Cancer as Perceived by a Middle-Aged Jewish Urban Population in Israel

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Breast cancer, colorectal cancer, and melanoma comprised 35% of all cancers diagnosed in Israel in 2005 (Central Bureau of Statistics, 2007). The five-year survival from was 78% for melanoma, 71% for breast cancer among Jewish women, and 45%–50% for colon cancer (Barchana, 2000). An increase in survival, particularly for breast cancer, has been observed in recent decades (Barchana).

Early-detection tests for breast, colorectal, and skin cancer are available for Israelis aged 50 years and older as part of the National Healthcare Services. However, despite guidelines for early detection, only 68% of women aged 50–74 years reported having a mammogram during the previous two years and only 53% of women ever had a cervical Pap smear test (Israel Center for Disease Control, 2006). Even less people have had colonoscopies and fecal occult blood tests (Shvartzman, Rivkind, Neville, Friger, & Sperber, 2000), and less than 10% of people aged 50 years and older have undergone colon cancer early detection tests (State Comptroller and Ombudsman, 2003).

Deciding to perform early detection tests for cancer is a complex process and many factors affect it, including organizational, social, and individual. A vast amount of literature exists on the attitudes and beliefs people have regarding cancer and early detection, and some attitudes depend on culture (Pasick & Burke, 2007; Russell, Perkins, Zollinger, & Champion, 2006).

Learning hierarchies suggest that knowledge changes affect attitudes that, in turn, affect behavior (K-A-B). Other possibilities have been suggested with different hierarchies. Dissonance attribution is when behavior change affects attitude change, which in turn will change knowledge (B-A-K); people will seek knowledge that will support their new behavior. Low-involvement hierarchy is when knowledge change affects behavior, which in turn affects attitudes (K-B-A) (Chaffe & Roser, 1986; Finnegang & Viswanatha, 2002).