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Cancer caregiving and health inequity in the West Bank, Palestine: a qualitative study of family caregivers in a conflict-affected health system

Suha Hamshari
s.hamshari@najah.edu

An-Najah National University
Muhammad A. Haq#
University of Dundee

Research Article

Keywords: health equity, cancer caregiving, access to care, Palestine, conflict-affected health systems, social determinants of health, qualitative research, family-centred care

Posted Date: September 14th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10694554/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

Cancer caregiving is shaped not only by disease burden but also by the social, geographic, economic and political conditions through which families seek care. In the West Bank, Palestine, cancer care is delivered within a fragmented and resource-constrained health system affected by occupation, mobility restrictions, medication shortages and recurrent conflict. These conditions may generate avoidable inequities in access to timely, continuous and dignified care. This study explored how family caregivers of adult cancer patients experience and respond to these inequities, and how their accounts can inform more equitable cancer-care policy and service design.

Methods

A qualitative study informed by a constructivist paradigm was conducted using semi-structured interviews with 13 informal caregivers purposively recruited through oncology clinics in Nablus, West Bank. Two pilot interviews informed refinement of the topic guide, and 11 interviews were included in the main reflexive thematic analysis. Data were collected online between November 2024 and January 2026 because of security and mobility constraints. Interviews were conducted in Arabic, transcribed verbatim, translated into English, anonymised and analysed using Braun and Clarke's reflexive thematic analysis. Reflexive memoing, peer debriefing and review of the developing thematic map supported analytic rigour.

Results

Three interrelated themes were developed. First, structural barriers to equitable caregiving described how checkpoints, fragmented geography, travel costs, medication and supply shortages, and hospital hierarchies transformed routine cancer care into uncertain, costly and emotionally exhausting work. Second, emotional labour under inequitable care conditions showed how caregivers contained distress, experienced anticipatory grief and role reversal, and relied on faith, kinship and informal peer networks to sustain care. Third, caregivers' equity-oriented recommendations called for decentralised cancer services, structured caregiver training, family-inclusive communication, psychosocial support and formal mechanisms for caregiver representation in oncology planning.

Conclusions

Cancer caregiving in the West Bank is an equity issue. Caregivers absorb costs, risks and responsibilities generated by geographically fragmented services, restricted mobility and weak family-inclusive communication. Health equity in cancer care requires more than clinical treatment availability; it requires reducing avoidable geographic, informational, psychosocial and institutional barriers faced by families. Caregiver-inclusive policies, decentralised services, communication reform and psychosocial support should be integrated into cancer-service planning in conflict-affected health systems.

Background

Cancer is a major global public health challenge and a leading contributor to mortality and disability. Its impact extends beyond patients to families who provide practical, emotional and financial support throughout diagnosis, treatment and follow-up. Informal caregivers frequently coordinate appointments, manage medication, provide daily care, interpret clinical information and sustain patients emotionally. This work is often unpaid, gendered and embedded in family expectations, and it can generate psychological distress, financial strain and social disruption (Finch & Groves, 1983; Given et al., 2001; Northouse et al., 2012; National Academies of Sciences, Engineering, and Medicine, 2016).

International research has documented multiple unmet needs among cancer caregivers, including information about diagnosis and prognosis, guidance on symptom management, practical training, communication with health professionals, psychosocial support and financial assistance (Stajduhar et al., 2010; Nguyen et al., 2020; Adejioh, 2021; Jenkins et al., 2021; Jabeen et al., 2024). However, caregiver needs are not experienced in a social vacuum. They are shaped by the health system, by the availability and geographic distribution of services, and by wider social and political conditions. From a health-equity perspective, caregiver burden becomes particularly important when families are required to compensate for system-level gaps in ways that differ by geography, socioeconomic position, gender, family networks or exposure to conflict.

The International Journal for Equity in Health is particularly concerned with evidence that improves understanding of political, policy-related, economic, social, health-system and service-related influences on the distribution of health and healthcare across population groups. This study is framed within that equity lens. It treats caregiver experience not only as a psychosocial issue, but also as evidence of how inequitable access to cancer care is produced and reproduced in everyday life.

The occupied Palestinian territory is geographically fragmented and marked by chronic political instability, restricted movement, economic vulnerability and recurrent conflict. In the West Bank, cancer care is shaped by limited specialist availability, referral pathways across cities, interruptions in medication supply, and the time and financial costs associated with travel. Prior Palestinian health research has shown how occupation, mobility restrictions and health-system fragmentation affect access to care and deepen health inequities (Giacaman, 2007; Giacaman et al., 2009; Hammoudeh et al., 2017). Yet the specific ways in which these conditions are experienced by family caregivers of adult cancer patients remain insufficiently understood.

This gap matters because caregivers often become the practical bridge between patients and a fragmented system. When services are centralised, medicines are unavailable, communication is poor, or travel is unpredictable, caregivers may become transport coordinators, information brokers, medication seekers, informal nurses and emotional anchors. These roles can reflect family resilience, but they may also indicate unjust transfer of responsibility from health systems to households. Understanding caregivers' experiences therefore offers an important route to identifying modifiable inequities in cancer-service delivery.

This study aimed to explore the experiences and perceived needs of informal caregivers of adult cancer patients in the West Bank, Palestine, with a specific focus on how structural, geographic, institutional and psychosocial factors shape equitable access to cancer care. It also sought to identify caregiver-generated recommendations for more equitable and family-inclusive cancer services in a conflict-affected health system.

Methods

Study design and epistemological orientation

This qualitative study was informed by a constructivist paradigm, which understands experience and meaning as socially situated and co-constructed between participants and researchers. This approach was appropriate because the study sought to understand how caregivers made sense of their roles, needs and struggles within a politically and institutionally constrained cancer-care environment. Semi-structured interviews were selected to allow exploration of pre-identified areas of interest while preserving flexibility for participants to introduce personally meaningful issues.

The study used reflexive thematic analysis as described by Braun and Clarke (2006). Reflexive thematic analysis was suitable because it enables systematic interpretation of patterns of meaning while recognizing the active role of the researcher in theme development. Themes were treated as analytic constructions generated through immersion in the data, reflexive engagement and iterative interpretation rather than as objective entities that simply emerged from the transcripts.

Setting

The study was conducted with caregivers living in the West Bank, Palestine, and linked to oncology clinics in Nablus. Data collection took place between November 2024 and January 2026. Because of ongoing insecurity, mobility restrictions and safety concerns, all interviews were conducted through Zoom. This was not only a logistical adaptation; it was also part of the context of the research. Online interviewing reduced travel risk and may have enabled some participants to speak from a psychologically safer home environment. At the same time, it may have excluded caregivers without reliable internet access, privacy or digital confidence, which is acknowledged as a limitation.

Participants and recruitment

Participants were informal caregivers aged 18 years or older who were caring for adult cancer patients aged 18 years or older. Caregivers included relatives and close social supporters who were involved in practical, emotional or logistical aspects of cancer care. Purposive, criterion-based sampling was used to recruit participants with direct experience of the phenomenon under study, while seeking diversity in age, gender, geographic location and caregiver-patient relationship.

Recruitment was facilitated through collaboration with oncology clinics at An-Najah National University Hospital. Clinic staff acted as gatekeepers by identifying potentially eligible caregivers and sharing a study invitation and participant information sheet. Caregivers who expressed interest were contacted by the researcher through email or WhatsApp, screened for eligibility and invited to schedule an interview. Thirteen caregivers participated: two pilot interviews were used to refine the interview guide, and eleven interviews were included in the main analysis.

Participant characteristics

Participant characteristics are summarized in (Table 1**)**. The sample was composed entirely of family caregivers. The majority were female; five caregivers were employed full-time, and three had current or previous experience in healthcare-related work.

Characteristic	Summary
Total interviewed	13 caregivers
Pilot interviews	2 caregivers
Main analysis sample	11 caregivers
Caregiver relationship	All were family caregivers
Gender pattern	Majority female
Employment	Five caregivers worked full-time
Healthcare experience	Three participants had current or previous healthcare-related experience
Data collection mode	Secure online interviews via Zoom

Table 1
Sociodemographic Characteristics and Caregiving Roles of the Participants

Participant	Age (years)	Residence	Gender	Marital Status	No. of Children	Monthly Income (NIS)	Education Level	Relationship to Patient	Living with Patient	Duration of Caregiving	Daily Care Hours	Share Careg
1	40	Village	Male	Married	—	3001–5000	University	Husband	Yes	—	—	—
2	41	City	Female	Married	4	> 5000	University	Mother	No	7 months	One day every four days	Yes - Sister
3	56	City	Female	Married	6	< 1800	High School	Wife	No	—	—	—
4	50	City	Female	Married	4	< 1800	University	Wife	Yes	—	All day	No
5	41	City	Female	Married	3	> 5000	University	Mother	No	24 months	—	Yes - Sister
6	48	City	Female	Married	4	> 5000	University	Mother	Yes	30 months	All day	No
7	26	City	Female	—	0	—	University	Daughter	—	30 months	All day	Yes - Sister
8	35	City	Female	Married	3	1800–3000	University	Sister	—	26 months	All day	Yes - Sister
9	40	City	Male	Married	3	3001–5000	University	Brother	No	24 months	As needed	—
10	42	City	Male	Single	—	3001–5000	Diploma	Mother	Yes	60 months	—	Yes - Sister
11	40	Village	Male	Married	—	3001–5000	University	Husband	Yes	—	—	—

Data collection

A semi-structured interview guide was informed by the literature on cancer caregiving, supportive care needs, family management, qualitative interviewing and the Palestinian health-system context (Stajduhar et al., 2010; Knafl & Deatrick, 2003; Jenkins et al., 2021; Ritchie et al., 2013). The guide explored caregiving responsibilities, access to services, communication with healthcare professionals, emotional burden, coping strategies, support needs and recommendations for service improvement. A short demographic and caregiving-background form was completed before the interview.

Interviews lasted approximately 50 to 70 minutes and were conducted in Arabic, the participants' native language. Before each interview, participants were reminded that participation was voluntary, that they could decline to answer questions, pause or stop the interview, and that their care would not be affected by their decision. With consent, interviews were audio-recorded using a secure platform. Field notes were written during and immediately after interviews to document contextual observations and reflections.

Transcription, translation and analysis

Audio recordings were transcribed verbatim in Arabic by the lead researcher. Transcripts were checked against the audio recordings for accuracy. Two bilingual specialists assisted with translation into English, with attention to preserving meaning, idiomatic expression and contextual nuance. Discrepancies were discussed and resolved collaboratively. All transcripts were anonymised using participant codes.

Analysis followed Braun and Clarke's six recursive phases: familiarisation, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun & Clarke, 2006). Coding was inductive and interpretive, with attention to both explicit accounts and latent meanings. Reflexive memos were used to document analytic decisions, assumptions and emotional responses. A second researcher reviewed the developing coding system and thematic map as a critical friend, helping to question assumptions and strengthen analytic coherence rather than to impose coding consensus.

Ethical considerations

Ethical approval

was obtained from the Institutional Review Boards of An-Najah National University and the University of Dundee (IRB numbers Med. July. 2025/40 and UOD-SMED-SLS-RPG-2024-24-78, respectively). All participants provided both written and verbal informed consent before participation. They were also informed that anonymized study findings, including relevant demographic characteristics and quotations, could be used in scientific publications and presentations. Participant confidentiality and anonymity were maintained throughout the study. Each participant was assigned a unique study code, and names, contact information, and other direct identifiers were removed from transcripts, study records, and reports. Electronic files were stored on password-protected devices, with access restricted to the research team. Participants were informed that discussing caregiving experiences could cause emotional distress and were advised of available psychosocial support services. No participant reported severe distress during data collection.

Results

The analysis developed three interrelated themes that illuminate caregiving as an equity issue: (1) structural barriers to equitable caregiving; (2) emotional labour under inequitable care conditions; and (3) caregiver-generated recommendations for more equitable cancer services. The themes show how caregivers were required to absorb the consequences of fragmented services, mobility restrictions, institutional hierarchies and limited psychosocial support. (Fig. 1)

Theme 1: Structural barriers to equitable caregiving

Caregivers described cancer care as taking place within a landscape of fragmented geography, high transport costs, unpredictable mobility and resource constraints. These conditions transformed routine treatment into a complex equity burden. Participants did not describe access barriers as isolated inconveniences; rather, they described a pattern in which the location of residence, the availability of transport, family income, checkpoint delays and the distribution of specialist services shaped the ability to reach and continue care.

Geographic fragmentation was central. Caregivers spoke of travelling repeatedly between cities such as Tulkarem, Jenin, Qalqilya, Nablus, Ramallah and Jerusalem. One caregiver described the cost of travelling from Tulkarem to Nablus as approximately 70 to 80 shekels per trip, a cost that rose during conflict because of longer routes and fuel costs. Frequent appointments meant that transport expenses accumulated and competed with household necessities. In this way, the financial burden of treatment was not limited to medical bills; it included the repeated hidden costs of reaching care.

Checkpoint delays also shaped access. One participant described families leaving before dawn to obtain permits and still failing to reach appointments on time. The phrase “we perform Fajr prayers on the road yet still fail to reach our appointments in time” captured both the temporal and spiritual disruption of caregiving. From an equity perspective, this account shows how mobility restrictions convert time, dignity and bodily endurance into conditions for access.

Resource shortages formed a second dimension of inequity. Caregivers reported medication and supply interruptions, expensive private-market alternatives and uncertainty about treatment continuity. These shortages forced some families to ration medication, search for alternatives or rely on informal advice. Caregivers expressed fear that these improvised responses might harm patients but felt they had few viable options.

Institutional hierarchies within hospitals added a further layer of inequity. Caregivers described feeling invisible, “ghosted by doctors,” and excluded from information or decision-making. Some had to interpret medical terminology alone, consult knowledgeable friends, search online or intercept staff informally to obtain updates. Families were expected to perform practical care tasks, such as dressing changes or tube care, without adequate training or supplies. The inequity was therefore informational as well as geographic: some caregivers could draw on education, digital tools or healthcare contacts, while others were left with uncertainty and risk.

Theme 2: Emotional labour under inequitable care conditions

Caregivers described emotional labour that went beyond ordinary family support. They contained their own distress in order to protect patients, managed family tensions, interpreted illness through religious and cultural frameworks, and in some cases experienced anticipatory grief. This emotional labour was intensified by structural barriers: uncertainty at checkpoints, medication shortages, poor communication and the need to compensate for institutional gaps.

Several caregivers described suppressing fear or sadness to prevent increasing the patient’s distress. Others used symbolic acts of solidarity, such as saying “we have chemotherapy” or shaving their hair to mirror a sibling’s chemotherapy-related hair loss. Such actions strengthened relational support but also blurred emotional boundaries between patient and caregiver.

Caregivers with medical knowledge or self-taught medical literacy described a paradox of knowledge. Understanding laboratory results, imaging or prognosis intensified vigilance and anticipatory grief. One healthcare worker described medical knowledge as a “curse” because it allowed her to foresee deterioration while lacking the authority or resources to change the course of events. This illustrates how inequity is experienced differently depending on knowledge, professional background and proximity to clinical information.

Coping strategies were both adaptive and revealing of system failure. Caregivers used YouTube, peer networks, hospital waiting-room conversations, cancer associations and village fundraising networks to obtain information, emotional support or transport assistance. These strategies created informal “shadow infrastructures” of care. However, such networks depended on social capital and were unevenly available, meaning that families with fewer connections were potentially more vulnerable.

Culture and religion were central to meaning-making. Participants framed caregiving as a familial and religious duty, often using Islamic teachings to sustain endurance and patience. Faith provided comfort and moral purpose, but it could also conceal exhaustion by making self-sacrifice feel non-negotiable. Caregivers’ accounts therefore reveal the dual role of culture: it can sustain care while also making it harder to ask for help.

Theme 3: Caregiver-generated recommendations for more equitable cancer services

Participants did not only describe suffering; they also offered practical equity-oriented recommendations. Their recommendations reflected experiential expertise developed through direct navigation of fragmented services.

First, caregivers called for decentralised cancer services. Local chemotherapy, specialist follow-up, outreach clinics or mobile services were seen as essential to reducing the physical, financial and emotional burden of travel. Decentralisation was not framed simply as efficiency; it was linked to fairness, dignity and the right to access care without repeatedly passing through costly and unpredictable routes.

Second, participants requested structured caregiver training. They wanted accessible education on medication administration, symptom monitoring, wound care, injections, emergency warning signs and treatment side effects. Training was viewed as a way to reduce trial-and-error caregiving and improve patient safety. Caregivers also wanted training to include emotional self-care and stress management, recognizing that knowledge alone would not address burnout.

Third, caregivers called for psychosocial support that was routine, non-stigmatizing and culturally sensitive. They envisioned individual counselling, family-based support and peer groups where caregivers could express distress without judgment. Such support was seen as necessary throughout the illness trajectory and after bereavement.

Fourth, participants emphasized communication reform. They wanted transparent, respectful and family-inclusive communication from oncology teams. Some described receiving difficult information by phone or being excluded from explanations. Caregivers recommended that each patient and family should have a reliable clinical contact, such as a nurse coordinator, who could answer questions, clarify care plans and reduce uncertainty.

Discussion

This study reframes cancer caregiving in the West Bank as a health-equity issue. The findings show that caregivers are not only affected by the emotional burden of cancer; they are also positioned at the point where structural constraints, service fragmentation and family responsibility intersect. Through this position, caregivers reveal inequities that may be less visible when cancer care is examined only through clinical outcomes or service availability.

The first contribution of this study is to show how geographic inequity becomes embodied in caregiving. Centralised services, checkpoints, permits, travel costs and unpredictable delays shaped whether and how families reached care. These barriers transformed geography into a determinant of cancer-care continuity. This finding resonates with Palestinian health literature showing how mobility restrictions and political conditions influence access to services (Giacaman, 2007; Giacaman et al., 2009; Hammoudeh et al., 2017). In the present study, caregivers' narratives make visible the household-level consequences of these structures: missed appointments, exhaustion, debt, interrupted work and distress.

The second contribution is to highlight informational inequity. Caregivers were expected to make decisions, monitor symptoms and perform care tasks without adequate communication or training. Families with higher literacy, healthcare contacts or digital access could partly compensate by searching online or consulting others. Families without those resources may face greater uncertainty and risk. This suggests that family-inclusive communication is not only a matter of compassion; it is also an equity intervention.

The third contribution is to identify the emotional consequences of inequitable care. Emotional labour, anticipatory grief and role reversal were intensified by poor communication, treatment uncertainty and the need to improvise. Although caregivers displayed resilience and agency, excessive emphasis on resilience risks obscuring system accountability. Caregivers should not be expected to compensate indefinitely for fragmented services, medication shortages or inadequate family engagement.

These findings have implications for cancer-service planning in Palestine and other conflict-affected or resource-constrained systems. Equity-oriented cancer care should include decentralised service models, structured caregiver education, psychosocial support and communication reform. Decentralisation may reduce the unequal burden placed on families living far from specialist centres. Training can improve safety and reduce uncertainty. Psychosocial support can make caregiver distress visible and legitimate. A named family liaison or nurse coordinator could reduce informational gaps and improve continuity.

The study also has implications for health-professions education. Participants' accounts suggest that clinicians may unintentionally reproduce inequity when they exclude families from communication or treat caregivers as logistical helpers rather than partners in care. Oncology and primary-care training should therefore include caregiver engagement, shared decision-making, culturally sensitive communication, and structural competency. Training clinicians to recognize how social and political conditions shape patients' and caregivers' experiences may support more equitable care.

This study has limitations. The sample was recruited through oncology clinics in Nablus, and experiences may differ among caregivers linked to other hospitals, private services or Gaza. Online interviews may have excluded caregivers without digital access or privacy. Self-selection may have favoured participants who were more willing to speak about their experiences. The sample was small, consistent with qualitative inquiry, and the findings are not intended to be statistically generalizable. However, the study offers rich, contextually grounded insights into mechanisms through which inequities are experienced and managed by caregivers.

Future research should examine cancer caregiver burden and access barriers across different Palestinian governorates and service pathways, using mixed-methods designs where appropriate. Intervention studies are also needed to evaluate caregiver training, nurse-navigation models, decentralised oncology outreach and culturally sensitive psychosocial support. Importantly, future policy and research should include caregivers as partners in design, implementation and evaluation.

Conclusions

Cancer caregiving in the West Bank is shaped by avoidable and unfair barriers related to geography, mobility restrictions, resource shortages, financial burden, institutional communication and psychosocial support. Caregivers demonstrated resilience, faith, ingenuity and commitment, but these strengths should not obscure the structural conditions that make caregiving more difficult and less equitable. Health equity in cancer care requires caregiver-inclusive systems that reduce travel burden, decentralise key services, provide structured training, improve family communication, and integrate psychosocial support into routine oncology care.

Equity implications for policy and practice

1. Decentralise selected cancer services through regional outreach clinics, mobile oncology support or telehealth-supported follow-up to reduce unequal travel burden.
2. Integrate structured caregiver training into oncology care pathways, including symptom monitoring, medication safety, wound care, injections, emergency warning signs and emotional self-care.
3. Establish a named clinical liaison or nurse coordinator for each oncology patient and family to improve continuity, reduce uncertainty and support shared decision-making.
4. Provide culturally sensitive psychosocial support for caregivers, including peer groups, family counselling and bereavement support.
5. Include caregiver representatives in cancer-service planning, evaluation and advocacy to ensure that policies reflect lived barriers to equitable care.

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from both the An-Najah National University and the University of Dundee Institutional Review Boards (IRB numbers Med. July. 2025/40 and UOD-SMED-SLS-RPG-2024-24-78, respectively). Participants were informed about the purpose of the study, their right to decline participation or withdraw within the specified period, and the confidentiality and anonymity of their data. Written and verbal informed consent were obtained. The study was conducted in accordance with the Declaration of Helsinki and the Belmont Report.

Consent for publication

Written informed consent for the publication of anonymized participant information, including relevant demographic characteristics and anonymized quotations, was obtained from all participants. No identifying images or directly identifiable personal or clinical information are included in this manuscript.

Competing interests

The authors declare that they have no competing interests.

Funding

No funding was received for this study.

Author Contribution

suha : contribute to whole work from creating the idea to write the ful work Mohmad : is supervising the whole steps in this reaserch

Acknowledgements

The authors are grateful to all caregivers who generously shared their experiences. The authors also thank Therese Zink for valuable editorial feedback and support during manuscript development.

Data Availability

The data are secured and could be requested according to the ethics

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Figures

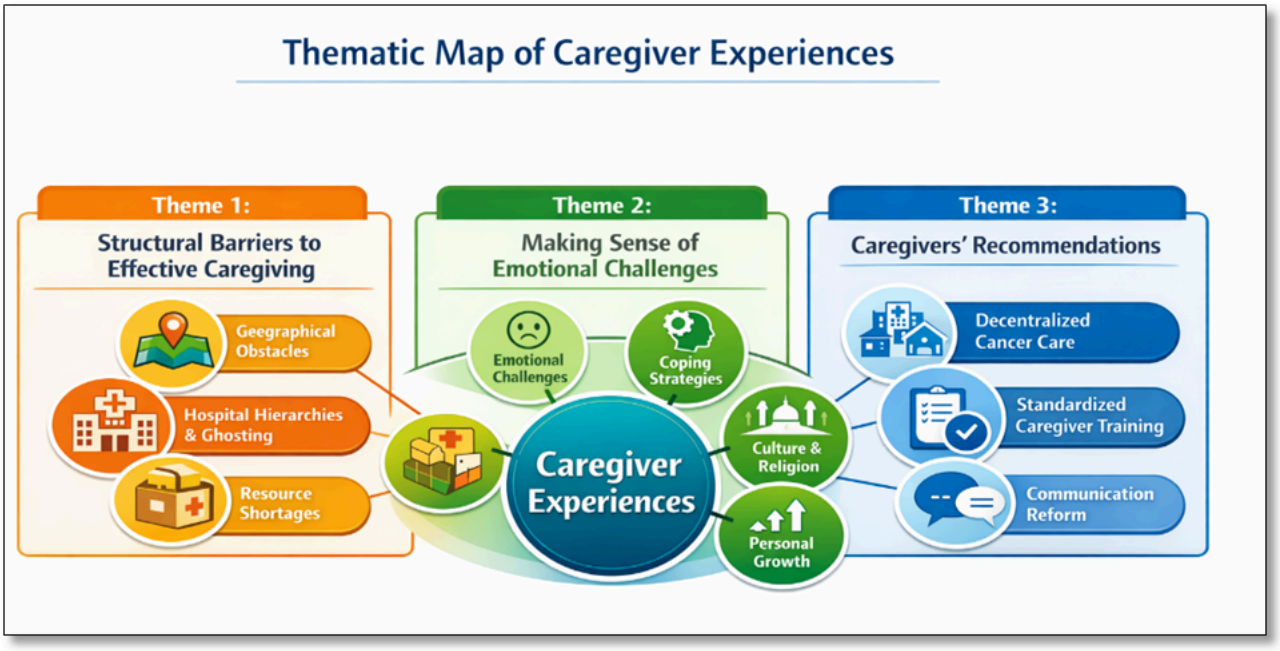


Figure 1

Thematic Map of Caregiver Experiences

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