

Reproductive Health Matters

An international journal on sexual and reproductive health and rights

ISSN: 0968-8080 (Print) 1460-9576 (Online) Journal homepage: <http://www.tandfonline.com/loi/zrhm20>

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To cite this article: Ayşecan Terzioğlu & Weeam Hammoudeh (2017) Coping with cancer diagnosis and treatment: a comparative study on women with breast cancer in Turkey and occupied Palestinian territory, *Reproductive Health Matters*, 25:sup1, 35-46, DOI: [10.1080/09688080.2017.1378066](https://doi.org/10.1080/09688080.2017.1378066)

To link to this article: <http://dx.doi.org/10.1080/09688080.2017.1378066>



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Published online: 09 Nov 2017.



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Coping with cancer diagnosis and treatment: a comparative study on women with breast cancer in Turkey and occupied Palestinian territory

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Abstract: *In this article, we explore the illness narratives of women with breast cancer in Turkey and the occupied Palestinian territory (oPt), underlining the similarities and differences in the ways in which they make sense of their diagnosis and cope with cancer treatment. The article is based on 30 and 35 semi-structured qualitative interviews conducted in Turkey and the oPt, respectively. We do find some parallels in the two settings. We find that a diagnosis of breast cancer is a dramatic event with very strong reactions among many women, with women in both settings pointing to sharp increases in cancer incidence. Interestingly, the perceived increase in the prevalence of breast cancer among women appears to make cancer more manageable. There are clear variations in the degree of medicalisation and prevalence of medical discourse in the two settings, with medical discourse around cancer more common in the Turkish context. Furthermore, socio-economic variations were more discernible in the Turkish setting, and perceived to impact care. The findings affirm that women's breast cancer experiences and the ways in which they make sense of their diagnosis are largely shaped by the cultural contexts they live in, within and across country and cultural settings.* DOI: 10.1080/09688080.2017.1378066

Keywords: breast cancer, coping with cancer, medicalisation, medical care, Middle East

Introduction

Cancer rates have increased consistently throughout the world, especially in low- and middle-income countries.¹ Cancer has become the second cause of mortality after cardiovascular diseases worldwide, and this has influenced local, national and global health policies.² Medical historian Julie Livingstone contends that cancer became the most common epidemic especially in the “developing world,” where more than half of the new cancer cases per year occur.³ The rise of chronic diseases, including cancer, in the developing world warrants a shift in focus in health research in low- and middle-income countries.⁴ The global rise in life expectancy together with the rise in the prevalence of chronic conditions have also brought into focus the illness experiences and narratives of chronically ill people, who live several decades with their chronic illness and cope with the physical,

psychological and social concerns brought about by their illness.¹ The literature shows that the ways in which people make sense of living with an illness are shaped by the social and cultural contexts in which people live;^{5,6} this includes how women's perceive, cope with, understand and experience their disease.

In this study, we explore the illness narratives of women who were living with or had survived breast cancer in Turkey and the occupied Palestinian territory (oPt), underlining the similarities and differences in the ways in which these women make sense of their diagnosis and cope with cancer treatment. The Middle East experienced a drastic increase in cancer rates since the 1980s.^{1,6} The rates and mortality levels are particularly high in breast cancer among women and lung cancer in men compared to the other types of cancer.⁷ Despite the increasing prevalence of cancer in

the Middle East, literature on the lived experiences of cancer patients, and particularly of women with breast cancer, is limited, where more of the literature focuses on disease risk factors, diagnosis and aspects of medical care.^{8,9} This article explores the social and cultural perceptions of breast cancer and discusses how these perceptions are related to the increasing medicalisation in both cultural contexts as well as in the patients' lives, and patients' reactions against this process. Recent studies show that medical, scientific and religious perspectives are interwoven in shaping illness perceptions and narratives, instead of excluding each other.^{10,11}

In his seminal work on illness narratives, psychiatrist and anthropologist Arthur Kleinman argues that understanding the ways in which the patients evaluate their own illness is crucial for the physicians in order to provide an effective, empathic and ethical health care. He emphasises that the patients' interactions in their social environment, as well as their social and economic conditions inform how they make sense of their illness and shape their illness narratives.¹²

Background and context

Breast cancer patients' illness experiences and narratives are also informed by the larger political and economic dynamics and inequalities in Turkey and oPt and how they are reflected in the health sector. In accordance with the policies of globalisation and neoliberalism since the 1980s, there is a strong trend of privatisation and commercialisation of the health sector in Turkey, where there is a rapid increase in the numbers of private hospitals. However, these private hospitals mostly cater to patients with a higher socio-economic status, who can afford a private insurance and who constitute roughly 15% of the population. The rest of the Turkish patients attend public hospitals with their state insurance, and are confronted with problems of overcrowding in the waiting rooms and inadequate infrastructure, because of the state's neglect of the public hospitals.¹³

In the oPt, the broader political and economic context is key to understanding limitations on health services, as well as women's access to cancer care. At the health systems level, limitations imposed on the Palestinian health sector have stunted the development of health services, including cancer treatment in the oPt, with a history of reliance on referral systems. Furthermore, the presence of restrictions on the entry of equipment,

particularly radiotherapy equipment, means that women requiring these services must be referred to East Jerusalem hospitals or Israeli or Jordanian hospitals if they require more advanced care. Healthcare facilities in East Jerusalem, previously at the centre of the Palestinian medical system, are out of reach for most Palestinians, requiring lengthy application procedures in order to secure the necessary permits to enter East Jerusalem from the West Bank or Gaza Strip, thereby creating more constraints on women's access to treatment. Women and hospital staff noted that oftentimes permits would be issued for the patient alone and denied for family companions, which meant that women would have to endure the difficulty of travel, including humiliating experiences at highly securitised checkpoints, before and after treatment without any assistance from family members.

For women coming to East Jerusalem from the Gaza Strip, permits are especially precarious, and once issued, women must remain in the hospital throughout the course of their treatment, thereby requiring them to be away from their children and families for weeks at a time, or longer. Within the West Bank, an intricate system of Israeli military checkpoints also meant that if women did not reside in the city where they received treatment, travel to and from treatment centres was a source of added stress for them, especially if they had to make the journey alone. Despite the limited scope or breadth of services and the mobility restrictions, various insurance schemes ensure access to some care, albeit at times requiring women to undergo difficult journeys to access services. Women from wealthier backgrounds or with access to certain types of private insurance often seek care in Israeli or Jordanian hospitals, especially if they require more specialised treatment.¹⁴

Methodology

In this article, we draw on two qualitative studies (in Turkey and the oPt) that were conducted as part of a larger comparative project, through the Reproductive Health Working Group (RHWG), exploring the quality of life (QoL) of women with breast cancer in four Middle Eastern countries. In this article, we focus on the portions of the studies focused on how women cope with diagnosis and treatment in Turkey and the oPt. We use qualitative research methods in order to capture the

patients' perspectives thoroughly, and investigate how women with breast cancer define and attribute meanings to various aspects of their illness and treatment experiences.

Although the studies were conducted separately, country teams coordinated with each other and provided feedback on the interview guide and study progress. While interview guides for each study included specific contextually relevant questions, there was overlap in questions across countries. Given the scarcity of research conducted on women's experiences with breast cancer in the Middle East, and our interest in understanding women's lived experiences of breast cancer, its psychosocial impacts, the various ways in which women coped with their disease, and the support and resources available to them, a qualitative approach seemed most appropriate. Furthermore, a qualitative approach allows for a deeper understanding of individuals' lives and experiences.^{14–16}

In total, we conducted 30 and 35 semi-structured interviews in Turkey and the oPt respectively between 2010 and 2012. Below, we discuss recruitment and methods used in each site.

Turkey

The Turkish team conducted 30 semi-structured interviews in Turkey between 2010 and 2012. In Turkey, 20 interviews were conducted in Istanbul, which is the most populated city in Turkey, and 10 in Aydın, which is a small town in the inner Aegean Region. Since Istanbul is the economic and cultural, if not political, capital in Turkey, it has a considerable number of well-equipped hospitals and clinics for cancer patients. Therefore, in order to be able to point out the effect of geographical variations on the breast cancer patients' narratives within Turkey, we also conducted interviews in Aydın, which is a much smaller, less cosmopolitan and more conservative city, which does not have adequate medical facilities to treat cancer patients. The comparison is also necessary to display some of the cultural and social variations in coping with cancer within Turkey. In Istanbul, 11 interviews were conducted in a state hospital's premises (cafeteria and waiting rooms), 5 interviews were conducted in a private hospital, and 4 of the patients, who had their treatment in a public hospital, preferred to be interviewed in their home. In Aydın, all 10 patients had their treatment in the public hospitals in this city or in the nearby metropolis of Izmir, and they were interviewed in

their homes. Informed oral consent was obtained from all women participating in the study. Interviews where women consented to audio recording were recorded and then transcribed by each research team. Interviews where women refused audio recording were recorded by handwritten notes verbatim by a research assistant accompanying the researcher, and with the women's consent.

The selection criteria required that women were aware of their diagnosis and that they were diagnosed with breast cancer at least three months prior to the interview. Furthermore, the research teams were cognisant of recruiting women from diverse socio-economic and demographic backgrounds, including age, marital status, education and employment. The ages of women participating in the Turkish study ranged from 31 to 71 years of age. They were diagnosed three months to five years before the interview. Six of those women were unmarried or divorced, 16 were married during the time of the interviews, and 8 were widowed. Their education level varied from two years of primary school to having a PhD degree, and their occupations included, but were not limited to, homemaker, bank employee, secretary, accountant, cleaning lady, teacher and a restaurant owner. Accordingly, we defined women who had university education or further, and who had private insurance, which led them to have most or all of their cancer treatment in the private hospital, as having higher socio-economic status. With respect to the women's patient status, 8 women were diagnosed with breast cancer less than 6 months ago, 19 of them were having chemotherapy and radiotherapy for the last 12–18 months, and 3 of them became cancer free in the last 6 months.

Occupied Palestinian territory

The Palestinian team conducted 35 semi-structured interviews in the oPt in 2010–2012. The same selection criteria and ethical concerns were also applied in that context. In order to capture the geographical and institutional variations, the interviews were conducted in the only three West Bank hospitals, including in occupied East Jerusalem, where cancer treatment was available at the time. Women's education levels ranged from preparatory school to completing a university degree, including one medical doctor. The women participating in the Palestinian study included younger women than the participants in Turkey, with ages spanning from 25 to 71. Most of the participants

were married at the time of interview, with the exception of one single woman, one divorcee and one widow.

Conducting fieldwork at all three sites allowed us access to a socio-economically diverse group of women, residing in different parts of the West Bank and a few women residing in the Gaza Strip who were undergoing treatment in East Jerusalem. All women diagnosed with cancer are eligible for insurance through the Palestinian Ministry of Health, and assigned to a hospital depending on their location as well as treatment needs. The East Jerusalem hospital is the only hospital that provides radiotherapy treatment. Women with private insurance, private funds or needing more specialised care are typically transferred to Jordanian or Israeli hospitals.¹⁴

In total, we conducted 10 interviews in the Northern West Bank, 13 in the Central West Bank (East Jerusalem) and 12 interviews in the Southern West Bank. Women were interviewed at the facilities, where arrangements for private rooms or corners were made with nursing staff at the hospitals. The interviews were conducted by the primary researcher and a research assistant, who also took notes during the interviews. Following the interviews, the researchers discussed the transcripts and notes to assure completeness as well as to outline steps for analysis.

In the sections that follow, from the rich information collected in both studies, we focus on how women came to terms with cancer, and more specifically: the process of how women were diagnosed with cancer; their conceptualisations and understandings of breast cancer; and their experiences with treatment. The following sections are based on the findings and focus on three important dimensions of women's experiences with breast cancer: initial diagnosis, reactions to diagnosis/making sense of breast cancer, and medicalisation and medical care.

Findings

Initial diagnosis

What happens in the initial diagnosis is related to the visibility of cancer in Turkey and oPt. Cancer, particularly breast cancer, has become a highly visible disease in Turkey since the 2000s, thanks to the publication of a number of books by public figures on their cancer experiences, formation of breast cancer organisations by patients and their

relatives, and TV serials depicting major characters with cancer. This type of visibility is not common in the Palestinian setting, although there has been a rise in public awareness and screening campaigns in recent years.

Most of the women participating in these studies were diagnosed after accidentally noticing some kind of irregularity, including pain, a lump or a pimple on the breast. Very rarely were women diagnosed through regular check-ups or mammograms. In a few cases, women noticed an irregularity through regular self or clinical examinations that included breast examinations. Given the high visibility of cancer in Turkey, these irregularities were immediately tied to breast cancer. For instance, a secretary in her 50s explains:

"I was getting my house ready for the Spring after a long winter and I had a big Spring cleaning ... When I was hanging the curtains that I had washed, its railing bumped to my chest, and I had such a sharp pain that I almost fainted. When the pain did not go away for a couple of days, I checked my breasts in the mirror, when I saw a weird shaped bump on the right hand side of my right breast, where it hurt, tumor and breast cancer came to my mind immediately. Even before going to the doctor, I said to myself 'that's it, I have cancer' and I was right unfortunately."

In the oPt, a few women did express an awareness of the need for self-examination, and noted they used to do them after learning about breast cancer. One homemaker in her 60s living in the North West Bank noted:

"I used to take education training courses about breast cancer with the YMCA ... I felt something like a lump, I told my daughter who is a doctor and she told me to go and have it checked. They [the medical staff] took a sample and immediately told me."

These women distinguished themselves as having more awareness of breast cancer than most Palestinian women and were thus more likely to act when they noticed something was unusual, and were thus generally diagnosed in an early stage of disease.

Reactions to diagnosis and making sense of breast cancer

In both settings, like in many other places, a cancer diagnosis is a very traumatic experience in itself. In

Turkey, many women with breast cancer claimed that thinking about cancer or even uttering the word cancer means inviting cancer to their lives. A homemaker in her 60s, who lives in Aydın, illustrates this:

“You should not say the name of the disease [breast cancer] openly. You also should avoid thinking about it often or spending a lot of time with people with breast cancer. The last rule was difficult to obey in my case, since one of my best friends, who also lives very close to me, had breast cancer. I sometimes think that I invited this disease into my life by spending too much time with this friend of mine and talking about the disease with her.”

This quote also refers to the common fear of cancer and it is consistent with Sontag’s concept of “moral contagion,”¹⁷ referring to the high prevalence and dreadfulness of cancer, which also cuts across the social and economic boundaries in a given society as well as to the view that cancer is caused by the wrongdoings of patients.

Cancer is less visible and discussed in Aydın, which is also considerably smaller and more conservative than Istanbul, therefore the taboo character of cancer is more pronounced in the interviews collected there. Although Istanbul has also a considerable amount of conservative and religious population, partly because of the increase in migration since the 1980s, the small population in Aydın prevents its dwellers from remaining anonymous or behaving differently than the others in a community setting, unlike in Istanbul. Aydın has also a considerably smaller number of hospitals than in Istanbul, therefore everyday life is less medicalised there. Even women who were undergoing treatment for several months avoided using the word cancer in the interviews in Aydın, referring to it as “that disease” and the “evil disease,” and preferred that healthy women also not use that word, since it would mean inviting it into their lives. This common self-censorship also imposed on other people, healthy or with cancer, contributes to the reproduction of a general fear of cancer in the society. The taboo character of the disease is also related to the fact that it is often associated with death, especially in the cases of late diagnosis and among the elderly.

In the oPt, there are clear parallels where the word cancer itself was rarely used by women, and was often referred to as the “bad disease.” As a homemaker in her 30s points out: “Its name

is scary.” Many women’s descriptions of their initial reactions to their diagnosis drew on metaphors of death. For example, a widowed homemaker in her 50s stated:

“I felt like I was going to die. I started to cry and cry as if there were ten dead people in front of me.”

Despite the fear of cancer, and a more heightened public awareness of its prevalence in the Turkish case compared to the oPt, women in both settings compared cancer to flu in an effort to point to its frequency, and the possibilities for its treatment. In the oPt, it was not uncommon for the research team to be told “it’s like the flu, there is treatment” almost as if to assure the researchers (and the speaker herself) that her breast cancer diagnosis is not as scary and is not an assured death sentence given that it is treatable.

Most Turkish women with breast cancer witnessed other people being diagnosed with cancer and breast cancer in particular in their social environment, before their diagnosis. Two of them also lost their husbands to lung cancer, and seven women had a mother, aunt or sister with breast cancer. In order to describe this high prevalence, a restaurant owner in her 50s said:

“Cancer is like flu, it is all around me all the time. Every year, I hear that at least three women I know through my family and friends are diagnosed with breast cancer. After my own diagnosis and all those others, I stopped being shocked anymore when I hear these news.”

Awareness of the prevalence of cancer and the experience of having it diagnosed in one’s own body occasionally also involved search for causes, some way of attributing meaning to it. These were typically causes external to women’s bodies, such as environmental factors or higher powers, including that disease is ultimately from God, thereby making a diagnosis more bearable than before. One unmarried woman residing in a camp in the North West Bank pointed to pollution of the physical environment:

“Our camp has a lot of cancer; because they plant vegetables and they put pesticides [nearby]. A committee for breast cancer and cervical cancer detection from Augusta Victoria came, and they discovered 30 new cases.”

In both settings, faith and spirituality were important ways women used to draw meaning out of

cancer, to understand what was happening to them, and accept their fate. Many women saw breast cancer as God's will. Many also reported that cancer enabled them to rediscover spirituality and religion. One retired Palestinian woman in her 50s from the Central West Bank said:

"I have put my situation in God's hands. I am bothered from the things I am in pain from. But God willing all of this will be on my balance of good deeds."

Tawakkul or in this case the belief that "God gave me this," that "this disease is from God" helped women accept the ordeal and find purpose in their struggle to keep up with treatment requirements.^{18,19} Spirituality and faith played a fundamental role in the acceptance of the disease as well as in the decision to accept treatment and fight for survival. Tawakkul was therefore not associated with fatalism as it includes the notions of building resilience and doing everything possible to fight the disease and then relying on God's will. In the oPt, God was seen by women as responsible for both the disease and the cure. Prayer and religious practice had an uplifting effect on women and were a source of strength.

Similarly, in Turkey, the process of rediscovering spirituality and faith was linked to that of becoming a better version of one's self. Most women stressed that they became emotionally stronger and learned to be more independent in spirit. One woman described the strength and independence as knowing when, for what, and to whom to ask for help. Two elderly women, who are homemakers and live in Aydın, said that they became more religious after their diagnosis and one of them began wearing a veil, also for the practical purpose of hiding her hair that was just growing back:

"Praying to God and visiting the tombs of the Saints became comforting activities that made me feel my pains and nausea less for a while. I used to do these even before my diagnosis, but I began to live in more religious terms during my cancer treatment. Through praying, I feel like, a special connection between me and the God is established, and that he hears whatever I say."

In Istanbul, one professional woman in her 30s explained that she "discovered" yoga during her chemotherapy, which helped her to calm down considerably and have a better, more nuanced and spiritual perspective on her life. Two women

also from Istanbul explained the benefits of *reiki*, which gives a particular type of comfort and sense of peace and spirituality.

Medicalisation and medical care

With a breast cancer diagnosis, medical care becomes a central part of women's lives. Despite some variations in the cultural conceptualisations of diagnosis, in both settings, women's lives had become quickly medicalised right after the diagnosis. Visits to doctors' offices, clinics and hospitals became a more regular part of women's daily lives, which had various effects on their bodies as well as on their social lives. Through our interviews, we note variations in the ways women reacted to or dealt with being a patient; and it is also perhaps here where we find more palpable differences between the Turkish and Palestinian settings.

We note that the narratives from both settings reflect differences in the context in which cancer and cancer treatments are dealt with both at the health provision level as well as discursively. In Turkey, the terminology used to discuss cancer was much more medical compared to the oPt, where cancer was almost always spoken of as being the will of God, but then also followed by a statement regarding the availability and importance of treatment.

In Turkey, particularly in Istanbul, medical terminology is a more regular part of the patients' everyday lives, language and conceptions of health and illness. Most women adopted the language of medicine, talked of their illness in medical terms. The adoption of the language of medicine was linked to knowledge and access to different sources of information. More of the women interviewed in Istanbul had a family history of cancer and in some cases lost their spouses or other family members to cancer, so there was also more familiarity with different phases of the disease as well as treatment options compared to Aydın, where the women's narratives are considerably less medicalised. For some women in Istanbul, this familiarity helped women come to terms with their disease. The narrative of a businesswoman who is in her 40s is an example of this:

"The more I learn about my illness, the more I realize that there is a medical name for everything related to my illness and treatment. Therefore, this shows me that the doctors and scientists have

conducted a thorough research on this topic for years, and this gives me confidence in the sense that I will be cancer-free one day!”

This stands in sharp contrast to the discourse of most women we interviewed in the oPt, where there was emphasis on the ultimate cure coming from God; although they also viewed physicians and treatment as the means to a cure, the success of that cure was ultimately determined by divine will. In the oPt, cancer awareness is also rising, but not with the same type of visibility and emphasis on the acquisition of medical terminology as in Turkey. Very few women tracked the biomedical progression of their disease, and relied more either on general/vague statements from their physicians or referred to changes in their functional well-being as indicators of improvement, which is distinct from the interviews with women in Turkey. In the oPt, the adoption of the language of medicine, although present in some cases, is less frequent. On the contrary, women’s involvement in the medical process is limited primarily to the role of a more passive patient. By passive, we mean that emphasis was placed on following the course of treatment prescribed by doctors, not trying to intervene even by trying to follow the medical intricacies of the process, but trusting that God ultimately determined whether a person was cured.

It should be noted, that women in the oPt often-times discussed the difficulties they faced in accessing care or the obstacles that prevented the Palestinian healthcare system from expanding their services due to limitations imposed by the Israeli military in terms of women’s physical access to treatment facilities, as well as the types of equipment allowed in. Within this broader context, many women expressed relief that treatment was available and often indicated that they were thankful for the available care and the diligence of health staff. They were especially thankful if the treatment they needed was available in the same city they lived in or if they did not require extra permits or have to pass through checkpoints to access services. While a thorough discussion of the broader political context is beyond the scope of this article, it is important to keep it in mind when interpreting some of the variations in expectation between women in Turkey and the oPt. Women’s demands and expectations of the health system in the oPt is likely to be impacted by their

awareness of the severe limitations placed upon it by the Israeli occupation.

Passive, however, does not mean neglect of the quality of the care being received. In their discussions about the medical care they were receiving, women did emphasise various aspects of care including: the way they were treated by medical staff; the availability of treatment; the physical conditions of the health facility; and the proximity to home and loved ones. But they were not as involved with the particulars of their treatment actively with their providers, and did not express a desire to be more heavily involved. Rather, their discussions focused on the ways they were treated by providers and hospital staff, the characteristics of the treatment facility, etc. One homemaker in the North West Bank stated:

“So far, good. But the building could be renovated because it is old. If the place is better, larger, and with a nice view, it would help enhance the psychological status of patients. But the treatment is very good. Personally, I did not face any problems and if I needed medication and I couldn’t find it, I can go buy it. But I hear from other patients that there is a deficiency ... As for here they [the medical staff] are very good. It is clean and sterilized. The treatment is excellent, they advise us. The doctor is very nice and the nurses are better. I feel content coming here.”

Another woman at the East Jerusalem hospital stated:

“The medical treatment is very good. The doctor is very nice, he treats the person [patient] as a friend; they [the medical staff] treat the patients very well.”

However, other Palestinian women, and particularly those in the South West Bank, had some complaints:

“Only if they give more attention to the patient who is here because she is sick. Only if they treat us like human beings.” (A single woman in her 50s)

“They [medical services] are fine. But the cure is from God. If one would want something, it would be something cleaner and better and if there is more than one nurse [referring to only one nurse attending the unit], because it is a mess and tiring like this.”

“I went five times for the operation, and each day they would say bring her fasting, and in the evening they would tell me there is no bed, come tomorrow.”

In contrast with Turkey, socio-economic variations between women at the same hospital did not appear to play a central role in the care women received in the oPt. Rather, place or the location of the treatment facility appeared to be more central. Within a given health facility in the oPt, patients generally received the same type or quality of care and were generally covered by various health insurance programmes. There is variation in terms of quality of care across treatment facilities, with the NGO hospital having a longer history of specialised care and better funding and equipment, partly due to foreign funding. The two government hospitals, both operating under the umbrella of the Ministry of Health, had some variations in the characteristics and the ways service was provided. The hospital in the North West Bank had separate rooms for women and men and more nurses on staff that were working at the chemotherapy unit. This reduced some of the crowding, and provided patients with more attention from nursing staff. At the Southern West Bank hospital, during the course of our fieldwork, there was only one male nurse diligently attending to patients in the chemotherapy room, which served women and men. There was also a shortage in beds or comfortable chairs for patients. Many of the women we interviewed in the South West Bank also appeared to come from more socially disadvantaged backgrounds, and were thereby at further disadvantage in terms of the demands they could make on the health system. This was not the case to the same extent at the North West Bank hospital where a few patients who stated they could have gone to Jordan for care decided to stay close and were generally content with the care they received. The East Jerusalem NGO hospital had more of a mix of patients, but also had more patients from the Central West Bank, who were generally better off socio-economically than their South West Bank counterparts. It should also be noted that in the Palestinian setting, women with higher socio-economic status generally seek care in Israeli or Jordanian hospitals. A few of the participants in the study came from higher socio-economic backgrounds, but indicated their decision to access care through the Palestinian Ministry of Health was related to their preference to be close to their homes or positive experiences with providers. We did observe, however, that women who were more highly educated, especially if they were health professionals

themselves or if their spouses were health professionals, there was a greater degree of information provided to them on their condition and treatment. On the whole, however, there weren't any great differences in the socio-economic backgrounds of participants.

In Turkey, women's satisfaction with healthcare services varied, and variations in socio-economic status appeared to play an important role in shaping women's experiences of medical care. The women's profession, level of education, the type of insurance (public or private), her area of residence (urban/rural), her clothing and general attire are the basic clues that the healthcare providers use to determine the women's background. Most women emphasised that the quality of their interactions with the healthcare providers depends largely on their socio-economic background, rather than the type of hospital that they are treated in. A breast cancer patient in her 30s, who works at a bank, explains:

“Although I have most of my cancer treatment in a state hospital, the medical staff treats me with a special attention and care. They know that I am a university graduate, and notice my professional attire and attitude. So they explain the details of my treatment and treat me more respectfully and carefully in contrast to other women who do not have any employment or formal education. Some of them know that I have to go back to work after my chemotherapies, so they do not make me wait in line, and take me in before some of the patients who had come before! They really appreciate that I am a strong woman who do not give up working even during cancer treatment.”

Turkish breast cancer patients, who have close family members working in the health sector also benefit from privileged social interactions in the hospital context. They are proud of the doctors, nurses and even pharmacists among their family members, and stress that thanks to those people, they were treated much better by the healthcare providers in general and have much better experiences in the hospital. For example, they did not wait for a long time for their doctor's appointment and dealt with fewer bureaucratic issues.

Women from low socio-economic background, however, reported experiencing the process of diagnosis and treatment as one of exclusion and condescension. These women reported that they are often marginalised and discriminated against

by the doctors and nurses during their treatment, even though they do their best to understand the doctors' explanations and follow the doctors' suggestions. In Istanbul, a homemaker in her 60s stated that the doctors and nurses treated her as an "ignorant villager," when they read that she quit primary school in her file:

"They readily assumed that I don't know how to read and write and anything about hospitals or medicine, although I learned to read and write in a special educational program and I am familiar with the hospitals, since I often took my children and grandchildren there ... However, they don't trust in anything I say, give me bad looks and repeat everything twice or three times in a really slow way, even though I say that I understood what they say the first time they tell that to me!"

The women of low socio-economic status often emphasised that the doctors and nurses do not trust their explanations in the state hospitals, where they mostly have their treatment. These women also expressed the idea of a loss of control over their body. Several of them complained that the doctors do not pay attention to privacy in the examination rooms in the state hospitals to the extent that anybody may enter the room without asking for permission and see the women half naked during the examinations. Two women noted that the doctors often bring their interns or students to "probe" their breast, without asking their permission. A home maker in her 60s also narrated that a nurse made her wait in the clinic deliberately, by allocating an appointment for her in the most crowded hours, although she had kept emphasising that she wanted to be examined as soon as possible, since she could not wait for a long time because of her sharp pains.

Discussion

In this article, we examine the experiences of women with breast cancer in two Middle Eastern settings, the oPt and Turkey. Such comparative studies based on qualitative methods, of which there is a dearth in the literature, enable us to gain an insight into how the cultural contexts play an important role in illness and healing experiences and narratives. Although, as the principal researchers and authors of the article, we do not claim that our findings are generalisable for all the women with breast cancer in Turkey

and in oPt, we believe that our findings and discussions provide important insights on how they give meaning to cancer and cope with breast cancer. While our studies show notable variations in the ways women experience breast cancer in these settings, particularly in terms of treatment, we do find some parallels in the two settings. Similar to other studies, we find that a diagnosis of breast cancer is a dramatic event with very strong reactions among many women.^{7,20,21}

In both settings, women perceived a notable increase in the prevalence of cancer generally, and breast cancer more specifically. While women's perception of this increase is consistent with cancer trends in the region,^{1,9} it is interesting to note that this perceived increase in the prevalence of breast cancer appears to the women to make cancer more manageable. In fact, in both settings, women compared cancer to the flu, implying that the cancer is highly prevalent now and is not scary as before. In terms of using medicalisation and religious discourses, there are more similarities between the ways in which many Palestinian women and disadvantaged Turkish women in Aydın, with less formal education and more conservative background cope with cancer. The emphasis on faith in coping with a breast cancer diagnosis has been noted in the literature, particularly among women in Muslim and Arab countries.^{7,11,14,19,20} For these women, faith did not translate into giving in to fatalism, but rather women emphasised their responsibility to seek treatment, but that the ultimate cure is from God. Here, faith largely contributed to women's psychosocial well-being and helped in the quest to make sense of their disease.

There are clear variations in the degree of medicalisation and prevalence of medical discourse in the two settings. While we do not want to overstretch our argument and the generalisability of our findings, medical discourse around cancer was more common in the Turkish context. In the Turkish setting, geographic and socio-economic variations were more discernible, where women's use of medical terminology and discourse was viewed to have a positive impact on their relationships with physicians and their treatment options.¹⁰ These socio-economic variations were not as visible in the Palestinian context, perhaps in part due to the fact that many women with higher socio-economic status seek care in other countries. There were instances where women

complained of not being treated like “human beings,” particularly in one of the hospitals that had a very busy caseload and fewer nurses on staff in the chemotherapy unit. A few of these women compared the care they received to what they heard about treatment in Jordan and Israel, primarily in terms of the number of patients a nurse was responsible for. In this particular hospital, at the time of our fieldwork, there was often only one nurse regularly attending to 20–27 patients at a given time, with sporadic assistance from another nurse. This, however, did not reflect the experiences of women at other hospitals, where they generally had positive experiences and interactions with hospital staff. One woman, a homemaker in her 30s, at a different West Bank hospital even noted that she and her husband had initially thought of leaving to Jordan for her treatment, but that after their positive experience with care they decided to continue treatment in the West Bank.

While similarities in the experiences of women in and within the two settings exist, the findings also make it clear that those women’s breast cancer experiences and the ways in which they make sense of their diagnosis are largely shaped by their social and economic conditions and the cultural contexts they live in, both within and across country and cultural settings. In pointing out the interactions among the women’s socio-economic background, illness experiences and illness narratives,¹² the article aims to contribute to bridging the communication gap between the healthcare providers and patients, by helping the former to be more aware of the latter’s psychological and social, as well as physical suffering.

The article is also crucial for the anthropology of health and illness, as one of the rare examples of comparative and qualitative research on breast cancer patients in the Middle East. However, a wider range of comparison, which would include a few other major countries in the Middle East, such as Lebanon and Egypt, would provide a richer

scope in understanding how the illness experiences and narratives of women with breast cancer are shaped in the Middle East. However, the article includes important socio-economic variations influencing the cancer experiences and narratives, both within and between the two cultural contexts. By pointing out these variations, the article challenges sweeping judgments, such as the fatalistic Muslim conception of illness and the ubiquitous influence of Islam in shaping people’s experiences and narratives in Muslim countries. The findings of this study provide some insights into an understudied area of research in the Middle East, and have some important implications for healthcare provision in terms of gaining insight on the patients’ perspective and a better understanding of patients’ struggles.

Acknowledgements

The RHWG has enabled the authors to convene in January 2011 in Beirut and in June 2014 in Istanbul for the coordination of the writing process. We would like to especially thank Rita Giacaman and Belgin Tekçe for their guidance throughout the project and through various drafts of this article. We would also like to thank Jocelyn DeJong for her useful feedback. We also thank Özlem Kaya, Yeşim Neşeriz Yasin and Mehmet Ekinici for their contributions to the research in Turkey; as well as Hadil Daloul and Gregoire Hervouet-Zeiber for their contributions to the research in the oPt.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

We would like to thank profusely the Reproductive Health Working Group (RHWG) for providing seed grant, which is available to its members, for this research and an academic platform to discuss our findings in July 2010 Egypt, July 2011 Tunisia and February 2014 Muscat Annual Meetings.

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Résumé

Dans cet article, nous explorons les récits de maladie des femmes atteintes de cancer du sein en Turquie et dans le territoire palestinien occupé, tout en soulignant les similitudes et les différences dans la façon dont ils comprennent leur diagnostic et font face au traitement du cancer. L'article est basé sur 30 et 35 entretiens qualitatifs semi-structurés effectués en Turquie et dans le territoire palestinien occupé respectivement. Nous avons trouvé des parallèles dans les deux paramètres, ce qui nous a poussés à constater qu'un diagnostic de cancer du sein est un événement dramatique avec des réactions très fortes parmi de nombreuses femmes, les femmes dans les deux contextes montrant une forte augmentation de l'incidence du cancer. Il convient de noter que l'augmentation perçue de la prévalence du cancer du sein chez les femmes semble rendre le cancer plus facile à

موجز المقال

يتطرق هذا المقال إلى قصص المرض الخاصة بالنساء المصابات بسرطان الثدي في تركيا والأراضي الفلسطينية المحتلة، مع تسليط الضوء على أوجه التشابه والاختلاف في كيفية فهم تشخيصهن وتعاملهن مع علاج السرطان. ويستند هذا المقال من 30 إلى 35 مقابلة نوعية شبه منظمة أجريت في تركيا والأراضي الفلسطينية المحتلة، على التوالي. ووجدنا بعض نقاط التشابه في البلدين موضوع المقالة، فنحن لنا أن تشخيص سرطان الثدي هو حدث دراماتيكي نجم عنه ردود فعل قوية جداً ما بين العديد من النساء، في ظل ازدياد بشكل كبير نسبة الإصابة بالسرطان لدى النساء في البلدين. وما يثير الاهتمام هو أن تصورهن هذه الزيادة الملحوظة في تفشي سرطان الثدي بين النساء جعلت هذا المرض أكثر طواعية. وثمة اختلافات واضحة في درجة إضفاء الطابع الطبي وانتشار المحاضرات الطبية في كلا البلدين، مع كون الحديث الطبي عن السرطان أكثر شيوعاً في الجانب التركي. إلى ذلك، بدت الاختلافات الاجتماعية والاقتصادية أكثر وضوحاً في الجانب التركي، وكان من المتصور إحدائها تأثيراً على الرعاية. وتؤكد النتائج أن تجارب النساء مع سرطان الثدي وكيفية فهمهن لتشخيصهن تشكل إلى حد كبير من السياقات الثقافية التي يعيشن

gérer. Il existe des variations claires dans le degré de médicalisation et la prévalence du discours médical dans les deux contextes, avec un discours médical sur le cancer plus commun dans le contexte turc. En outre, les variations socio-économiques étaient plus discernables dans le contexte turc et perçus comme ayant des effets sur les soins. Les découvertes confirment que l'expérience des femmes face au cancer du sein et leur façon de comprendre leur diagnostic sont en grande partie façonnées par les contextes culturels dans lesquels elles vivent, à l'intérieur et à travers les pays et les milieux culturels.

فيها، سواء داخل البلدين موضوع المقالة و عبرهما أو من خلال الخلفيات الثقافية.