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Breast Self-examination Knowledge and Practice among Kuwaiti Women

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Abstract:

Breast cancer (BC) is the most common type of cancer among women living in both developed and developing countries and one of the most common causes of death among women in developing countries. Most cases of BC are diagnosed at late stages of the disease due to insufficient knowledge about breast self-examination (BSE) and clinical breast examination (CBE). The study objective is to report Kuwaiti women's practice, knowledge, and etiological reasons that discourage women from performing BSEs. A questionnaire was distributed among 716 women of ages between 15 and 62 years old with two scales, (1) Knowledge of BSE performance and (2) Reasons for not practicing BSE, as well as socio-demographic questions. The findings show that Kuwaiti women's reasons for not practicing BSE were related to the fact that the majority (78.1%) did not know about the frequency of performing BSE, nor how to perform it. The participants (70.7%) also claimed that they did not know the right time to perform BSE. There was a significant relationship between the participants' ethnic roots, BC frequency among them, family history of BC, and family history of cancer and the participants' knowledge about performing BSE ($P < 0.05$). Also, there was a significant relationship between participants' BSE awareness and age, educational level, marital status, and family history of BC ($P < 0.01$).

Keywords: Brest self-examination, Breast cancer, Kuwaiti women, medical anthropology, awareness

Introduction:

As reported by the World Health Organization (WHO), breast cancer (BC) is the most common type of cancer among women living in both developed and developing countries, with about one million new cases of BC diagnosed annually around the world (WHO, 2007). According to the WHO's International Association of Research on Cancer (2007), there is a high rate of the incidence of BC in developing countries and it is one of the most common causes of death among women in developing countries. The number of new BC patients around the worlds expected to increase from 10 million in 2002 to 15 million by 2025, with more than half of the cases (60%) being diagnosed among women who live in developing countries . Arab women who were diagnosed with BC are ten years younger than Western women (Saadat, 2008). According to the Kuwait Cancer Registry data obtained from the Kuwait Cancer Control Center (KCCC) of the Ministry of Health, the highest incidence among the Kuwaiti population was women's BC (15 cases/100,000 women), which increased by more than threefold (50 cases/100,000 women) over the last 33 years (El-basmi et al., 2010). And the average age at diagnosis was 45 years, which is one decade younger than that in most Western countries (Motawy et al., 2004) .According to the Kuwait cancer registry report, Kuwaiti patients between years 2000-2009, show that the most common cancers in Kuwait are breast, colorectal, and lung. And the rate of cancer patient is expected to increase and reach 1200 cases compared to889 cases in 2009. The prevalence rate of BC among Kuwaiti women are (49.4/100,000) (El-Basmy et al., 2012).

The national program for the early detection of breast disease in Kuwait started in February 2014, when 3,100 Kuwaiti women were examined by using mammography. The women were between the ages of 40 and 69 years old and had not reported any warning signs or indications of BC. Out of those who were screened, 25 women were diagnosed with BC. According to the Kuwait Center for Cancer Control, 44% of Kuwaiti women ages 40 years old and older were diagnosed with BC in 2011. According to the American Cancer Society (ACS, 2007) report, BC is curable when detected at an early stage, and the survival rate is 100% within five years for early stages. Thus the European Commission and the ACS advocate for annual mammogram examinations and clinical breast examinations (CBE) for all women over the age of 40, and recommends women over 20 years of age to perform BSE once a month (Gurdal et al., 2012; Perry et al., 2008; Smith et al., 2010). These methods can be helpful for women to easily

recognize any unfamiliar changes in their breasts at an early stage of the disease when they have no other symptoms, which in turn can lead to earlier diagnoses of BC (Blanchard et al., 2004; Maxwell et al., 2001). Community health awareness programs regarding BSEs are considered necessary in order to improve BC patients' survival rates and decrease mortality rates (Ozanne et al., 2014). These programs are important health facilities especially in developing countries, where there are shortages of screening resources, insufficient CBEs being conducted, and limited medical treatment available (Nafissi et al., 2012).

Cross-sectional research has examined women's knowledge, attitudes, and practice of BSEs, as the most important protective method for preventing incidences of BC (Anderson et al., 2003; Bevers et al., 2009; Bi Suh, 2012; Manasciewicz, 2003; Sim et al., 2009). Karayurt et al. (2008) revealed that the survival rates are high among young Turkish women who perform regular BSEs because of early detection. Nafissi et al., (2012) presented the significant impact of Iranian women's knowledge, attitudes, and practice of BSE on improving their quality of life and increasing their survival rate because of early detection of cancer.Akhtari-Zavare1 et al., (2015) illustrated that although a high percentage of Malaysian respondents were aware of BC, 70.5 % of the respondents do not practice BSE, and do not know how to perform the procedures. In addition, the etiologies of why women did not perform BSE and the factors that contributed to advanced stages of BC diagnoses were considered by many cross-cultural studies. Among them, Karayurt and Dramali (2007) and Ceber et al. (2010) illustrated that the main reasons why Turkish women did not perform BSE on a regular basis are lack of knowledge regarding how to perform BSE, inadequate knowledge about what to do if a lump is found, and fear of learning that they have BC. Al-Dubai et al. (2011) revealed that the reasons why Malaysian women do not perform BSE are lack of knowledge about BSE, geographical isolation, and negative socio-cultural perception of BC. Sambanje and Mafuvadze (2012) revealed that more than 70% of African women were diagnosed with BC at Stages III or IV, which are advanced stages. And the late diagnosis of the disease among premenopausal African women was attributed to their community's poor awareness and knowledge of BC, screening programs, and difficulty in acquiring medical treatment.

Some studies examined myths and cultural factors that lead to late tumor diagnoses. Among them, Oluwatosin and Oladepo (2006) illustrated that in Nigeria, "breast cancer" means death, and women do not believe that early treatment of BC may prevent death. Somdatta and Baridalyne (2008) demonstrated that the

topic of BC in Indian society is not freely discussed with others because the topic is taboo. Consequently, more than 70% of the cases reported for diagnosis and treatment are in late stages of the disease, leading to high mortality rates. Saadat (2008) illustrates that shyness and embarrassment of exposing their breast in front of doctors, fear of having cancer, and insufficient health education and programs delayed young women who live in GCC countries in seeking medical advice and examination. Al-Sharbatti et al. (2013) revealed that 24.2% of women in Ajman, United Arab Emirates feel shy about having their breasts examined by a clinician and are afraid to examine their breasts themselves; and 12.7% of them reported that they believe BSE would cause harm to the breast tissue. Religious beliefs also play a significant role in African-American women's attitudes toward seeking medical treatment for BC in Eastern North Carolina, USA. Patients believe that the BSE is not an important method in detecting BC, because God alone could cure the tumor, rendering medical treatment useless (Mitchell et al., 2002).

Also, Kim et al. (2010) emphasized the influence of the cultural perceptions of health and illness on the use of mammography and the practice of BSE among Korean American women living in the USA. Among most Korean women, there is a strong belief that being in perfect health and staying away from being sick, including getting cancer, is a personal responsibility, and an individual must achieve a clean mind and body to reach this condition. Thus, according to their fatalistic view, these Korean women consider cancer screening and early detection as a marginal and insignificant practice because it is not part of their health belief about maintaining a clean mind and body. Moreover, Korean culture has taboos regarding women's reproductive health issues (menstruation, menopause, gastrointestinal disorders, and breast-related health). Therefore, they feel socially restricted from discussing these topics with others and they feel especially uncomfortable about exposing their breast in front of a health care provider to obtain mammography (Sadler et al., 2001). Other cross-sectional studies have revealed that Arab women's median age at diagnosis with BC is between ages 48 and 52 years old and almost 60-80% of the women who are diagnosed present with advanced stages of the disease (Inumaru et al., 2012). The late detection of a malignancy may be attributed to several bio-cultural, socioeconomic, and demographic factors that might affect women's awareness and knowledge of the risk factors and warning signs of BC, as well as the performance of BSE (Madanat & Merrill, 2002). The increased incidence of BC cases among Arab women, including Kuwaiti women, may be due to the influence of Western life style and behaviors on most Arab societies. These behaviors include sedentary life

habits, food intake with less fiber and more fat, marrying at an older age, fewer women choosing to breast feed their children, and taking birth control pills for an extended duration (Inumaru et al., 2012).

Purpose of the Study:

Kuwaiti women's hesitation to seek medical consultation is related to how cancer is viewed in Kuwaiti culture as a "sensitive" topic. Furthermore, there may be religious beliefs that encourage or discourage women from preforming monthly BSEs. The purpose of the current study is to assess Kuwaiti women's practice, knowledge of BSE, and the reasons that prevent women for not preforming BSE from an anthropological perspective.

The study concentrates on different sociocultural perspectives associated with Kuwaiti women's knowledge and awareness of BSE as the most effective way for early detection of BC. It tries to answer the following research questions:

1. What are the participants' knowledge about BSE practice?
2. What are the most significant sociocultural factors that affect participants' knowledge and awareness of BSE?
3. Are there significant differences between sociocultural factors (age, level of education, religious sect, ethnic roots, economic status, family history with cancer, and family history with BC) and women's habits of performing or not performing monthly BSE?
4. What are women's reasons for not performing BSE?

Anthropological research on the relationship between sociocultural factors and health status is rare in Kuwait. To the best of the author's knowledge, no research has been conducted in Kuwait to examine sociocultural factors associated with BSE and health status from an anthropological perspective. The current study aims to answer the above questions by identifying the socio-demographic factors that may influence women's resistance to and awareness of performing BSE and educating women about the procedure of conducting regular BSEs so that they may detect any abnormal changes in their breasts in time to treat a potentially lethal disease.

Methodology:

Study Sample

The current study used a descriptive method to answer the research question. This cross-sectional study was conducted among 716 Kuwaiti women. The sample was convenient; participants came from the six governorates in Kuwait (Al-Asimah, Al-Ahmadi, Al-Farwayniyah, Al-Jahra, Hawalli, and Mubarak Al-Kabeer). Monthly income in Kuwaiti Dinars (KD) was categorized into eight sectors; the lowest monthly income was 500 KD/month and the highest monthly income was 2,301 KD/month and higher.

The instrument used for data collection was a structured questionnaire that consisted of three sections, with a total of 32 items.. The ages range between 15 and 62 years old; the mean age is 27.92, SD = 11.76. Out of 716 women, 7.7% have secondary and diploma degrees; 55.7% have bachelor and diploma degrees, only two women have their master's degrees. The participants' marital statuses were the following: 43.2% were married, and 50.4% were not married. According to the participants' report regarding their ethnic roots, 51.8% were Bedouin and 38.4% were urban Kuwaitis. Regarding the participants' religious sect, the majority (85.1%) were Sunni and 12% were Shia. One-fourth (25.8%) of the participants had monthly incomes ranging between 801 and 1,100 KD; 15.5% of the participants reported monthly incomes ranging between 1,101 and 1,400 KD, which was the second largest monthly income among the participants (Table 1).One-fourth (25.4%) of the participants said they do not know if BC is the most common cancer among women, compared to 74.3% who acknowledged that the most common type of cancer women have is BC. Regarding the occurrence of BC in their families, almost one-fourth (24.3%) of the participants said that they have incidences of BC in their families, compared to 74.6% who said they did not have a history of BC in their families. More than half of the participants (56.6%) said that they did not have a history of cancer in their families, compared to 42.0% who said they have had incidences of cancer in their families. The participants reported the following performances of BSE: more than three-fourths (78.1%) of the participants answered they do not perform BSE; 6.6% participants said they do practice BSE on a regular basis, and 13.7% said they practice BSE, but rather irregularly. On believing the possibility of detecting BC by practicing BSE, 60.5% of the participants said it is not possible and 38.7% said they believe it is possible to detect BC when performing BSE. Only 6.6% of the participants reported that they examine themselves on a regular basis, compared to 13.7% of the participants

who said that they practice BSE, though not regularly. The majority (81.3%) of the participants believed that the chances of recovering from BC are high if the tumour is detected early, compared to 18% who said that they believe the chances of recovering from BC were weak, even if it was detected early. More than half (60.5%) of the participants believed that it is possible to detect BC by BSE and 38.7% said that it is impossible to detect BC by BSE.

Table (1): Characteristics of the sample (716)

Characteristics	N (%)
Age (in years)	
< 19	124 (17.3)
20-29	369 (51.5)
30-39	70 (9.8)
40-49	88 (12.3)
> 50	65 (9.1)
School grade	
Secondary and diploma	55 (7.7)
High School	151 (21.1)
High school and diploma	101 (14.1)
>Bachelor's degree	399 (55.7)
Missing	9 (1.3)
Marital status	
Married	309 (43.2)
Not married	361 (50.4)
Divorced	21 (2.9)
Widow	19 (2.7)
Missing	5 (0.7)

Religious Sect	
Sunni	609 (85.1)
Shia	86 (12.0)
Missing	14 (2.0)
Roots	
Bedouin	371 (51.8)
Urban	275 (38.4)
Missing	53 (7.4)
Kuwait Governorates	
Al-Asimah	134 (18.7)
Al-Ahmadi	193 (27.0)
Al-Farwayniyah	130 (18.2)
Al-Jahra	74 (10.3)
Hawalli	91 (12.7)
Mubarak Al-Kabeer	90 (12.6)
Monthly Income (in KD)	
< 500	51 (7.1)
501-800	95 (13.3)
801-1100	185 (25.8)
1101-1400	111 (15.5)
1401-1700	50 (7.0)
1701-2000	40 (5.6)
2001-2300	33 (4.6)
> 2301	56 (7.8)
Missing	90 (12.6)
Family history of cancer	
Yes	301 (42.0)
No	405 (56.6)
Missing	9 (1.3)

Family history of BC	
Yes	174 (24.3)
No	534 (74.6)
Missing	6 (0.8)
BC is most common in women	
Yes	532 (74.3)
No	23 (3.2)
I don't know	159 (22.2)
Frequency of BSE	
Regular	47 (6.6)
Not regular	98 (13.7)
Recovery from BC is weak even with early detection	
Yes	129 (18.0)
No	582 (81.3)
Missing	1 (0.1)
It is impossible to detect BC by BSE	
Yes	277 (38.7)
No	433 (60.5)
missing	5 (0.7)

*Some data is missing

Variables:

Information on demographics, participants' family history of BC, and their knowledge and performance of BSE were obtained for the purpose of the current study. Demographic characteristics – age, education level, marital status were obtained. Sociocultural information was also obtained from the participants, such as ethnic roots (Bedouin and urban) and religious sect (Sunni and Shia). Regarding BSE, participants were asked whether they practiced BSE and if they answered "yes", they were asked the regularity of practicing BSE.

Questionnaires included two scales: knowledge of BSE scale, and reasons for not practicing BSE scale. These scales are described below.

- Knowledge of BSE scale. The scale was obtained from Rashidi and Rajaram (2000). It consists of 4 items. The participants were asked to respond to each question with True (= 1), and False (= 0). The questions were related to participants' knowledge of BSE, such as their knowledge about the frequency of BSE, appropriate age to start BSE, knowledge about appropriate time for performing BSE, and knowledge of the BSE procedure.

- Reasons for not practicing BSE scale. The scale was obtained from Karayurt et al.'s (2008) study in Turkey. It consists of 8 items. The participants were asked to respond to each question with True (= 1), False (= 0), and Don't Know (= 0). The guideline of the participants' knowledge of BC symptoms is based on 8 items: not knowing the frequency of BSE, not knowing how to perform BSE, not having time, not expecting to get BC, not giving importance to health, having more important problems, fear of finding a breast lump, and not having a close relative with BC.

Vitality and reliability were examined. Both scales were reviewed by five sociocultural faculty members at Kuwait University. They were asked to review, edit and make sure that the items were adapted to Kuwaiti culture. The scales showed high internal consistency (Cronbach's alpha were 0.85, 0.90, and 0.89, respectively).

Statistical Analysis:

A number of statistical techniques were used. Version 19 of SPSS was used for analysis. A T-test was used to examine the differences between sociocultural factors (age group, religious sector, and family history of cancer) and the participants' awareness regarding BSE practice. ANOVA and T-test were applied to compare women's knowledge of BSE across socio-demographic variables (age, level of education, religious sect, roots, marital status, family history with cancer, family history with BC, practicing BSE, knowledge of BC frequency, belief in the possibility of detecting BC by BSE). The accepted level of significance was set below 0.05 ($P < 0.05$).

Results:

1. Participants' knowledge about BSE practice

Regarding knowledge of performing BSE, more than three-fourths (78.1%) of the participants reported that they did not know the accurate frequency of BSE, and 70.7% reported that they did not know the right time to perform BSE. This was followed by 64.7% of the participants reporting that they did not know the procedure for performing BSE, and 58.0% said that they did not know the appropriate age to start BSE.

Table (2): Participants' knowledge of BSE practice

Participants' knowledge of BSE practice	Yes N (%)	No N (%)
Appropriate age to start BSE	301 (42.0)	415 (58.0)
Knowledge about the frequency of BSE	156 (21.8)	559 (78.1)
Knowledge about appropriate time for BSE	207 (28.9)	506 (70.7)
Knowledge of BSE procedure	253 (35.3)	463 (64.7)

2. Significant sociocultural factors that affect participants' knowledge and awareness of BSE

Marital status and BSE awareness:

The study attempted to determine whether there is a significant difference between participants' marital status and their BSE awareness by using the ANOVA test. As shown in Table 3, there are differences in the participants' level of awareness of BSE and their marital status ($p < 0.001$). The findings indicate that married women are more knowledgeable about BSE ($m = 5.80$, $SD = 1.47$) than unmarried women.

Table (3): BSE awareness and marital status

Marital status	Mean	SD		Sum of square	df	Mean square	F	Sig
Married	5.48	1.47	Between group	44.929	2	22.465	12.115	0.000
Single	5.04	1.24	Within group	1318.355	711	1.854		
Even married	5.80	1.40	Total	1363.284	713			

Age and BSE awareness

The study attempted to verify whether there are significant differences in participants' BSE awareness by age group by using the ANOVA test. Table 4 reveals that there are differences in participants' level of awareness of BSE and their age ($p < 0.001$). The age group of women 40 years old and older had more knowledge about BSE ($m = 5.82$, $SD = 1.49$) than younger women (under 40 years old).

Table (4): BSE awareness and age

Age (in years)	Mean	SD		Sum of square	df	Mean square	F	Sig
< 19	5.00	1.25	Between group	61.814	4	15.453	8.419	0.000
20-29	5.13	1.29	Within group	1301.471	709	1.836		
30-39	5.45	1.41	Total	1363.284	713			
40-49	5.82	1.55						
> 50	5.78	1.49						

Educational level and BSE awareness

Using ANOVA, the study attempted to verify whether there is significant difference between the participants' educational level and their BSE awareness. Table 5 reveals that there is a significant relationship between the participants' level of awareness of BSE and their educational level ($p < 0.01$). However, there

are small differences between women whose educational levels are secondary with diploma (m = 5.54, SD = 1.48) and high school with diploma (m = 5.53, SD = 1.46) who have more awareness of BSE than women with a bachelor's degree (m = 5.12, SD = 1.30).

Table (5): BSE awareness and educational level

Educational level	Mean	SD		Sum of square	df	Mean square	F	Sig
< Secondary & Diploma	5.54	1.48	Between group	23.917	3	7.972	4.237	0.006
High School	5.44	1.43	Within group	1317.265	700	1.882		
High School & Diploma	5.53	1.46	Total	1341.182	703			
Bachelor	5.12	1.30						

3. Significant differences between sociocultural factors and women's habits of performing or not performing monthly BSE

As shown in Table 6, no significant relationship was found between sociocultural factors (religious sector, BSE performance, detecting BC by BSE practice, and possibility of recovering from BC) and participants' awareness regarding the performance of BSE. However, a significant relationship was found between the participants' ethnic roots ($P < 0.05$), BC frequency among women ($P < 0.05$), family history of cancer ($P < 0.05$), and family history of BC ($P < 0.01$) and their awareness of performing BSE.

The data showed that women with urban roots are more aware of BSE procedures than women with Bedouin roots (m = 5.32, SD = 1.43). Moreover, the data showed that women with a family history of cancer are more knowledgeable about BSE practice than women with no family history of cancer (m = 5.51, SD = 1.40). Also, the data showed that women with a family history of BC are more knowledgeable about BSE performance than women with no family history of BC (m = 5.67, SD = 1.43). The data also showed that women who reported that BC is more frequent among women who have more awareness of BSE practice than

women who did not consider BC is more frequent among women (m = 5.43, SD = 1.42) .

Table (6): Knowledge of BSE by sociocultural characteristics (n = 693)
BSE awareness Variables

	M	SD	T value
Sect			
Sunni	5.2	1.37	
Shiite	5.28	1.40	0.010
Roots			
Urban	5.32	1.43	
Bedouin	5.17	1.32	1.42*
Family History w/ Cancer			
Yes	5.51	1.40	
No	5.09	1.33	3.984*
Family History w/ BC			
Yes	5.67	1.43	
No	5.15	1.33	4.346*
BSE performance			
Yes	6.48	1.14	
No	4.99	1.25	-9.637
BC among women			
Yes	5.43	1.42	
No	4.78	1.12	2.154*
Detecting BC by BSE			
Yes	5.16	1.34	
No	5.36	1.40	-1.809
Possibility of BC recovery			
Yes	5.24	1.38	
No	5.30	1.38	-0.411

* $P < 0.05$

4. Women's reasons for not performing BSE

The highest reason that prevented Kuwaiti women from performing BSE was that the participants (68.4%) did not know the frequency of BSE, followed by 62.4% who reported that they do not know how to practice BSE. "Not having a close relative with BC" was reported by 50.3% of the participants and "fear of finding a breast lump" was reported by 45.9%. About one third (35.8%) of the participants reported that their reason for not performing BSE was "not expecting to get BC" and 33.7% reported "not having time to practice BSE". Having more important problems (21.1%) and not giving importance to their health (18.2%) were the least frequently given reasons given for not performing BSE (Table 7)

Table (7): Women's reasons for not performing BSE

Women's reasons for not performing BSE	Yes N (%)	No N (%)	Do not know N (%)
Not knowing the frequency of BSE	490 (68.4)	152 (21.2)	66 (9.2)
Not knowing how to perform BSE	447 (62.4)	208 (29.1)	56 (7.8)
Not having time	241 (33.7)	412 (57.5)	58 (8.1)
Not expecting to get BC	256 (35.8)	201 (28.1)	253 (35.3)
Not giving importance to health	130 (18.2)	533 (74.4)	42 (5.9)
Having more important problems	151 (21.1)	487 (68.0)	71 (9.9)
Fear of finding a breast lump	329 (45.9)	297 (41.5)	84 (11.7)
Not having a close relative with BC	360 (50.3)	286 (39.9)	64 (8.9)

Discussion:

The current study findings indicate that participants' knowledge about how to perform BSE was comparable to the following cross-cultural study: Sambanje and Mafuvadze (2012) among Angolan women that shows most of the participants were unknowledgeable about the BSE procedure; Jahan et al.'s (2006) study among Saudi women in the Qassim region shows that only 18.7% of Saudi women reported that they know how to perform the BSE. Moreover, and Negussie

et al., (2015) among Ethiopian women revealed that only 16.5 % of the women heard about BSE. However, more than half (59.17%) of the women participants in Cameroon reported that they know how to perform the BSE (Bi Suh et al., 2012).

The practice of BSE in the following studies is also comparable to the current study finding: Al-Sharbatti et al. (2013) among Emirates women in Ajman show that only 22.7% of the participants reported that they perform the BSE; Kandasamy et al. (2011) illustrate that in Riyadh, only 23.1% of Saudi women reported they preform the BSE; Bener et al. (2009) show that 24.9% of Quatrain women who participated in their study reported practicing the BSE; and 13.3% among the Nigerian women who participated in a research study reported practicing the BSE (Gwarzo et al., 2009). On the other hand, the following studies show more awareness among women about how to perform the BSE than the Kuwaiti participants in the current study: Dundar et al.'s (2006) study among Turkish women reveals 59.1% of the participants never performed BSE; Simi et al.'s (2009) study among Iranian women living in Shiraz shows 52.9% of the participants reported they did not know the BSE procedure. Yan's (2009) findings illustrate the majority (94.4%) of the Chinese women who participated in the research study were practicing the BSE, and Ghanem et al.'s (2011) study shows that 75% of Moroccan women reported practicing the BSE.

The current also study reveals that 70.7% of the participants claimed being unaware of the correct timing of performing the BSE, which is comparable to Al-Sharbatti et al.'s (2013) study among Emirates women in Ajman, UAE, which presents 65.2% of the participants claimed they did not know the right time to practice the BSE. Also, the current findings are similar to Karayurt et al.'s (2008) findings among Turkish university students that indicate (75.4%) of the students who participated in the study reported that they did not know the appropriate time for practicing the BSE. Unlike Sambanje and Mafuvadze's (2012) study among Angolan women that illustrates 50% of the participants in the study claimed they did not know the correct timing to perform the BSE, the current study findings show that Kuwaiti women are more aware about the accurate timing of BSE performance than Turkish, Angolan, or Saudi women. According to Milaat (2000) only 7.1% of Saudi women were knowledgeable about the accurate time of performing the BSE. Kuwaiti participants' knowledge about the proper frequency of performing BSE is similar to that of Saudi women, of whom only 14.4% were aware about the correct frequency of the BSE (Milaat, 2000); and among Turkish university students, more than half (66%) of the participants indicated they were

unknowledgeable about the frequency of performing the BSE (Karayurt et al., 2008).

The current study reveals that (58.0%) of Kuwaiti women reported lack of information regarding the correct age to start performing the BSE, compared to 88.2% of Nigerian women (Gwarzo et al., 2009), which demonstrates that Kuwaiti women are more aware than Nigerian women regarding the correct time to start performing the BSE. Comparable to the current study findings about the possibility to detect BC by performing the BSE, Yan's (2009) study reveals that over 70% of Chinese women who participated in the study believed that the BSE could help early detection of BC, and Sambanje and Mafuvadze's (2012) study illustrates that 78% of the Angolan women who participated in their study claimed that the BSE is one of the best ways to detect BC at an early stage. However, Gwarzo et al.'s (2009) study shows that 89.1% of the Nigerian women who participated in their study did not believe that the BSE can help with early diagnosis of BC. Also the current finding about Kuwaiti women's belief that recovery from BC is high if the tumor is diagnosed early is similar to Ghanem et al.'s (2011) findings that show 86% of the Moroccan women who participated in their study believed that BC can be cured if detected early.

Regular performance of the BSE among Kuwaiti participants that the current study revealed is similar to the following cross-cultural studies: Nafissi et al., (2012) reveals that 12.9% of the Iranian women who participated in the study practiced the BSE regularly, 16% of South Asian women participants reported performing monthly BSEs (Milaat,2000), and 3.3% of Emirates women participants in Ajman, UAE (Al-Sharbatti et al., 2013) . In addition, Beydag and Karaoglan's study (2007) reported that 10.2% of Turkish women who are practicing the BSE on a regular basis, and only 5.3% of Nigerian women perform BSE monthly (Olorunfemi and Oluwayemisi ,2015).The following studies reveal that women's performance of the BSE on a regular basis is higher than the current study findings: 21 % among Saudi Arabian women participants (Abolfotouh et al., 2015) , 31% among Austrian women participants (Tuna-Malak & Dicle (2007), 42% among women participants from Cameroon (Bi Suh et al., 2012), and 29.5% among Turkish women participants (Beydag & Karaoglan, 2007).

The current study shows that one of the reasons that Kuwaiti women did not perform the BSE was their inadequate knowledge of BSE procedures, which is similar to the following cross-cultural studies: Al-Sharbatti et al. (2013) among Emirates women in Ajman show that 59.9% of the participants reported that they

do not preform the BSE, because of lack of information about how to do the examination. Also, Karayurt and Dramali (2007) and Ceber et al. (2010) among Turkish women, and Abolfotouh et al., (2015) among Saudi Arabian women find the participants claimed they do not perform BSE because they do not know how to examine their breast due to lacking of BSE practice information. Unlike the current study findings about Kuwaiti women, Nafissi et al., (2012) states that 33.4% of the Iranian women participants reported not practicing BSE due to insufficient BSE information. However, Negussie et al., (2015) revealed that knowledge about BSE practice was significantly associated with Ethiopian women performance of BSE.

Moreover, the current findings demonstrate that 18.2% of the Kuwaiti women participants reported not performing BSE because they do not care about their health which is similar to the reason Iranian women in Shiraz, Southern Iran gave (Simi et al., 2009). Also the current findings reveal that 50.3% of the Kuwaiti women participants reported that they do not practice BSE because they do not have a close relative with BC. A greater percentage of Kuwaiti women gave this reason than Ghanaian women participants (5.1%; Opoku et al., 2012).

Fear of finding out whether they have cancer was the reason for not performing the BSE that 45.9% of Kuwaiti participants reported, which is comparable to the following studies: Karayurt and Dramali (2007) and Ceber et al.'s (2010) findings illustrate the reason why Turkish women did not perform BSE was fear of finding out that they have BC. Akhtari-Zavare1 et al., (2015) found that 64.7% of Malaysian women did not perform BSE because they were not diagnosed with any symptoms of BC and 61.5 % reported worries to detect BC and 24.2% of Emirates women in Ajman, UAE reported that fear was the cause of not preforming the BSE (Al-Sharbatti et al., 2013). Only 4% of Ghanaian women participants reported that their reason for not performing the BSE is fear of discovering a breast tumor (Opoku et al., 2012). Another reason that prevents Kuwaiti women participants from practicing the BSE as this study found is that 33.7% of the participants said they do not have time to practice the BSE, which is comparable to Al-Sharbatti et al.'s (2013) finding among Emirates women participants in Ajman, UAE (44.4%).

The current study demonstrates that there is no significant relationship between Kuwaiti women's awareness regarding the BSE and the following sociocultural factors: economic status, religious sect, BSE performance, fear of detecting BC by BSE practice, and belief in the possibility of recovering from BC or not. However, the current study revealed that Kuwaiti women participants with urban roots are more aware of BSE practice than women with Bedouin roots, which might be

explained by the differences between cultural attitudes regarding the importance of the BSE as an essential procedure to discover any abnormal tumor growth in the breast area. Also the current finding presents that Kuwaitis women participants with a family history of cancer and BC are more knowledgeable about the BSE than women with no family history of cancer or BC. Living with a cancer patient in their family and sharing their fear, anxiety, and knowledge regarding everything related to BC would most likely make a person more aware of risk factors, symptoms, treatment, and precautions about BC. This finding is similar to the findings of the following cross-cultural studies: Al-Naggar et al. (2011) among Malaysian women, Karayurt et al. (2008) among Turkish women, Maxwell et al., (2001) among Canadian women, and Akhtari-Zavare1 et al. (2015) among Malaysian women present women participants with a family history of BC are more aware of the BSE performance and regularly practice the procedure. However, Al-Sharbatti et al. (2013) among Emirates women participants in Ajman, UAE and Montazeri et al. (2008) among Iranian women demonstrate no significant association between family history of BC and BSE performance. Moreover, the current finding reveals that women who recognize that BC is the most common cancer among women, are those who have more information regard BSE performance. This finding is comparable to that of Karayurt et al. (2008) illustrating the influence of Turkish women's BC information and knowledge on their practice of BSE.

Moreover, the current study reveals that a significant relationship between Kuwaiti women's ages and their awareness of BSE performance. Older women gained more information about how to perform the BSE than younger women, which can be explained by their greater awareness of their health condition and the changes that they may encounter at midlife, such as hormonal fluctuation, osteoporosis, menopause, and BC. At midlife, many women or their partners may encounter health issues due to aging or receive medical treatment for chronic diseases, and they may know a friend or a relative who is a cancer patient; therefore, they may obtain health information and be more aware of taking precautions against disease. This finding is similar to those of Akhtari-Zavare1 et al., (2015) among Malaysian women, Karayurt et al. (2008) among Turkish women, Alsaif (2004) among Saudi women, and Petro-Nustas (2001) among Jordanian women that illustrate older women are more aware and knowledgeable about the BSE than younger women. Unlike the current study findings, Oluwatosin and Oladepo (2006) among Nigerian women and Simi et al. (2009) among Iranian women demonstrate that there were no significant differences in the mean knowledge scores across age groups and their awareness of BSE practice.

Furthermore, the findings of this study demonstrate that married Kuwaiti women are more familiar with BSE performance than single women. This can be explained as married women may be more cautious about their health if they have experienced the loss of their partner and thus they may have psychosomatic health problems after their loss. Women become single parents and their exposure to many responsibilities might affect their health negatively, which in turn may make them more cautious to maintain good health. This result is in contrast with Simi et al.'s (2009) finding among Iranian women and Oluwatosin and Oladepo's (2006) finding among Nigerian women, that there was no association between women's marital status and their practice of the BSE. The current study result is similar with the findings of other studies done by Akhtari-Zavare1 et al. (2015) among Malaysian women and Al-Sharbatti et al. (2013) among Emirates women in Ajman reveal that married women have higher recognition of BC and are more educated about the practice of BSE.

The current study's findings demonstrate that the participants' level of awareness of the BSE is associated with their educational level; women acquire much information regarding the most common diseases that women experience. And it makes them knowledgeable about the risk factors and warning signs of BC that can be detected by the BSE, if it is performed correctly and at the right times. Thus many health programs emphasize education as a first and an important factor for detecting BC tumors at an early stage. The following cross-cultural studies are similar to the current study's findings, revealing higher education is associated with more common belief in early diagnosis of BC, and higher awareness of the BSE procedure: Kandasamy et al. (2011) among Saudi women, Gurdal et al. (2012) among Turkish women, and Oluwatosin (2010) among Nigerian women. In contrast, the following cross-cultural studies reported no significant association between women's level of education and their awareness of performing the BSE: Dundar et al. (2006) among Turkish women and Oluwatosin and Oladepo (2006) among Nigerian women.

The current study findings show that the majority of Kuwaiti women did not practice BSE because they did not know about the accurate frequency of performing BSE, how to perform it, and did not know the appropriate time to perform BSE. Also the current study results demonstrated that the most significant sociocultural factors that affected participants' knowledge and awareness of performing BSE are participants' ethnic roots, BC frequency among women family history of cancer, and family history of BC and their awareness of performing BSE. And

participants' age, marital status, educational level and family history of BC are significantly associated with participants' BSE awareness.

The survival rate of BC is high when diagnosed in the beginning stages of the tumor. Health awareness programs in Kuwait strongly recommend the BSE among young women, annual mammograms, and (CBE) through social media, academic lectures, school curricula, and mass media to reach Kuwaiti women. These programs encourage women to be more health wise about any abnormal changes in their breasts and to seek immediate medical treatment. The Kuwaiti government has advanced health facilities with state-of-the-art equipment for CBE free cost for Kuwaiti women. Economic factors are not the barrier that prevents women from having annual breast examinations; the cultural and educational factors pose two serious obstacles to women's not performing the BSE or not seeking CBE. Further research is need to identify ways to encourage women to practice the BSE and to increase their knowledge and awareness of the main methods for detecting BC at an earlier stage in order to increase the life expectancy and quality of life among Kuwaiti women.

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مدى الوعي وممارسة الفحص الذاتي للثدي لدى النساء الكويتيات

مها مشاري السجاري

كلية العلوم الاجتماعية - جامعة الكويت

مدينة الكويت - الكويت

ملخص البحث:

يعد سرطان الثدي من أكثر أنواع السرطان شيوعاً بين النساء اللواتي يعيشون في البلدان المتقدمة والنامية، وأحد أكثر أسباب الوفاة شيوعا بين النساء في البلدان النامية. ومعظم حالات سرطان الثدي التي تم تشخيصها تكون في مراحلها المتأخرة بسبب عدم كفاية المعلومات عن الفحص الذاتي للثدي وعدم القيام بالفحص السريري للثدي. وهدف الدراسة هو قياس مدى ممارسة النساء للفحص الذاتي للثدي ومدى معرفتهم بالقيام بالفحص الذاتي ، والعوامل المسببة التي تعوق دون قيامهم بعملية الفحص . تم توزيع استمارة الدراسة على 716 امرأة تتراوح أعمارهن بين 15 و62 عاماً، وتكونت الاستمارة من مقياسين: (1) مقياس المعرفة بالقيام بالفحص الذاتي، و(2) مقياس أسباب عدم القيام بالفحص الذاتي. وكشفت الدراسة أن السبب الرئيس الذي يمنع النساء من القيام بالفحص الذاتي هو عدم معرفتهم عدد مرات الفحص و كيفية القيام بالفحص. فأجاب 78.1% من النساء بعدم معرفتهن بعدد مرات الفحص وأجاب 70.7% بعدم معرفتهم بالوقت الأمثل للقيام بالفحص. وهناك فروق ذات دلالة احصائية بين مدى وعي النساء بممارسة الفحص الذاتي للثدي وكلٍّ من المستوى التعليمي، والأصول (حضرية وقبلية)، ومدى شيوع الإصابة بسرطان الثدي، وتاريخ الاصابة بمرض السرطان بين أفراد العائلة وكذلك تاريخ الإصابة بمرض سرطان الثدي بين أفراد العائلة . ($P < 0.05$) مع وجود فروق ذات دلالة إحصائية بين مدى وعي النساء بالفحص الذاتي للثدي وكل من العمر، الحالة الاجتماعية، الحالة التعليمية، تاريخ الإصابة بمرض السرطان بين أفراد العائلة . ($P < 0.01$)

الكلمات الدالة: الفحص الذاتي للثدي، سرطان الثدي، المرأة الكويتية، الأنثروبولوجيا الطبية، الوعي.