

## Barriers to Health Care Utilization Facing Prostate Cancer Survivors Living in Gaza Strip

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**Abstract:** There are several studies that aimed to identify barriers to health care utilization, but none of them was conducted in a developing country that addressed barriers to health care utilization facing prostate cancer survivors. This study aimed at identifying barriers to health care utilization facing prostate cancer survivors who live in Gaza Strip. A qualitative approach with a semi-structured interview was used to collect data.

Participants reported several barriers to health care utilization. These barriers were categorized under the following major categories: 1) barriers due to unavailability, 2) organizational barriers, 3) communication barriers, 4) geographical barriers, 5) socioeconomic barriers, and 6) barriers related directly to the blockade imposed on Gaza Strip. Within each category several subcategories emerged.

**Key words:** barriers to health care utilization, prostate cancer, Gaza Strip

العوائق التي يواجهها مرضى سرطان البروستاتا القاطنين في قطاع غزة وتحد من

استفادتهم من الخدمات الصحية المتاحة

**المخلص:** يوجد العديد من الدراسات المعنية بالتعرف على العوائق التي تواجه المرضى و تحول دون استفادتهم من الخدمات الصحية المتاحة. على الرغم من وجود العديد من الدراسات المعنية بهذا الموضوع، إلا أنه لا توجد أي دراسة أجريت في دولة نامية أو تهدف إلى التعرف على العوائق التي تواجه مرضى سرطان البروستاتا. لذا تهدف هذه الدراسة إلى تحديد العوائق التي يواجهها مرضى سرطان البروستاتا القاطنين في قطاع غزة. لذلك تم التوجه الي المرضى المصابين بسرطان البروستاتا حيث استجاب منهم 195 و بنسبة استجابة بلغت 97,98%. هذا و قام المشاركون في هذه الدراسة بتحديد العديد من العوائق التي تحد من استفادتهم من الخدمات الصحية المتاحة و التي تم تصنيفها تحت ست عناوين رئيسة و هي: (1) عوائق ناتجة عن نقص بعض الأدوية و المعدات الصحية، (2) عوائق مؤسساتية، (3) عوائق في التواصل، (4) عوائق جغرافية، (5) عوائق اقتصادية، (6) عوائق لها علاقة مباشرة بالإغلاق. هذا و يوجد العديد من العوائق التي تم تصنيفها بعناوين فرعية تحت العناوين الست الرئيسية.

## Introduction

The term barriers to health care utilization was defined as obstacles within a “health care system that prevent vulnerable patient populations from getting needed health care, or that cause them to get inferior health care compared to advantaged patient populations” [1, paragraph 1]. On the other hand, multiple authors of the major modes of health-related behaviors defined barriers to health care as “beliefs the individual holds concerning the costs associated with taking a health action” [2, p. 196]

Barriers to health care utilization reported in the literature can be grouped into several categories. Some [1] categorized them into four groups: a) geographic barriers, b) cultural barriers, c) socioeconomic barriers, and d) organizational barriers. McKinlay [3] reviewed literature related to utilization of health services and reported six approaches that explain the utilization behavior for health services and those are: a) the economic approach, b) the socio-demographic approach, c) the geographic approach, d) the socio-psychological approach, e) the sociocultural approach, and f) the organizational approach.

Regardless of the number of categories of barriers to health care; many studies, especially in the United States, reported extensively on these barriers. In an extensive review of literature, McCulloch-Melnyk [2] concluded that the following were the most often reported barriers: cost (direct cost and cost of lost work), time lag to the appointment, waiting time, travel time, availability of transportation, proximity to the health care providers, issues related to health insurance coverage, lack of primary health care providers, provider/consumer ratio, prior negative experience, and differences between provider and patient in regard of cultural and social characteristics. Others [4] added that communication skills and the pattern of communication between providers and clients, especially those who are disabled, is a major barrier to health care among the disabled.

Based upon the data from the Medical Expenditure Panel Survey Household Component, Weinick, et al. [5] found that inability to afford health care services was the major barrier to health care. The second major barrier was related to health insurance issues. Other barriers included problems related to transportation, child care limitation, physical barriers, time-related barriers, issues related to lack of information.

In Palestine, some reports about the health care system included some of the barriers to health care in general. In a report prepared to the WHO, Abed [6]

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included several barriers to health care. For example, the report included issues such as the inability of the Palestinian National Authority (PNA) to prioritize the provided health care services and intervention which impacted negatively the efficiency, effectiveness, and sustainability of the provided health services. The report also included that there was a lack of several services due to inability of the Ministry of Health (MoH) to finance these services.

Regardless of the abundance of literature about barriers to health care, it was noticed that none was conducted in a developing country and none was aiming to identify barriers to health care utilization facing cancer patients in general and prostate cancer in particular. Only a few studies [7,8] addressed barriers to prostate cancer screening. Prostate cancer is the second common type of cancer among men in the world [9] and in Palestine [10]. It is also the second leading cause of cancer-related deaths among men in Palestine [10]. In spite of that, the survival rates have improved in recent years [11]. Because of the high incidence of prostate cancer and the excellent survival rate, it is important to enable prostate cancer survivors to maximize the utilization of provided health care services and eliminating barriers to health care that they may face during treatment time as this will improve their quality of life.

The purpose of this study was to identify barriers to health care utilization that face patients with prostate cancer in Gaza Strip during treatment period. Identifying such barriers will help policy makers to change or manipulate current health policies to overcome these barriers which will result in improving the quality of provided care which will be reflected on the quality of life of men with prostate cancer. For the purpose of this study, barriers to health care were defined as any obstacle within or outside the Gazan health care system that patients with prostate cancer who reside in Gaza Strip think that it prevents them from getting the needed health care.

### **Methods**

#### ***Design, Participants, and Sampling:***

The design for this study was a cross-sectional design that contains a qualitative approach. All adult patients live in Gaza Strip and diagnosed with prostate cancer were the target population for this study. A list of patients was identified from the two hospitals that provide treatment for prostate cancer. All of the identified patients were recruited to participate in this study. Those who agreed to participate were interviewed privately by the researcher at one of the two hospitals. Some of the participants were interviewed by the telephone.

Before the interview, the purpose of the study was explained to participants who then had to sign a consent paper or give a verbal consent in case they were interviewed over the phone. Participants were asked open questions about the barriers to health care utilization that they faced during treatment time. The researcher intervened when necessary to probe participants to enhance the depth and richness of their responses. According to Babbie [12], interview survey usually has a high response rate and eliminates the ‘don’t know’ responses. He described a response rate of 80-85% of interview survey as a “completion rate” [12, p. 258].

***Data Analysis:***

Data were analyzed through careful reading of the scripts of participants’ responses. Data analysis consisted of identifying, coding, and categorizing patterns found in data [13]. In this study the researcher used thematic analysis which is considered a way of seeing, as well as a process of coding qualitative information [13]. Throughout data coding, the researcher began with determining labels, defining the concern of each theme, describing how to know when each theme occurred [13]. Besides that, categories and subcategories were developed from the gathered information and the investigator did observe how frequently they appeared in the data base to establish the patterns of these categories and subcategories. When appropriate, quotes were used. Finally, a concept map was drawn to depict the emerged categories and subcategories (Figure 1).

**Findings and Discussion**

***Description of the Sample:***

A total of 199 patients were recruited to participate in this study. 195 of them agreed to participate in this study with a response rate of 97.98%. The high response rate in this study could be related to the fact that participants were approached directly by the researcher, which provided them with details about the purpose of the study and gave them a chance to answer their questions which encouraged hesitant participants to participate in the study.

Age of participants ranged between 49 and 91 years with a mean of 70.29 (SD = 8.81). Age of the participants at the time of diagnosis ranged between 46 and 85 with a mean of 65.99 years (SD = 8.27). 62 participants (31.8%) did not receive any education at all, 28 (14.4%) received some education but did not complete the primary level (sixth grade), 20 (10.3%) finished primary school, 18 (9.2%) completed the preparatory (9<sup>th</sup> grade) school, 37 (19.0%) completed high school, and 30 (15.4%) had higher education. Results also showed that 155

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participants (79.5%) were married and lived with their wives. The rest of participants (n=40, 20.5%) were divorced, widowed, or not married. The majority of participants (n=142, 72.8%) were receiving treatment at the time of data collection, while the rest of them, (n=53, 27%), were not receiving any treatment at that time.

### ***Barriers to Health Care***

After examining the scripts of participants' responses, emerging themes were identified and coded into the following major concepts: barriers due to unavailability, organizational barriers, geographical barriers, socioeconomic barriers, and barriers related directly to the blockade imposed on Gaza Strip. Under the umbrella of each concept, there were several sub-concepts that had emerged (Figure 1).

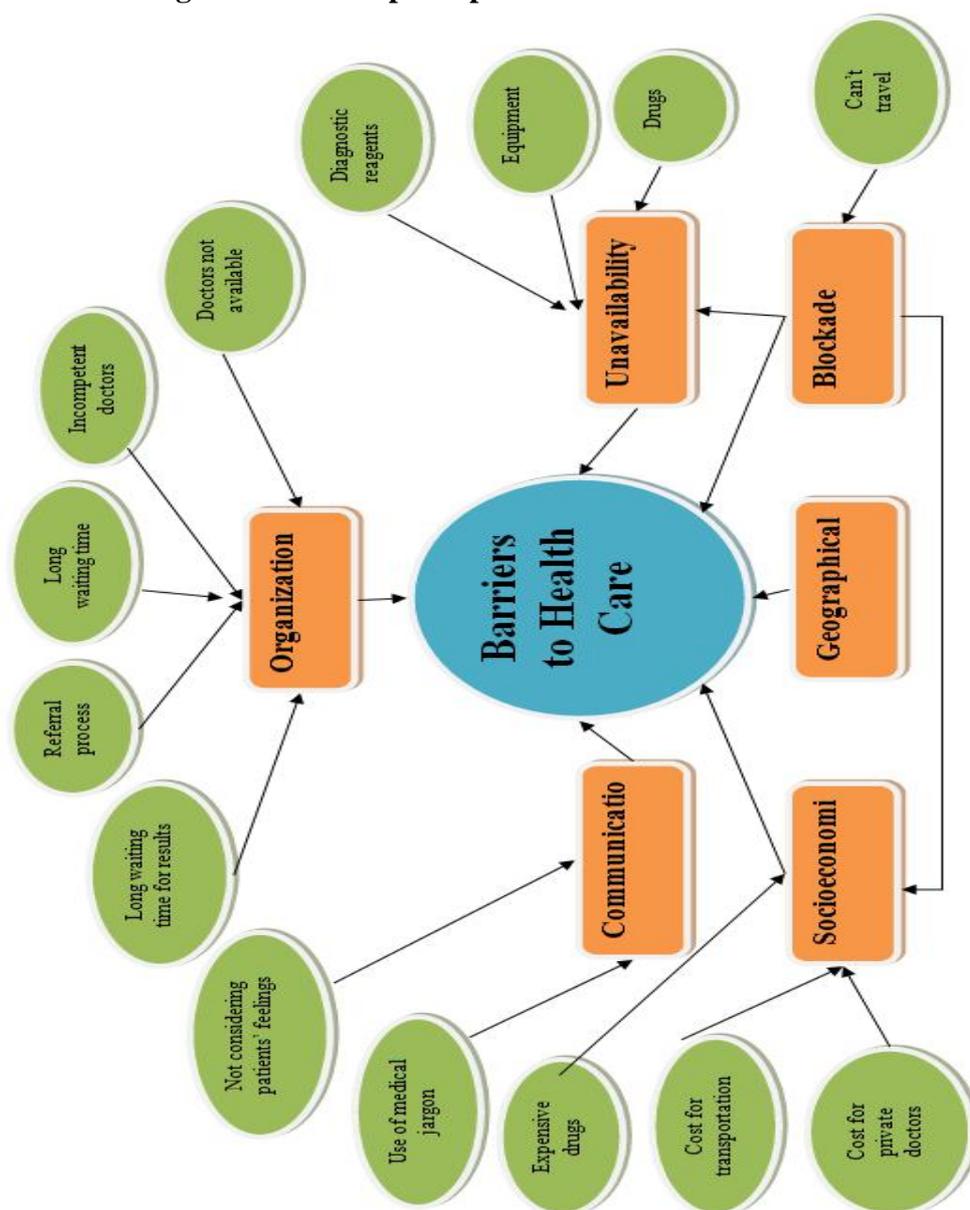
In total, there were 119 participants (61.02%) reported facing at least one barrier at a certain point of their treatment time. The barriers reported by participants of this study were compatible with the barriers reported in the literature with the exception of those barriers related directly to the impact of the blockade imposed against Gaza Strip [1, 2, 3, 5, 7, 8, 14-22].

#### ***1. Barriers Related to Unavailability:***

Many participants (n=86, 44.1%) reported that several items and services were not available at the health care system in Gaza. These items included drugs, equipments, diagnostic reagents, and the absence of radiation therapy. The most commonly reported missing item was drugs. Therefore, participants were purchasing their drugs on their expense (if they can afford it and if the drug was available at outside drug stores) or they had to stay without their drugs until drugs would become available at the governmental health care system. In response to lack of certain drugs, doctors had to prescribe other available drugs that were not as effective as the needed drugs. One participant mentioned: "Drugs are not available most of the times; therefore, the doctors had to change me to another drug. The problem was that the first drug was very expensive as I need about 2000 New Israel Shekel (NIS) each month, which I can't afford."

In several instances, when the drugs were not available, some participants had to find their own way to get their drug supply. For some participants, they asked friends or relatives in Egypt to buy the drug for them and pass it to Gaza from one the tunnels connecting Gaza with Egypt. Others, who had some friends or relatives living in West Bank or in Israel, asked them to buy the drug

**Figure 4-1: Concept Map of Barriers to Health Care.**



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for them and pass it with any person who will get into Gaza. For those who couldn't manage to get their drugs, they had to spend the time without taking their drugs until it becomes available again at the governmental health system. This could take several weeks or several months. Some participants expressed that the lack of drugs had affected negatively their health status and this was reflected on the level of their Prostate-Specific Antigen (PSA) results.

Other items that were reported as "unavailable" by other participants were the lack of some equipments and chemical reagents for some diagnostic procures. The result then would be waiting for the equipment to become available or waiting for a referral to be treated outside Gaza then waiting again for either a permission to pass Israel or waiting for the border to open so that they can travel to Egypt to receive treatment.

Other participants (n=13) expressed their frustration about the lack of the diagnostic equipments and some chemical reagents that needed for diagnostic processes. Such lack would delay the diagnoses for their cases which will result in physical and emotional distress. One of them mentioned: "The lack of the diagnostic equipments is one of the biggest barriers. It's true that they took a biopsy from me, but they sent it to outside laboratories (laboratories outside the governmental system) and the result took so much time to appear. You can imagine how my emotional and psychological condition was at that time while I was waiting for the result".

The impact of the blockade on QOL in general and on health-related quality of life in particular was well recognized by international organizations. For example, Max Gaylard, the Resident Humanitarian Coordinator for the occupied Palestinian territories (oPt), said: "The continuing closure of the Gaza Strip is undermining the functioning of the health care system and putting at risk the health of 1.4 million people in Gaza. It is causing on-going deterioration in the social, economic and environmental determinants of health. It is hampering the provision of medical supplies and the training of health staff and it is preventing patients with serious medical conditions getting timely specialised treatment outside Gaza" [23, p. 1].

Usually, drugs, equipments, and other medical supplies were provided to Gaza from Rammallah stores in the West Bank or provided directly to Gaza when some humanitarian organizations succeed to challenge the siege and enter Gaza through the Mediterranean Sea or from the Egyptian borders. At either

case, the importation of the supplies is contingent on the permission of the Israelis to let the supplies provided from Rammallah to enter into Gaza and the permission of the Egyptians to open the borders between Gaza and Egypt which used to be opened for limited hours per day for two to three days every few months.

Generally, disposables and drug supplies were allowed into Gaza, but there were usually a shortage of some items on the ground. For example, between March and December, 2009, shortage in drug supplies ranged between 14-30% while shortage of medical disposables ranged between 10-20%. The list for essential drug supply includes 480 drugs while the list for essential medical disposables includes 700 items [23, 24].

At the same time, certain types of medical equipments including those needed for x-ray and other electronic devices were very difficult to be brought into Gaza. Furthermore, provided equipments were either broken or out of date and spare parts were not available [23, 24]. Such lack of equipment and drug supply will hamper the quality of provided health care to patients living in Gaza Strip and therefore their QOL.

Gaza Strip has a unique situation due to the pertaining political situation that prevails in the area. Such a situation contributed to the lack of several drugs, equipments and supplies to be available at the medical centers that provide oncology care. Besides that, there is a lack of several services at the MoH due to the inability of the MoH to finance such services [6]. Such constraints on the health care system can impede the delivery of care for beneficiaries and alter the quality of provided care.

Not so much literature addressed the availability of drugs, equipments, and other services in the health care system. For example Battista et al. [15] reported that the lack of radiation therapy was one of the barriers to health care reported by adult cancer patients. Weinick et al. [18] reported that lack of appropriate equipments was a barrier for health care utilization and Estrada et al. [17] reported that care was not available when needed.

## **2. *Organizational Barriers:***

Several barriers were reported under the concept of organizational barriers. The sub-concepts emerged under the organizational barriers included: long waiting time, incompetent physicians, physicians are not available at their offices, complicated referral process for treatment abroad, and long time to hear about the results of their diagnosis.

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The oncology outpatient clinics opens between 8:00 am to 1:00 pm. Usually, patients do not have exact appointments for follow up. Therefore, they are served on the basis of “first comes, first served.” Depending on how busy is the clinic at that day, the process may take between 30 minutes and up to more than four hours. Usually, the clinic gets busier at the beginning of the month, the time the drugs are delivered to the pharmacy.

Fifty one patients had expressed their feelings that the waiting time was too long to them. The reported waiting time varied between two and four hours. One participant reflected his frustration about the long waiting time by saying: “Waiting time is too long. Sometimes it takes me about 4 hours to wait in order to be seen by the doctor. It is very boring. I have to bring my wife with me each time I come to the clinic so that I can find someone to talk to”.

Sometimes the rule of “who comes first served first” is violated by health care personnel who sometimes allow their family members, friends, and acquaintances to be seen by the doctors without following the order they came to the clinic. This usually leads to prolonging the waiting time for other patients and occasionally leads to verbal or physical violence among waiting patients and personnel. One participant expressed his feelings: “Employees in the health care system do not follow the order for seeing the patients. Some patients come late, but because they know someone in the hospital, they will be seen by the doctor before the patients who have been waiting for hours. Some doctors too allow the patients who come to their private clinics to be seen before us who were waiting for hours outside”.

The process even becomes more complicated and the waiting time becomes even longer, according to some participants, as some physicians leave their offices for a long periods of time which leads to frustration among the waiting patients. Physicians are supposed to stay in their office during the working hours to see their patients. But because the system lacks a disciplinary action policy, some physicians leave their offices to chat with other colleague or go home early.

Seven participants expressed lack of confidence in their physicians and described them as being incompetent. This is in fact a general feeling in Gaza Strip about the competency of physicians, especially about young physicians who graduated from the former Soviet Union counties and Romania. The reputation of graduates from these countries is not good as people heard so many stories about how these graduates pass their exams by paying money or

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buying presents to their professors. One participant described his concerns as: “The doctors here (in Gaza Strip) are not good. They don’t understand anything in medicine. For example, one doctor told me that my treatment is by passing a tube into my urethra and take small chips of the prostate (Trans-Urethral Resection of Prostate). Another doctor told me that the prostate should be removed by a surgical operation. A third one treated me for urinary tract infection. The issue is that there are no doctors who are competent in the area of urology. When I went to Palestine Hospital in Cairo, the doctor there asked to do some tests for prostate cancer, but here, none of the doctors; I went to, asked for this test”.

Fifteen participants expressed that the process of getting a referral to be treated abroad (outside Gaza Strip) was very complicated. Usually the process is time consuming and has to be signed by several doctors and other personnel from the Ministry of Health. With the presence of blockade, the process even became more complicated. The MoH works to limit the number of the referred patients to the lowest possible number, therefore, when the borders open, it will be much easier to manage the process for a smaller number of patients.

Five more participants reported that the results for the diagnostic tests and procedures took too much time and that such a long time of waiting for them is very difficult. One participant expressed his feeling as: “The result of the diagnostic tests takes so much time. One time, the result of the PSA took about a month and a half as the material (reagent) was not available because of the blockade. You can’t imagine how my condition was while I was waiting to hear about the results. I was living in sever distress for that period of time”.

Organizational barriers reported by participants of this study are not unique. The reported barriers are consistent with similar barriers reported in the literature. For example, Weinrich, et al. [18] mentioned that participants in their study reported that doctors’ hours were not convenient.’ The long waiting time, in spite of having a previous appointment, was reported as a barrier to health care by several other studies [1, 4, 5, 8, 16, 17, 22]. Long waiting time was not the only time-related barrier. Some studies also reported that participants complained about waiting too long to get an appointment or that there were a long time between appointments themselves [1, 5, 17, 18].

Because occasionally some physicians were not available at their offices, patients had to wait for them until they come back or in some instances, they would see another physician. Seeing a different physician may lead to

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interruption and inconsistency in the treatment plan. Demark-Wahnefried [7] reported that not having a regular physician was reported by both blacks and whites as a barrier for prostate cancer screening. Margolis et al. [14] identified limited availability of health care providers as a barrier to health care while Rutten, et al. [20] reported that having 'no physician' was a barrier for pap smear and mammography which are used to screen for cervix and breast cancers.

The participants of this study were not unique of mistrusting their physicians. In another study [25] participants, reported that mistrust of health care recipients in their physicians was one of the barriers that impeded the utilization of health care services.

### **3. *Communication Barriers:***

Some of the participants (n=24, 12.3%) complained that the treating physicians and other health care professionals were not considering their emotional status when they talk to them and felt that they were humiliated by the way the physicians talked to them. Participants thought that they deserve special treatment and communication methods when physicians communicate with them as they felt that being diagnosed with cancer is a big issue by itself. One participant described the way his doctor talked to him: "Some of the doctors don't think that we are human beings. We are like them, flesh and blood and have feelings like they have. Some of them (the doctors) are inconsiderate to what we feel. It is enough to be diagnosed with cancer. They should put this into their consideration and know how to deal with us.

Six participants complained about the medical jargon that some doctors used during communication. They expressed that sometimes they were nodding their heads to convey to those doctors that they understood what they were saying while they were not. They even complained that if they (the participants) will go to the private clinics of the same doctor, they will be treated much better and that the doctor will spend more time to explain for them about their health condition and discuss with them what to do and what not to do.

The reported communication barriers by participants are congruent with the literature. Communication skills and the pattern of communication between providers and clients were described as major barriers to health care that could lead to frustration among that vulnerable group of clients [2]. Others added [5,19] that communication problems were one of the most common reported barriers to health care. Furthermore, Mandelblatt et al. [26] mentioned that

health care providers are usually not prepared well to communicate with patients diagnosed with cancer especially when communicating the complexities related to cancer care, treatment, and its complications to their clients.

Some studies [4, 7, 22, 26] reported that some of the major barriers to health care and health education were related to language and cultural differences among health care providers and health care recipients. Such differences may alter the process of communication between providers and recipients of health care services. The good thing about Gaza is that all people are speaking the same language and have the same cultural background; therefore, neither culture nor language by its sake was reported as a barrier to health care.

#### ***4. Socioeconomic Barriers:***

Under the socioeconomic barriers, several sub-concepts emerged. These sub-concepts related to the high cost of drugs, diagnostic procedure, and private doctor visits. Many participants reported that they could not afford to buy these expensive drugs or to go to the private clinics of physicians. A few participants reported that they even could not afford to pay for their transportation to go to the medical centers.

For example, 35 participants complained that the cost of the drugs were very expensive. One participant expressed his concerns: “When the drug becomes unavailable at the hospital, my children look for it at the private drug stores. If they found it, it is usually very expensive. In one time, I bought 50 capsules of my drug. The cost was very, very expensive as it was 5,000 NIS (About \$1300). I could afford to buy the drug this time, but if it becomes unavailable one more time, I will not be able to buy it. Where shall I get the money to buy it? It is very expensive as you see. For me I could buy the drug at that time, but most of other patients are not able to buy the drug at such an expensive cost. What shall they do? Shall they wait and die slowly?”

For this participant, he could manage to buy his drug, but many other participants reported that they could not afford to buy theirs. Therefore, they will stay without treatment for several weeks or months until the drug becomes available in the governmental health system. Such a thing would negatively impact their health status.

Inability to afford to cover the cost of drug supply was not the only socioeconomic barrier. A few participants complained that they could not

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afford to cover for the cost of transportation to the medical health centers to see their doctors and obtain their drug supply.

Because doctors show more interest and spend more time with patients when they come to their private clinics, some patients prefer to be seen at the private clinics of their doctors and they will come only to the governmental health centers to collect their drug supply. But not all participants can afford to cover the expenses to see their doctors at their private clinics. Some of them expressed their concerns about the high cost of seeing their doctors at their private clinics (visit cost between \$10-15 for specialized physicians).

The high cost of services also applied to some diagnostic procedures. As mentioned previously, sometimes some diagnostic procedures or some chemical reagents were not available at the health care system; therefore, patients needed to do these procedures or tests at clinics or laboratories outside the health care system and cover for the cost from their pocket money. Usually, the expenses for such procedures and tests are expensive and several participants expressed that they were not able to cover for their costs. One participant put it straight forward and said: "The cost of treatment at the outside clinics (private clinics) and the outside diagnostic centers is very expensive. I can't afford to pay for seeing the doctors at their clinics or to do exams outside (means outside the health care system). I hardly can cover the cost of the basic issues for me and my family to live".

Since the siege was imposed on Gaza on June 2006, living in Gaza became very hard and the cost of living increased and became intolerable by many people. A large number of people who used to work in Israel lost their jobs and therefore their income. Recent reports showed that there were over than 140,000 citizens (constituting 41.5% of work force in Gaza) living in Gaza unemployed in the first quarter of 2009 [27]. As a result, poverty level increased. According to a household survey conducted by ICRC [28] in May 2008, over than 70% of Gaza families had less than one US dollar per day per person with about 40% of surveyed families were living on income of less than 0.5 US dollar per person per day.

Besides that, the expenses of living became very high as the quantity of many goods became limited or unavailable in the market because of the blockade. As a consequence, poverty level increased among Gaza inhabitants and several families became unable to afford providing their basic physical needs. Such hardship affected quality of life of most people living in Gaza including

prostate cancer survivors. Due to their inability to afford buying their drug supplies, several participants reported that when the drugs were not available at the governmental health care system they could not afford to buy these drugs and they had to wait without their drugs for several days, weeks, or months until the drug became available at the governmental health care system. Such a delay of drug would affect the health-related QOL of these patients.

The literature had reported about issues related to cost and inability of patients to afford the expenses of health care. Weinrich et al. [18] reported that participants with total family income of less than \$59,000 per year were less likely to perform screening for prostate cancer than men who had higher family income. Chin et al. [19] reported that diabetic patients and health care providers reported inability to afford buying devices to monitor their blood glucose at home as one of the major barriers to health care. Weinick et al. [5] found that inability to afford health care services was reported by about 60% of families as the major barrier for family members to receive the needed health care.

On the other hand, Blazer et al. [29] reported that cost was a major reason for patients to delay seeking health care especially for those living in rural counties. Many others had also reported that the cost of health services, cost of transportation, and other financial issues were a major barrier to health care [17, 4, 5, 8, 26, 15, Ahmed et al., 2001; 2, 22].

##### ***5. Geographical Barriers:***

Geographical barriers reported by the participants of this study included few sub-concepts: distance, physical accessibility, and availability of public transportation. Physical accessibility was a very major barrier before September 2005 (the time the Israelis pulled out from Gaza Strip). At that time, Israelis used to have checkpoints at the main roads between the major cities of Gaza Strip. One could spend a few minutes or several hours to pass from these check points. Sometimes, the Israelis used to block the major roads between cities up to several days that could extend to more than a week in rare occasions. As a result, several participants could not physically access either one of the two medical centers that provide oncology care at that time. After September 2005, physical accessibility became not a major concern as only a few participants reported that distance and availability of public transportation were a major barrier to health care at the current time.

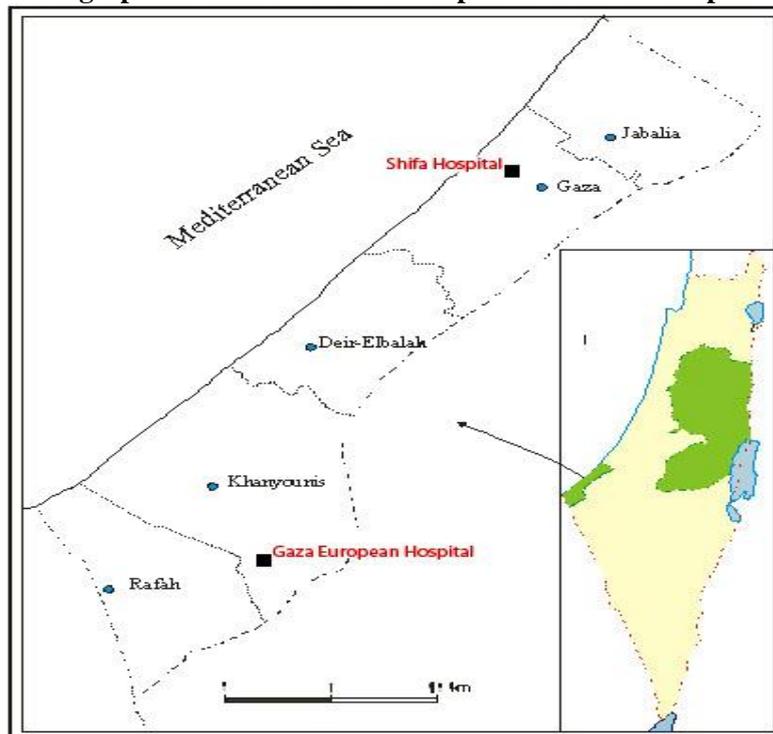
This is because the two oncology centers are located in strategic geographical positions to be accessible by patients (Figure 2). For example, Shifa Hospital is

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located at Gaza city and serve both the Northern and the Mid-Zone Governorates beside Gaza Governorate. On the other hand, Gaza European Hospital is located between Rafah and Khanyounis Governorates and it is easily accessible by participants who live there. In general, the location of the two hospitals was accessible by most of the participants and public transportation was usually available and relatively the cost of transportation was not expensive. Only a few number of patients who lived away from major roads had reported geographical-related barriers.

Geographical and transportation-related barriers were reported in many studies. For example, Guidry et al. [30] reported that transportation was one of the major barriers for African Americans to cancer treatment. In another study, Blazer, et al. [29] reported that transportation was a barrier to access health care services for those who live in the rural areas. Others [4, 5, 15, 30] reported that

**Figure 2: Geographical location of Shifa Hospital and Gaza European Hospital.**



physical proximity and distance between place of living and health care facilities were barriers to health care. Other related barriers that were reported in the literature included not having transportation [17], not having a car, inability to drive, lack of public transportation [5], lack of access to automobile and unavailability of someone to drive patients to health care facilities [30].

**6. Blockade:**

Blockade as a barrier is related directly to the barriers labeled under the titles of “unavailability” and “socioeconomic barriers.” In fact, most of the items that were not available within the health care system and the low socioeconomic status were due to blockade.

After the election which took place in Palestine in January 2006, Hamas, an Islamic political party that is not accepted by Israel and the Western countries, won the election and formed the government in April 2006. Sanctions were imposed against Gaza Strip started at that time and were tightened after imprisoning an Israeli soldier by Palestinian fighters in June, 2006. Since that time, Israel limited the number and quantity of items that enter Gaza Strip including food, fuel, and medical supplies. Besides that, Israel restricted the movement of people living in Gaza. As a result, the majority of patients who can't find treatment in Gaza Strip and used to be referred for treatment in hospitals in West bank, Egypt, Jordan, and Israel were prohibited to travel. The most affected categories of patients affected by the blockade were those who had cardiology and oncology problems [23, 24].

The process to travel outside Gaza for medical purposes is very complicated. After the patient gets a referral from the governmental health system (which is a complicated process), if they want to travel to West Bank or to Israel, they need to apply to the Israelis to get a permission to travel through the Gaza-Israeli border. Israelis give a little number of permissions to patients and many patients were denied permission to cross Israeli borders to receive treatment. For example, in December 2009, 1103 patients applied to get a permission to cross the borders to travel for treatment in an Israeli hospital or a Palestinian hospital at the West Bank. Out of them, 21% were denied these permissions or the permissions were delayed so patients had lost their appointments and had to start over to set a new appointment and start a new process to get a new permission to cross the Israeli borders [24].

Several patients died while waiting to get permissions or because they were denied permissions to travel to receive treatment outside Gaza Strip [23].

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Indeed, many patients were denied such permissions under the excuse of “security reasons” which may apply to any person live in Gaza who himself or one of his immediate or extended family members were in prison, were injured, or killed due to the Israeli Palestinian conflict.

On the other hand, patients who are referred to receive treatment in Egypt need to wait until the borders open and they will be lucky to pass at the first attempt as a few hundreds of travelers are allowed to pass at each occasion the border opens. One participant summarized his agony about his inability to travel freely to Egypt by saying: “My treatment is in Egypt. The biggest barrier to me is the blockade. When I traveled to Egypt last time, I had to wait for three months in order to be able to get to Egypt. Now, I am scheduled for a follow up visit in Egypt and I am very worry that the borders will not be open in the near future and I will not be able to go to Egypt for my follow up appointment”.

### **Summary and Recommendations**

Several barriers to health care were reported in this study by men diagnosed with prostate cancer that were categorized into five major categories; barriers due to unavailability, organizational barriers, geographical barriers, socioeconomic barriers, and barriers related directly to the blockade imposed on Gaza Strip. Under the umbrella of each category, there were several subcategories that had emerged (Figure 1). Such barriers may influence negatively the quality of provided care and limit the utilization of health care services by recipients. According to the Health Promotion Model, “situational influences in the external environment can increase or decrease commitment to or participation in health-promoting behavior” [31, p. 63-64]. Therefore, eliminating barriers to health care in Gaza is expected to increase utilization of health care services which will be reflected on the health-promoting behaviors.

The health policy makers then are required to eliminate these barriers by taking some actions to “control the system, to help solve problems within it or caused by it, or to help obtain benefits from it” [32, p. 13]. Of course not all reported barriers are mutable as there are many barriers that are not directly related to the system but they were imposed on the system. Barriers related directly or indirectly to the effect of blockade are almost non-mutable. On the other hand, almost all barriers reported under the concepts of organizational and communication barriers are mutable and could be eliminated.

For example, workshops can be arranged to train health professionals about how to communicate with patients in general and how to communicate with

patients with sensitive diagnosis such as prostate cancer. Especially the literature reported that health care providers are usually not prepared well to communicate with patients diagnosed with cancer especially when communicating the complexities related to cancer care, treatment, and complications to their clients [26]. Such workshops also may address the importance of communication and stress the avoidance of using medical jargon while communicating with patients and stress the use of simple terms that are understandable by their clients. Improving health professionals' communication skills is expected to help them to achieve the goals and benefits of communicating with their patients.

Establishing and enforcing a disciplinary policy for those professionals who leave their offices for hours is recommended so that they can abide to their working hours. Long waiting times could be solved by establishing an appointment system so that a certain number of patients will be given appointments for certain dates. Such policy may reduce waiting time and crowdedness at the outpatient oncology clinics.

To resolve the barriers related to unavailability of drugs, equipments, and some diagnostic reagents, MoH is encouraged to be opportunistic and ask for extra supply when the Israelis will allow the entrance of medical supplies from the main stores in the West Bank and request donating countries and organizations to supply them with the needed equipment and provide them with a list of needed drugs to bring with when the crossing borders with Egypt will open. Finally, it might be wise at this time that the government exercises its regulatory role and observe and control the prices of drugs and other services provided outside the governmental health care system.

**References:**

- [1] Breaking Barriers: <http://www.amsa.org/programs/barriers/barriers.html>.
- [2] McCulloch-Melnyk K., 1998- *Barriers: A critical Review of Recent Literature*. Nursing Research, Vol. 37, No. 4, P: 196-201.
- [3] McKinlay J., 1972- *Some Approaches and Problems in the Study of the Use of Services - An Overview*, Journal of Health and Social Behavior, Vol. 13, No. 2, P: 115-152.
- [4] Removing Barriers to Health Care: A Guide for Health Professionals: <http://www.fpg.unc.edu/~ncodh/rbar/>.
- [5] Weinick R. Zuvekas S., Drilea S., 1997- *Access to Health Care—Sources and Barriers, 1996*. Rockville: (MD) Agency for Health Care Policy and

## Barriers to Health Care Utilization Facing Prostate Cancer

- Research*, MEPS Research Finding No. 3. AHCPR Pub. No 98-0001: [http://www.meps.ahrq.gov/mepsweb/data\\_files/publications/rf3/rf3.pdf#xml=http://meps.ahrq.gov/cgi-bin/texis/webinator/search/pdfhi.txt?query=barriers+to+heath+care&pr=MEPSFULLSITE&prox=page&rorder=500&rprox=500&rdfreq=500&rwfreq=500&rlead=500&sufs=0&order=r&cq=&id=49faf9c9102](http://www.meps.ahrq.gov/mepsweb/data_files/publications/rf3/rf3.pdf#xml=http://meps.ahrq.gov/cgi-bin/texis/webinator/search/pdfhi.txt?query=barriers+to+heath+care&pr=MEPSFULLSITE&prox=page&rorder=500&rprox=500&rdfreq=500&rwfreq=500&rlead=500&sufs=0&order=r&cq=&id=49faf9c9102)
- [6] Abed, Y., 2007 -*Health Sector Review: A Summary Report 2007*: [http://www.emro.who.int/palestine/reports/health\\_policy\\_planning/Health\\_Sector\\_Review\\_Report\\_2007.pdf](http://www.emro.who.int/palestine/reports/health_policy_planning/Health_Sector_Review_Report_2007.pdf).
- [7] Demark-Wahnefried W., Strigo T., Catoe K., Conaway M., Brunetti M., Rimer, B. et al., 1995- *Knowledge, Beliefs, and Prior Screening Behaviors Among Blacks and Whites Reporting for Prostate Cancer Screening* Urology, Vol. 46, No. 3, P: 346–351.
- [8] Dale W., Sartor O., Davis T., & Bennet C., 1999- *Understanding Barriers to the Elderly Detection of Prostate Cancer Among Men of Lower Socioeconomic Status*, The Prostate Journal, Vol. 1, No. 4, P: 170-184.
- [9] Global Cancer Facts & Figures: 2007: [http://209.135.47.118/downloads/STT/Global\\_Facts\\_and\\_Figures\\_2007\\_rev2.pdf](http://209.135.47.118/downloads/STT/Global_Facts_and_Figures_2007_rev2.pdf).
- [10] Ministry of Health. (2006). *Annual Report 2006*: <http://MoH.ps/en/>.
- [11] Cancer Facts & Figure:2007: [http://www.cancer.org/acs/groups/content/@nho/documents/document/caff\\_2007pwsecuredpdf.pdf](http://www.cancer.org/acs/groups/content/@nho/documents/document/caff_2007pwsecuredpdf.pdf).
- [12] Babbie E., **The Practice of Social Research**. Wadsworth Thomas Learning, Australia. 2001.
- [13] Bryne M., 2001- *Data Analysis Strategies for Qualitative Research-Research Corne*., AORN Journal, Vol. 74, No. 3, P: 401-403.
- [14] Margolis P., Carey T., Lannon C., Earp J., Leininger L., 1995- *The Rest of the Access-to-Care Puzzle. Addressing Structural and Personal Barriers to Health Care for Socially Disadvantaged Children*, Archives of Pediatric and Adolescent Medicine, Vol. 149, No. 5, P: 541-545.
- [15] Battista R., Williams J., MacFarlane L., 1986- *Determinants of Primary Medical Practice in Adult Cancer Prevention*. Med Care, Vol. 24, No. 3, P: 216-224.

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- [16] Beckman C., Buford T., Witt J., 2000- *Perceived Barriers to Prenatal Care Services*, The American Journal of Maternal/Child Nursing, Vol. 25, No. 1, P: 43-46.
- [17] Estrada A., Trevino F., Ray L., 1990- *Health Care Utilization Barriers Among Mexican Americans: Evidence from HHANES 1982-84*, American Journal of Public Health, Vol. 80(Suppl), P: 27–31.
- [18] Weinrich S., Reynolds W., Tingen M., Starr C., 2000- *Barriers to Prostate Cancer Screening*, Cancer Nursing, Vol. 23, No. 2, P: 117-121.
- [19] Chin M., Cook S., Jin L., Drum M., Harrison J., Koppert J., et al., 2001- *Barriers to Providing Diabetes Care in Community Health Centers*, Diabetes Care, Vol. 24, No. 2, P: 268-274.
- [20] Rutten L., Nelson D., Meissner H., 2004- *Examination of Population-Wide Trends in Barriers to Cancer Screening from a Diffusion of Innovation Perspective (1987–2000)*. Preventive Medicine, Vol. 38, No. 3, P: 258-268.
- [21] Fowler-Brown A., Ashkin E., Corbie-Smith G., Thaker S., Pathman D., 2006- *Perception of Racial Barriers to Health Care in the Rural South*, Journal of Health Care for the Poor and Underserved, Vol. 17, No. 1, P: 86-100.
- [22] Horwitz R., Roberts L., Warner T., 2008- *Mexican Immigrant Women 's Perceptions of Health Care Access for Stigmatizing Illnesses: A Focus Group Study in Albuquerque, New Mexico*, Journal of Health Care for the Poor and Underserved, Vo. 19, No. 3, P: 857–873.
- [23] UN Humanitarian Coordinator and Association of International Development Agencies (AIDA): "The Closure of the Gaza Strip Puts at Risk the Health of People in Gaza and Undermines the Functioning of the Health Care System.": [http://www.emro.who.int/eha/pdf/GAZA\\_PR\\_Jan2010.pdf](http://www.emro.who.int/eha/pdf/GAZA_PR_Jan2010.pdf).
- [24] Gaza Health Fact Sheet: [http://www.emro.who.int/Palestine/reports/advocacy\\_HR/advocacy/Gaza\\_health\\_fact\\_sheet\\_20Jan2010.pdf](http://www.emro.who.int/Palestine/reports/advocacy_HR/advocacy/Gaza_health_fact_sheet_20Jan2010.pdf).
- [25] Geber G., 1997- *Barriers to health care for street youth*. Journal of Adolescent Health, Vol. 21, No. 5, 287-290.
- [26] Mandelblatt J., Yabroff K., Kerner J., 1999- *Equitable Access to Cancer Services: A Review of Barriers to Quality Care*, Cancer, Vol. 86, No. 11, P: 2378-2390.
- [27] Locked in: The humanitarian impact of two years of blockade on the Gaza Strip: <http://unispal.un.org/unispal.nsf/f45643a78fcb719852560f6005987ad/0dff75bb11e6929285257612004b4859?OpenDocument>.

## **Barriers to Health Care Utilization Facing Prostate Cancer**

- [28] ICRC. (2009). *Gaza: 1.5 Million People Trapped in Despair*: <http://www.icrc.org/web/eng/siteeng0.nsf/html/palestine-report-260609>.
- [29] Blazer D., Landerman L., Fillenbaum G., Homer R., 1995- *Health Services Access and Use Among Older Adults in North Carolina: Urban Vs. Rural Residents*, American Journal of Public Health, Vol. 85, No. 10, P: 1384-1390.
- [30] Guidry J., Aday L., Zhang D., Winn R., 1997- *Transportation as a Barrier to Cancer Treatment*, Cancer Practice, Vol. 5, No. 6, P: 361-6.
- [31] Pender N., Murdaugh C., Parsons M. (2002). **Health Promotion in Nursing Practice**. Prentice Hall, Upper Saddle River, NJ. 2002.
- [32] Walker W., 2000- *Policy Analysis: A Systematic Approach to Supporting Policymaking in the Public Sector*, Journal of Multi-Criteria Decision Analysis, Vol. 9, No. 1, P: 11–27.