Short Report

A Brief Encounter with the Middle East: A Narrative of One Muslim Woman Diagnosed with Breast Cancer

Lea Baider[1], Gil Goldzweig[2]

[1]Psycho-Oncology Services, Oncology Institute, Assuta Medical Center, Tel-Aviv, Israel, [2]School of Behavioral Sciences, Tel-Aviv Yaffo-Academic College, Tel-Aviv, Israel

Corresponding author: Gil Goldzweig, PhD.

Associate Professor of Psychology Dean

School of Behavioral Sciences

The Academic College of Tel-Aviv-Yaffo, Israel

Tel: +972-3-6802525

E-mail: giligold@mta.ac.il

Received: September 17, 2015, Accepted: October 21, 2015

ABSTRACT

One of the major challenges the healthcare profession face is understanding the variability and different meanings of the concepts of age and aging within different cultural, social, religious, and ethical contexts. People over the age of 65 in the Middle Eastern countries are estimated to comprise 4.7% of the population and are expected to grow rapidly. In the Middle East, cancer is the leading cause of death among women aged 40-79 and one of the leading causes of death for women over 70 years of age. Many women in the Middle East live within a system of religious values and moral perceptions based on an intergenerational family structure and clear family roles. We present a singular case study describing the importance of the ability to successfully understand cross-cultural issues in a clinical setting. Attention should be given to barriers and facilitators related to health and cancer education. It is recognized that personal, psychological, religious, environmental, social, and economic factors influence participation in any health programs. Cultural and religious factors, in particular, have been shown to play a vital role in women's attitudes to breast cancer screening. It has to be noted that the case presented is meant to present and demonstrates cross-cultural issues rather than to represent Muslims in the Middle East.

Key words: Cancer, healthcare, Muslim women, psycho-oncology, cancer, healthcare

Introduction

Interlocution: A brief encounter with the Muslim Middle East

"It is the meaning that men attribute to their life, it is their entire system of values that define the meaning and value of old age. The reverse applies: by the way in which a society behaves toward its old people it uncovers the naked, and often carefully hidden, truth about its real principles and aims."[1]

Access this article online	
Quick Response Code:	Website: www.apjon.org
	DOI: 10.4103/2347-5625.172485

Cite this article as: Baider L, Goldzweig G. A brief encounter with the middle east: A narrative of one Muslim woman diagnosed with breast cancer. Asia Pac J Oncol Nurs 2016;3:205-10.

The process of aging within a multicultural world population brings with it an increased need to include more focused age considerations when discussing issues of geriatric health and wellbeing. One of the major challenges the healthcare profession face is understanding the variability and different meanings of aging and health concepts within different cultural and social structures of the Middle East. While the world's population is projected to grow by 35% in the coming decades, the number of Muslims is expected to increase by 73% from 1.6 billion in 2010 to 2.8 billion in 2050.[2] In 2010, Muslims made up 23.2% of the global population, and more than a third are concentrated in Africa and the Middle East, which are projected to have the biggest population increases. However, even within these high-growth regions-as well as others – Muslim populations are projected to grow faster than any other group.[2] The same dynamics hold true in many countries where Muslims live in large numbers alongside other religious groups. For example, India's Muslim population is growing at a faster rate than the country's majority Hindu population and is projected to rise from 14.4% of the 2010 population to 18.4% (or 311 million people) by 2050.[2]

Demographic trends in the Middle East should be part of the considerations guiding healthcare policy. Compared with developed countries, the population of the Middle East is relatively young, according to the World Bank 2010 report The percentage of the population over the age of 65 in the Middle East and Northern Africa is estimated at 4% (in comparison to 7% worldwide and 18% in Europe), the range varies from under 2% in the United Arab Emirates (UAE) to 10% in Lebanon. [3-5] In contrast to the declining Global fertility rates over the past half-century, the onset of declining fertility in the Middle East is a relatively recent trend.[5]

Life expectancy in the Middle East (Eastern Mediterranean Region), has raised from 62 years in 1990 (61 years for men, 63 years for women) to 68 years in 2013.[6] Although the process of aging is in early stages in Arab countries, it should be noticed that the number of people aged 65 and above has more than doubled between the years 1980 and 2010.[7] There are large variations in different countries. For example: In Lebanon older persons represented 8.4% of the population at 2010 while in Palestine older persons represented only 2.8% of the population. Since the pace of the increase in the older population in the Arab countries is expected to pick up in the next decade, Arab countries will need to allocate more resources to the aging population.[7]

With the changes in life style in Middle East chronic non-communicable diseases are expected comprise most of the of the region's disease burden and are anticipated to rise to 60% by 2020.[4,8]

Cancer and chronic disease rates vary within different Arab and Middle Eastern countries with the majority having rates of above 45% of older adults suffering from at least one chronic disease.[9]

Israel and the Middle East

Out of the total population in Israel 75.5% are Jews, and 20.3% are Arabs. Within the Arab population the share of Muslim Arabs rose from 78% in 1990 to 84% in 2009.[10]

The total fertility in Israel is the highest in all Western countries. As a result of both an increase in the birthrate and an increase in immigration from neighboring countries, the Median age for Muslim Arabs 19.[10] Most of the Muslim Arab citizens of Israel are define themselves as affiliated to the Sunni branch of Islam. As of 2008, Israeli Arab citizens comprised just over 20% of the country's total population. About 82.6% of the Israeli Arab population was Sunni Muslim (with a very small minority of Shia), another 9% were Druze, and around 9% were Christian (mostly Eastern Orthodox and Catholic denominations).[11] The Israeli Arab Muslims also include the Bedouins, who are divided into two main groups: The Bedouin in the North of Israel, who live in villages and towns, for the most part, and the Bedouin in the Southern parts of Israel ("Negev"), who include half-nomadic inhabitants of towns and unrecognized villages. Seventy-one percent of the Arab population lives in 116 different localities throughout Israel. In these localities, Arabs are a heavy majority. Twenty-four percent of Arabs live in cities that have a Jewish majority. Of the remaining 5%, approximately 4% live in Bedouin communities in the Negev, and 1% lives in areas that are almost completely Jewish.[11,12]

Israel: Cancer incidence and mortality

According to published mortality rates the Central Bureau of Statistics (CBS), cancer caused 25.9% of all deaths among Israeli Jews, as opposed to 20.7% among the country's Arab population in 2012. Arabs make up roughly a fifth of the country's 8.2 million residents as of 2014, according to the CBS.[13] The main cancers accounting for over 50% of overall mortality are similar among the Jewish and Arab populations: Lung, colorectal, and pancreatic cancers among men; and breast, colorectal, and lung cancers among women. An international comparison uploaded to the Globocan website indicates that Israel ranks relatively low among the top 20 countries with the highest incidence and mortality rates in the world. Israeli men rank 19th highest and Israeli women rank 15th highest in both incidence and mortality. Compared with OECD countries as of 2011, Israel ranks below average with a relatively low mortality rate (8th lowest).[14]

Breast cancer is the most common malignancy in women in Israel. Comparisons of incidence, mortality rates, and stage at diagnosis between Arab and Jewish women for the period of 1979-2002 revealed that among Arab women,

age-adjusted incidence rates increased by 202.1% from 14.1/100,000 in 1979-1981 to 42.0/100,000 in 2000-2002. Among Jewish women, the rates increased by 45.7% from 71.1/100,000 women in 1979-1981 to 103.6 in 200-2002. The ratio of incidence to mortality rate increased for both population groups but is still lower among Arab women. In every age group, Arab women were more likely to be diagnosed at a more advanced stage of the disease. The rise in breast cancer incidence, mortality rates, and the later stage of diagnosis among Arab women emphasize the urgent need for increasing early detection of breast cancer in the Arab population by improving rates of compliance with screening mammography.[14-17]

Longevity brings with it chronic disease and increased resource utilization, and the Middle East is currently ill-prepared to handle either. Longevity also increases the lifetime, cumulative risk for many types of cancer. Epidemiological studies show that all-cause cancer incidence peaks around age 70.[5] Over the next few decades, the incidence of cancer in the Middle East is expected to surge in parallel with the aging population. In fact, registry data already indicates an increasing regional burden of cancer. Naturally, it is not age alone that shapes cancer prevalence and outcome. An indolent preventative care culture and a lackadaisical approach to cancer screening coupled with a high prevalence of cancer-promoting behavior such as smoking and sedentary lifestyle mean that many cancers present at an advanced stage when the only reasonable treatment is palliative care.[18]

Muslim Arabs: perception and appraisal of cancer and death

There are over 75 million illiterate adults in the Middle East. Among them, around 13 million illiterates are girls and adult women.[19] A worrying aspect of this demographic is the lack of health education for Muslim Arab women.[20] Less health awareness leads some Muslim women to defer responsibility for their own healthcare to Allah and fate. Some women may still believe that death is inevitable when cancer is present.[20] Attention should be given to barriers and facilitators related to health and cancer education. It is recognized that personal, psychological, religious, environmental, social, and economic factors influence participation in any health program. Cultural and religious factors, in particular, have been shown to play a vital role in women's attitudes to breast cancer screening.[21]

Control over pain and other symptoms is generally required and advocated by most people, whereas some Muslims interpret suffering as atonement for one's sins. This interpretation paradoxically helps patients and family members cope with diseases. More importantly, Muslims do not generally believe that life is pointless, even when it is associated with a significant amount of suffering. They believe that Allah has the ultimate wisdom and is the most merciful and will reward those who express patience and satisfaction when inflicted with disease or suffering.[22] It is recognized that subjective, religious, cultural, social, and family factors influence women's participation in health cancer programs and screening activities.

One cause of increased suffering is facing a lonely death surrounded by strangers, along with advanced technologies and procedures that needlessly prolong the dying process without realizing the fact that the end of life is approaching.

In many cases, patients who grew up in traditional families prefer to meet death in their own home surrounded by their families.

Participation in any healthcare activity would lead to a possible early diagnosis of cancer, which could conflict with a Muslim woman's traditional duties.[16] Women's health priorities still reflect the patriarchal state and the power of the male interpretation of Islamic religious law (Shari'ah):[23]

- Unequal power positions between males and females.
- Inequality based on religious tradition and patriarchal social structures.
- Family values and social traditions.
- Redemption in the afterlife.
- No physical exposure to male physicians or nurses.
- Mistrust of cancer treatments.
- Perception of cancer as punishment and death.
- Sterility from cancer leading to rejection and divorce.
- Genetic family illness causing dishonor and stigma.

A cancer narrative: the grief of Aaima and Mohamed

(The following case was referred to the first author for consultation at the end of patient hospitalization. The patient gave written permission to publish the information, and any identifying data were changed (names, residence, age, etc.).

"O, my Lord! How shall I have a son seeing my wife is old and barren?"

– Qur'an 3:40

Aaima was a 55-year-old woman born in a small Arab Muslim village and the oldest of eight siblings. At the age of 13, she married Mohamed, her cousin — A culturally accepted decision made by both families. Mohamed, 61, was already considered a mature man when he married at age 19. They were religious, Arab Muslims with strong belief in Islam and obedience to the Qur'an. Aaima and Mohamed lived in the same household with his parents and their extended family. Four daughters were born to Aaima. Every year, her

husband's family expected the arrival of a son that never came. Aaima lived in shame and guilt, feeling condemned, and stigmatized for not being able to conceive a much-desired son for Mohamed.

From age 40, Aaima had pain, weakness, and a lump in her breast. A nurse in the village explained her symptoms as "menstrual changes and menopause" as she could not conceive more children. Aaima felt old, tired, and ostracized by her husband's family. She prayed for forgiveness to Allah for her sins and wished to be taken to the holy paradise. She was hospitalized due to severe pain and anorexia and diagnosed with Stage IV invasive breast cancer with metastasis to the liver and brain. The oncologists gave her Tamoxifen and strong medication for pain control. The family emphatically requested that the name of the illness not be mentioned to anyone and explained the humiliating consequences to them should the real diagnosis be known.

Mohamed described Aaima as an "old woman" who lacked the strength in her body to conceive sons for him and his family. In the time before Aaima's death, Mohamed's family arranged a new marriage for him with a young distant cousin. The first author met with Aaima during her short hospitalization. She was experiencing severe pain, bleeding from her right breast, leukopenia, and anorexia. She expressed lamentations related to her "sins, faults, and inner guilt:"

"…I did not give my husband sons that would preserve his name and soul… His new wife will give him sons so his name will be written in the Book of Allah… I am very old, but not by the number of years. Allah decides when our bodies are old and not able to function anymore… Now I do not deserve to have any place in my husband's house. I do not hide my wrinkles… they are like a stream of Allah's wisdom, as it is written in the Qur'an. My eyes inside my old skin are already dead, dreaming of Allah's new life."

Discussion

Realm of beliefs: a good death

Several aspects of "good death" as perceived by Western communities are not recognized as important by many Muslim patients and healthcare providers. The definition of "good death" that is acceptable to Muslim patients and healthcare providers consist of several principles. There is some consensus on the importance of dignity and privacy, which can be explained by the Islamic perspective that respects every individual and regards each as a fundamental pillar of *Shari'a*. Muslims by and large value spiritual and emotional support and believe that death is closely linked to faith.[24] The Qur'an builds a system of religious values and moral perception for elderly women based on the integral family structure and clear family roles, life, and death as prescribed in Islam.[24]

The quality of death is related to a Muslim's faith, belief, and preferences during the dying process. This includes being sure that someone is there to prompt them with *Shahadah* as a final statement of faith (bearing witness that there is no true God but Allah and Muhammed is verily his servant and his messenger) and to recite chapters of the Noble Qur'an, an also making sure to die in a position facing the Holy Mosque in Makkah and in a holy place (e.g., Madinah, Makkkah, or a Mosque) or in their own bed.[25]

Aaima and Mohamed's narrative opens an opportunity for thought and reflection on the diversity of cultures, rites, systems of belief, health, illness, and death. Aaima models the role of Muslim women defined by marriage and male children.[16] Participation in care for the body (besides fertility) would interfere with women's traditional duties as a woman and her religious beliefs. Women may be reluctant to see a physician for gynecological symptoms, cervical smear tests, or intrauterine device checks for fear of bleeding following a pelvic examination. Women may be unaware that traumatic bleeding of this kind is distinct from menstrual bleeding, and hence, the religious constraints do not apply. Education is needed both within the Muslim family members and among professionals so that the importance and implications of genital symptoms can be better understood.[26,27]

Moreover, as the Middle East population is aging rapidly and with aging as the main risk factor for cancer, the incidence and prevalence of the disease are increasing among all the populations in the region. These developments represent huge challenges for national and society-based health services. The focus and emphasis in facing these changing circumstances lie in the education and training of professionals (mainly physicians and nurses) at the primary, secondary, and tertiary levels of health services. It is imperative that these training initiatives include clinical practice with priority given to the creation of multidisciplinary teams, both at cancer centers and for family-based services [Appendix A].

Conclusion

The path of cultural awareness

The Middle East is a diverse region where politics, social and family traditions, and religion pervade most aspects of life, including health and healthcare. Middle Eastern countries and even microcosms within those countries can differ widely in religious practices, economic privileges, social structures, and cultural traditions. It is imperative that healthcare researchers have a seasoned understanding of the nuances that unite or separate different systems of

belief. These factors inevitably have bearing on the health of the population and make a collective analysis of the region difficult and somewhat noncohesive.

The ability to successfully understand cross-cultural issues in a clinical setting plays an important role in today's practice of health education and oncology care in Middle Eastern Muslim countries.[28] Such ability is based on cultural competence that entails the recognition and awareness of the role that culture, religion, and belief systems play in the patient–family interrelation and within the system of healthcare. Thus, healthcare professionals should refer not only to the individual as a patient but also the social and household unit of family care: The patient, the caregiver, and the cultural context surrounding their life.[29]

Cancer is often undiagnosed or poorly controlled until serious complications arise, and paradoxically, the use of high-tech interventions for prolonging life is pushed beyond reasonable limits. The current situation calls for initiatives of strong primary healthcare and the promotion of educated and well-trained health professionals willing to work in the community. Moreover, emphasis should be placed on family and religious-based services, which will involve informal caregivers and community members.

Within Middle East Islam, the current practice of healthcare for women diagnosed with cancer is based more on traditional stereotypes of collective obedience than individual independent behavior that may challenge their society. Empirical evidence describing the relevant needs of Islamic Arab women diagnosed with cancer is strikingly limited in the face of growth in elderly women populations in the Middle East.[30] Pursuing solutions to these challenges should be spurred through social awareness, education, knowledge, and creativity. Innovations in medical and health paradigms that are embedded within the normative and cultural belief of Islam are urgently required. Without any doubt, a change can be achieved in the here and now the Middle East.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

Appendix A

For several years, we have been conducting seminars and workshops delivering skills to nurses for different kinds of cultural populations. These seminars comprise behavioral and psychological intervention for nurses, volunteers, and nurses working within the community. Covered areas are the stigma of cancer, fears, geriatric oncology for families, and couples communication for extended families. Protocols can be requested from the first author.

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