to learn from women, such as these research participants and other members of diverse communities, about, for example, the pre-migration experiences of immigrant women (Weerasinghe & Mitchell 2007) and that spirituality and religiosity play varied and important roles in the lives of some women, Health care providers also need to acknowledge that the general reluctance of Arabic-speaking, such as those in this research group, to participate in cancer screening is due not to their lack of interest or sense of self but, as indicated in this research, to several complex variables. Further,

Black feminism reminds us to reject the idea of a homogeneous Arabic-speaking (immigrant) woman in Atlantic Canada and recognize "women's multifaceted experiences, cultures, heritage, knowledge, politicization, and identities" (Timothy, 2007, p. 161).

Health care providers are adult educators, playing a key role in educating their patients and communities at large. They are also lifelong learners, regularly learning new medical knowledge and reflecting on their own practices. Recognizing health care providers' dual role as educators and lifelong learners, we recommend an on-going adult educational program focusing on diversity issues for current health care providers and those preparing to enter the health field. Such a program would provide health care providers time and supportive dialogical spaces to think critically about the complexity of diversity and consider the many ways that they and their patients are affected by it, e.g., race, gender, sexual orientation, ethnicity, and class (and other cultural exclusions, such as dis/ability, age, and geography); identify personal beliefs and attitudes related to diversity; and reflect on and challenge the ways in which they currently work with diverse populations (Brigham, 2009). Part of such a program would also require interacting with Arabic-speaking communities, both within and outside of formal health care settings.

Implications for community groups

We further recommend providing a range of creative learning experiences that are culturally and linguistically appropriate in 'safe' accessible learning environments, such as within community groups, to encourage women to discuss and learn more about this so-called "taboo" topic. For example, we have written an audio play, *Nala's Story*, which is much like a radio play, based on the narratives from this research. See Appendix 1. The resource is available as a standard single audio compact disc (CD). The script and discussion questions accompany the CD, which can be photocopied and used to guide small group discussions. This educational tool provides an inexpensive portable and accessible method for opening up discussions on this topic and reflects the method used by the National Farmers' Radio Forum[5] (NFRF) which was active in Canada between 1942 and 1965 (Sims, 2009). *Nala's Story* discusses the realistic fears and concerns about cancer expressed by research participants while also including humorous exchanges between lively characters and warm-hearted moments. These fears and concerns are brought into discussion in a non-threatening and supportive manner using the language of the research participants. It is hoped that the play will be professionally produced in both Arabic and English

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[5] The NFRF, through the support of the Canadian Broadcasting Corporation (CBC), the Canadian Association for Adult Education (CAAE), and unions, was a method of adult education that came about as a way of reaching out to educate and link people from rural areas around a topic of common interest. Often, groups of individuals would meet together over a kitchen table or in a community hall and tune in to the weekly NFRF broadcasts. Over time the NFRF found ways of developing interaction among listeners by sending out discussion questions to listening groups in advance of the broadcast and encouraging the groups to report back to the NFRF. Responses were shared at the beginning of the next week's broadcast. The slogan "Read. Listen. Discuss. Act." appeared on all the NFRF literature, which "represented an underlying assumption that: people could do something about the problems that beset them. Some issues lent themselves to local solution, but others called for governmental action" (Sims, 2009, para 15). According to Sims (2009), some groups moved beyond the discussions into what became known as Action Projects in different locations across Canada. He elaborates:

> Health services, or their lack, was [a] topic that set off a series of co-op medical insurance projects, usually on a county-wide basis involving several forums. This was a precursor to national health insurance. In other cases, local co-ops and farm groups gained support indirectly from leadership that emerged from local forums. (para 16)

and copies of the CDs made available to health clinics, as well as to community groups and women's organizations. This concept is supported by research participants' recommendations on how/where this topic should best be discussed and information on breast and cervical cancer communicated. Health care providers can also use this in their diversity program to learn about some of the fears and concerns women may have about breast and cervical cancer and screening. This play has been already been included in the training of health professionals who are going to work with women from immigrant communities in Halifax and can be used in conjunction with guest speakers in the health care field.

Nala's Story provides an adult education method that is simple in form but with great potential for community education and activism. It is one possible activity for engaging groups of women, including these research participants, who have expressed a hunger for knowledge about health issues such as breast and cervical cancer and screening, in particular, as well as about other related topics of common concern and interest.

This research has important implications for increasing and improving not only Arabic-speaking women's knowledge of, and skills and abilities related to health issues but also their attitudes about and sensitivities toward them, specifically related to breast and cervical cancer. It is also relevant for health policy makers, adult educators, health care providers and others interested in health promotion aimed at immigrant groups and non-English-speaking Canadians, particularly women.

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Appendix 1

Nala's Secret: An Audio Play[6]

By Susan M. Brigham & Maha Abdelrahman Amin

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Scene 1

Sounds: Banging pots and pans, dropping something, glass breaking…[a pause follows].

Nala sighs loudly as she sits heavily in a chair at the kitchen table and begins spooning sugar into her tea.

Daughter Sara: Mama, what is the matter?

Nala: Nothing, why do you ask?

Daughter Sara: Because you just put 10 teaspoons of sugar in your tea and it seems like there is something bothering you.

Nala: No, no, nothing is bothering me except you! Now go to school.

Daughter Sara: But I'll be half an hour too early.

Nala: Don't forget your books. Go.

Daughter Sara: Oh, (sigh) OK, mama.

Nala: Go on. Goodbye daughter. Yella, have a good day, habibtee and I'll see you later.

Daughter Sara: Bye, Mama. *Kisses her mother.*

As daughter Sara leaves friend and neighbour, Nena, comes in.
Nena and daughter greet one another.
Nena and Nala say hello.
Nala invites Nena in.
Nena talks (says several sentences about the family …) but Nala does not reply.

Nena: Didn't you hear anything I just said?

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[6] Based on research data collected by Maha Amin (2008) for her Master of Arts in Education degree and is loosely adapted from **All in the Family** episode 076: *Edith's Christmas Story* (1973), which was co-directed by John Rich & Bob Le Hendro, scripted by Austin and Irma Kalish, story by Don Nicholl.

Nala: What?

Nala drops something then instead of giving Nena tea, Nala gets unsuitable things out of the fridge, including a jar of pickles and puts them in front of Nena along with a tea cup.

Nena: Nala, what is the matter?

Nala: Nothing, why do you ask?

Nena: Well I don't usually drink pickles when I come to visit you.

Nala: Oh. Sorry. Would you like tea?

Nena: I know something is bothering you. What is it?

Nala: Don't tell anyone. I've got a lump in my breast.

Nena: Ya Lateef, Ya Lateef! I am shocked!

Nala: Yes. 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.

Nena hugs Nala.

Nala: That's the first time I said this out loud.

Nena: Oh. Ya Lateef, Ya Lateef.

Nala: 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: How did you find the lump? Did you go for screening?

Nala: I found it myself. I go for Pap test yearly as I have problem so yearly they take sample, but I never heard of breast screening. 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.

Nena: You need to go and get it checked. My doctor told me 9 times out of ten that a lump may be nothing at all.

Nala: You know that Arabic women are very hesitant to go for these kinds of examinations.

Nena: Yes, and 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.

Nala: Yes, I know. Breast and cervical cancer and screening are one of the closed topics among Arabic women. 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.

Nena: I know what you are saying. But every woman must go to be screened.

Nala: 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. You can't expose yourself to foreign men. Oh yes this is very clear in our religion and culture as long as there are no 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. Female issues are completely different. If I have a fever, no problem to see a male doctor.

Nena: Request a female doctor then.

Nala: Yeah, and I would prefer a Canadian one because I will not be embarrassed to discuss with her this sensitive issue. And 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.

Nala: A female Arabic physician is my preference as she knows my culture and language… but where is she?

Nena: I don't know, Nala. You know, 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.

Nala: Hmmm. 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.

Nena: Ah, but I think education is not always the only reason to force women to go for screening. "Awareness" is important. It is the number one reason to go for screening. 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.

Nala: Ya Lateef. This is serious! Breast cancer is more serious than other cancers. It can spread to all parts of the body which makes it the worst. For cervical cancer only we can remove the uterus or even ovaries and that's it. 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.

Nena: But Nala…

Nala: 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?

Nena: But Nala…

Nala: 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.

Nena: I know fear from this terrible disease prevents 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.

Nala: Yah, Nena, but 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?'

Nena: But Nala…

Nala: Traditionally, if my husband's 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.

Nena: Nala don't think of it like this. When are you going to tell Amr?

Nala: Oh never.

Nena: But Nala, you have to tell him. He's your husband!

Nala: Oh no. He has enough to worry about at work. You've got to promise you won't say anything about this to my family.

Nena: But Nala..

Nala: Promise me!

Nena. OK. I promise.

Scene 2

Later in the week.

Nena knocks at the door and comes into the dining room where Ahmed is waiting for his mother. He is reading a newspaper while he waits.

Nena: Salam Alaykum.

Ahmed: Alaykum salam.

Nena: You had better hurry up so you can get your mother to her appointment for the surgeon on time. How is Amr taking the news?

Ahmed: He doesn't know.

Nena: He doesn't know?

Ahmed: No.

Nena: But why do you and Sara know?

Ahmed: She had to tell us so we would know what not to tell Baba. [Pause] (*reading newspaper*): Look at this. The government is spending more money on the war in Afghanistan than they do on cancer research!

Amr (*Coming into the room*): Research? What research? And why is everyone up so early?

Ahmed: No reason, Baba.

Amr: Don't tell me that. Something is going on. What is it?

Ahmed: Nothing Baba.

Amr: Where's the coffee?

Nena: I'll get it.

Amr: Oh, Salam Alaykum.

Nena: Alaykum salam.

Nena goes to the kitchen.
Nala is washing a cup in the sink in the kitchen. Nena has been washing the same cup for a long time.

Nena: You should probably wash the other cups now.

Nala: Oh. What? Yeah. Salam Alaykum, Nena.

Nena: Alaykum salam, habibtee. Look, Nala, it is probably just a cyst. That's all it usually is. Don't worry.

Nala: But what if it isn't?

Nena: Than have the operation. It is a great way to save your life. There's one draw back though. You get well and you will have to continue to wash dishes and cook! [*Laughs*].

Nala: [*Laughs*].

Nena: [*Laughs*]. Good. You can still laugh.

Nala sees Amr entering the kitchen and says "Shhh."

Amr: What is this? Every time I come into a room people shush up. What is going on?

Nala: No, Amr. It is nothing. Do you want coffee?

[Nala *pours Amr a cup of coffee – sound of spoon stirring a cup*]

Amr: Yes. I thought I was going to get some a while ago. What are you doing here so early anyway, Nena?

Nena: Oh, I was just talking with Nala about my sister's pregnancy. You know [*draws out the words slowly and speaks a little louder*] it was a heavy labour and they thought it would be a breech birth, so they were discussing a caesarean section and they had to break her water, and it was ....

Amr: Ahh! Why do you have to talk about that with me in here? Can't you talk about something else when I'm in here? Let me have that coffee! (*Leaves the kitchen*).

Nala: Thanks, Nena. [*Pause*]. I'm afraid if I have to have an operation Amr will not think of me in the same way.

Nena: Amr loves you. That won't change.

Nala: But I will be changed.

Nena: It will still be alright, believe me.

Nala: You don't know.

Nena: That's just the point Nala, I DO know.

Nala goes back to washing dishes and says nothing.

Nena (*louder voice*): I KNOW.

Nala: You mean you?

Nena: 6 years ago.

Nala: Oh, Nena!

Nena: See how my husband and I get along. It has not made one bit of difference in our marriage. [Pause] Don't bother looking you can't tell.

Nala: Oh I wouldn't think of it. I mean I would think of it but I wouldn't ask.

Both laugh.

Nala: Oh you made me feel so much better!

Scene 3

Later in afternoon.

Amr: I know what is going on. Your mother is trying to buy me a surprise, right?

Sara: Umm. Ah.

Amr: That's it. I knew it. Ha. I can see from your face I am right.

Someone knocks at the door. It is Nena arriving. Sara answers the door.

Nena: Is Nala back yet?

Sara: No, not yet.

Nena [*whispers*]: Have you heard anything from the hospital?

Amr: You don't have to whisper, Nena. I know everything. The secret is out!

Nena: Oh thank goodness. Did you hear from the hospital? Is she alright?

Sara: No. Um, Nena, I, we…

Amr: Huh?

Nena: She's at the IWK hospital. You said you knew!

Amr: What? What hospital? What is she doing there? Let’s go! What happened? Did she have an accident?

Nena: No no. Just a test, Amr. Just a test.

Amr: What is it?

Sara: I’ll tell you, Baba on the way.

Amr: Never mind that. Tell me on the way!

Scene 4

At hospital.

Nala is asleep in bed. Sara and Nena leave the room to go find a doctor.

Nala wakes up.

Nala: Oh, Amr. You didn’t have to come here.

Amr: What do you mean? You are my wife no matter what happens.

Nala: Oh, Amr. That’s so nice of you to say that.

Amr: You better rest.

Nala: [*Yawns*] I don’t need to rest. I’ll be going home now.

Amr: But Nala they told me you have cancer.

Nala: I thought I did too. But it was just a cyst and the surgeon got rid of it just like that. Alhamdulelah.

Amr: Oh. Alhamdulelah. [*Pause*]. So what are you laying here for?

Nala: Well when they told me everything was alright I was so excited I jumped off the chair and danced around the room and tripped and I twisted my ankle.

Amr: You twisted your ankle?

Nala: Yes. It’s sprained. So, I was just laying here until you came.

Amr: You know I was scared half to death?

Nala: Sorry.

Amr: Oh, Nala.

Nala: Oh, Amr.

Nala & Amr [*together*]: Alhamdulelah.

The End

Discussion questions

1. What were some of the main issues expressed in this play?
2. In what ways are the characters learning about cancer?
    a. Where and how are they getting their knowledge?
3. How would you have handled this situation if you were Nala?
    a. What might you have done differently than Nala?
    b. Who would you turn to for help, advice and/or information?
4. What were the reasons for Nena's fears?
5. How might these fears have been reduced for Nena?
6. What were some statements that you wondered about, or you felt were questionable or you would like to know more about (i.e. Nena said 9 times out of 10 the lump is benign or Nena said "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", etc.)
7. What, if anything, should be done within communities, the health care system, medical practitioners'' training, etc. to help women like Nena?
8. Are there any actions you could take to improve the situation for Nena and other women like her? Please explain.

Maha Abdelrahman Amin, YMCA

Susan M. Brigham, MSVU