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"We Need to Go Back Home (to) the Philippines Healthy": An Interpretive Phenomenological Analysis of Migrant Domestic Workers' Experiences of Having Breast Cancer in Hong Kong

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Abstract

Diagnoses of breast cancer are continuing to increase in the Philippines, but little is known about incidence rates among the significant number of Filipino women working abroad as migrant domestic workers (MDWs). These women are often the main income providers for their families, and their ability to work depends upon their physical health and strength. In this article, we use interpretive phenomenological analysis to explore the experiences of 10 MDWs from the Philippines who were diagnosed with breast cancer during a period of employment in Hong Kong. Analysis of these narratives revealed numerous points at which their status as temporary, transnational migrant workers intersected with their experiences of breast cancer detection, diagnosis, and treatment. We argue that these women's experiences of breast cancer were shaped by the structures of migration that link the Philippines with host destinations like Hong Kong. These structures create a unique context in which these women had to constantly renegotiate their identities as migrants, financial providers, and breast cancer patients.

Keywords

breast cancer, migrant domestic workers, Philippines, Hong Kong, interpretive phenomenological analysis

Introduction

Cancer is predicted to become the leading global cause of premature death in the coming decades (Cao et al., 2018; Soerjomataram & Bray, 2021). Breast cancer is currently the most commonly diagnosed malignancy worldwide across all genders (World Health Organization, 2021). In 2020, the World Health Organization (WHO) reported 2.26 million new cases in one 12-month period and 685,000 associated deaths. These mortality figures made breast cancer the fifth most common cause of cancer-related death across all groups during that period (WHO, 2022). There has continued to be an upward trend in diagnoses of breast cancer in high-income countries such as the United Kingdom and Australia. This is attributable to improved public awareness and screening services as well as demographic changes, population aging, and the associated growth in non-communicable diseases (Bray et al., 2018; Ginsberg et al., 2017). Despite the higher incidence rates in developed economies, the greatest *burden* of breast cancer is currently experienced in low- and low-middle-income countries (Sharma et al., 2021). Limited access to screening and treatment as well as the social and familial repercussions of the diagnosis mean that women in these countries are more likely to die or experience long-term physical, social, or economic disability as a result of being diagnosed with breast cancer (Samarasekera & Horton, 2017).

This uneven distribution of the burden of breast cancer correlates with the established understanding that an

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individual's short- and long-term experiences *of* and *with* cancer are shaped by the disease itself as well as the socioeconomic conditions in which they are situated (Samarasekera & Horton, 2017; Shilling, 2003). The impacts of these structural inequalities are evident in the economically and culturally diverse Asian regions. Hong Kong, Japan, Singapore, and South Korea have highly developed health systems with both private and public oncology services that aim to cater to a range of medical and economic needs (Molassiotis et al., 2019). In contrast, low-middle-income countries, including Indonesia and the Philippines, have less developed systems and significant rural and low-income populations with minimal access to screening or treatment services (Molassiotis et al., 2019). Additional challenges to the development of cancer care in the Philippines include diverse cultural beliefs about causes and treatments as well as the financial inaccessibility of the predominantly private-sector services (Dee et al., 2022).

In addition to these structural features that influence health trajectories, there is an emerging interest in how gendered patterns of migration impact women's health, recovery from illness, and aging (Amrith, 2021). In 2015, 7% of global work-related migration occurred within East and Southeast Asia as people moved from low-middle-income home countries including the Philippines to high-income host destinations such as Hong Kong and Singapore (Fong & Shibuya, 2020). This pattern reflects what has been described as a model of "migrating out of poverty" (Spitzer et al., 2023) as workers send significant remittances home to extended families in the hope of improving their financial position. Most of this inter-regional migration involves women moving to host destinations for employment on temporary work contracts as migrant domestic workers[1] (MDWs) engaged in home-based care and cleaning jobs. These women take on heavy responsibilities as both long-distance carers and income earners for intergenerational family units in their home countries. A serious illness like breast cancer presents great risks to both the woman affected as well as their financial dependents.

Although the long-term and multidimensional effects of breast cancer are well established (Luo et al., 2020; Ugalde et al., 2017), little is known about the potential relationships between migration status and breast cancer diagnosis, survival, and recovery in low-middle-income countries such as the Philippines. Research has shown that residual changes in strength and mobility reduce employment options, income, and social engagement (Molassiotis et al., 2019). The emotional and psychological impacts of these physical changes as well as ongoing fear of relapse have been linked with long-term anxiety, depression, and relationship issues (Molassiotis et al., 2019). These impacts on social relationships as well as employability present significant challenges to an individual's social identity and psychological well-being (Trusson et al., 2016). From a sociological perspective (Kerr et al., 2018), we do not yet know how these challenges are manifest in the experiences of migrant women who are diagnosed with breast cancer in a host destination.

There are significant differences in the legal frameworks that support MDWs across host destinations and that influence their experiences of breast cancer. In Hong Kong, MDWs are usually employed on 2-year contracts linked to single employers. Unlike migrants on skilled work visas, these women have no pathways to citizenship or residency in Hong Kong regardless of how long they work and live in the city (Hong Kong Immigration Department, 2023). MDWs are also subject to what is referred to as the '2-week rule' which means they must leave Hong Kong within two weeks of a work contract ending (including if the contract is terminated by an employer) (Cheung et al., 2019). While they are legally employed, MDWs are entitled to low-cost public healthcare in Hong Kong, employers are encouraged to take out specific insurance to cover MDWs, and it is illegal to terminate work contracts while individuals are on medically authorized leave. The reality, however, of MDWs' ability to access and use healthcare in Hong Kong is complicated by factors that drive their migration (such as family poverty), reliance on individual employers following employment laws, and challenges in the enforcement of these protections by the relevant authorities (Fong & Shibuya, 2020). The location of domestic work within the home of the employer also keeps many of these women out of public view and intensifies pre-existing power imbalances (Boersma, 2019).

In this paper, we examine how breast cancer and migration intersect by exploring the experiences of a group of female MDWs from the Philippines who were diagnosed with breast cancer during a period of employment in Hong Kong. The rationale for this focus is two-fold. Firstly, breast cancer is of increasing concern in the Philippines and rates have been rising in line with global trends (Kim et al., 2015; Lagarde et al., 2019). In 2015, the Philippines had the highest incidence rate among Asian nations (Mendoza-Dreisbach & Dreisbach, 2018). Compared to high-income countries, mortality rates are also relatively high—28% of all cancer deaths of women in the Philippines are attributed to breast cancer (Lagarde et al., 2019). These statistics draw on data collected in the Philippines, and there is currently no comprehensive information or analysis published about the breast cancer profile or long-term trajectory of migrant women who receive a diagnosis while residing in a host destination. This gap in knowledge connects to the second aspect of the rationale for this study. The Philippines is a global leader in labor migration and has established systems with various host destinations to facilitate the flow of workers and money between locations (Piper, 2017). In 2021, 1.1 million Filipino women were reported to be employed outside the country with 64.8% working on temporary contracts as MDWs (Philippine Statistics Authority, 2022). There is increasing acknowledgment of the multidimensional impact of this temporary migration on families (Garabiles et al., 2017; Islam & Cojocaru, 2015; Lu & Zhang, 2016; Peng, 2017), as well as local health services that are affected by the loss of qualified medical staff (Ortiga, 2014). However, little is known about the general health needs of this heterogeneous population who occupy a precarious position as both migrants in host destinations and “absentee citizens” in their own countries (Piper, 2017, p. 376). Some research has highlighted the tendency of these women to prioritize keeping their employment in the host location over their actual physical and mental health (Turnbull et al., 2023), but there are limited insights into what happens and how individuals make decisions after a diagnosis of a serious illness like breast cancer.

To investigate aspects of migration, identity, and breast cancer, we adopted the methodology of interpretative phenomenological analysis (IPA). IPA is an established qualitative and interpretive method of inquiry grounded in the phenomenological work of Heidegger (Nizza et al., 2021). In keeping with this approach, the analysis presented here addresses the following research question: *what are the experiences of female MDWs diagnosed with breast cancer during a period of employment in Hong Kong*? Recent work using IPA, published in this journal and elsewhere, has provided valuable insights into a range of the physical and psychological consequences of a cancer diagnosis including brain cancer (Zanotto et al., 2023), prostate cancer (McGeechan et al., 2018), cervical cancer, and breast cancer (Brunet et al., 2013; Le Boutillier et al., 2022; MacLennan et al., 2022). Some research has focused on the breast cancer experiences of female migrants in the United States (Burke et al., 2012; Schwartz & von Glascoe, 2021) and the United Kingdom (Patel-Kerai et al., 2015). However, to the best of our knowledge, IPA has not been used as a methodology to explore experiences of breast cancer within the context of temporary, transnational migration in Asia. As this type of migration continues to develop alongside increases in breast cancer diagnoses, insights into individual experiences provide a valuable starting point for investigation. The findings of this research contribute to the broader fields of women’s migration, health, and cancer.

Methodology

The IPA methodology used in this research has demonstrated utility in examining existential aspects of critical life experiences and has become more widely used in cancer studies (Zanotto et al., 2023). IPA acknowledges the participant as an embodied and socio-historically situated individual who acts as a sense-making agent. Thus, the main objective of IPA is the exploration of how people make sense of their personal experiences (Smith et al., 2009, as cited in Nizza et al., 2021). The analysis begins with an idiographic focus before tracing patterns of convergence and divergence across groups of people with some shared characteristics or experiences (Eatough & Smith, 2017). Smith and Osborn (2007) explained that IPA is particularly useful when the topic of interest is dynamic, context-dependent, and underexplored.

IPA acknowledges the role of the researcher who is actively engaged in ongoing and reflective processes as they seek to “make sense of the participant who is trying to make sense of themselves” (Dwyer et al., 2019, p. 35). Nizza et al. (2021) emphasized the complexity of the experiences that are the focus of IPA. As the idiographic approach of IPA focuses on a shared and critical life experience, purposive sampling is usually used to gather a small group of participants (Smith et al., 2009) or when limited insights into the phenomenon are available (Dwyer et al., 2019).

Ethics and Support for Participation

This research was granted ethical approval by the relevant board at The Hong Kong Polytechnic University. The first author was the lead interviewer and was supported in data collection by a bilingual assistant who was a native speaker of Tagalog. The first author had pre-established contacts with a range of MDW non-government organizations (NGOs), and information about this study was disseminated through those networks. A lead volunteer from one of the NGOs who heard about the research offered to take on the role of facilitating contact with Filipino MDWs who had been diagnosed with cancer in Hong Kong. This contact person was also the organizer of an informal Filipino MDW cancer support group and had previously received cancer treatment herself (this individual was not a research participant in the study reported here). After an initial meeting with the first author to discuss details of the project, this person shared information about the research with potential participants and arranged locations for the women to meet with the interviewers.

Ten women who were legally employed as MDWs in Hong Kong and who had been diagnosed with breast cancer during their employment volunteered to participate. At the time of the interviews, all participants were undergoing treatment for breast cancer. Principles of informed and voluntary consent were observed. All information in relation to the research was provided both verbally and in writing to potential participants (written versions of information sheets and consent forms were provided in both English and Filipino[2]). Potential participants were asked if they would like to speak to the researchers in English or Tagalog, and their preferences were accommodated. Due to the sensitivity of the topic and potential reluctance of interviewees to share information about their health and employment conditions with the researchers who were ‘outsiders’, contact was facilitated by the NGO volunteer and interviews were done at times and places selected by the interviewees. Locations included several public parks and rest areas throughout Hong Kong between October and December 2022. All interviews were conducted on Saturdays or Sundays which are the usual rest days for MDWs in Hong Kong. Participants arrived at the interview location in small groups of two or three people. After initial introductions and information sharing, the women were encouraged to discuss the information sheet provided among themselves and to ask questions before opting to give consent to participate. Participants were made aware that they could withdraw from the research at any time. All women who were approached to participate agreed to do so. As attendance was facilitated via the NGO volunteer, no personal contact or identifying details were collected from participants, and pseudonyms are used throughout this article to refer to individuals.

Procedure and Interview

After giving informed, written consent, participants were invited to disclose basic demographic details in relation to their age, education, and cancer diagnoses. One participant (referred to by the pseudonym Iona) did not disclose these details. As the research focused on experiences and perceptions, this omission did not affect data analysis. Eight women were aged between 41 and 59 and one woman was under 40 years of age. All interviewees had completed secondary school in the Philippines, and one woman had completed a university degree. All women were married and four had children in the Philippines aged under 18 years. Five women had children aged over 18 years. One woman had worked in Hong Kong for less than 5 years, five women had worked in the region for between 5 and 10 years, and two had been in Hong Kong as MDWs for more than 20 years.

The semi-structured interviews began with the following question: *When someone asks you about your health, what sort of things do you think of?* Two other questions in relation to health behaviors and the impact of employment were used as prompts if needed (*Does your job affect your health? What are your experiences of accessing healthcare in Hong Kong?*). In keeping with the idiographic approach of IPA, interviewees were able to lead discussion toward aspects of their cancer experience that were of significance to them. Five women were interviewed individually. The other women chose to sit together in small groups of two or three people but told their stories as individuals. Although a semi-structured interview design was adopted, the women spoke very openly about topics and limited prompts were needed. One woman chose to speak in Tagalog and was interviewed by the bilingual research assistant. The other women chose to participate in English. Possible implications of these language choices are discussed later in the Limitations section of this article. To thank participants for their time and contribution, after the interview individuals were given a voucher to use at a local grocery store.

All interviews were audio-recorded and transcribed verbatim. Transcripts were then checked for accuracy by another member of the research team. The interview transcribed in Filipino was translated into English and checked for accuracy by another native speaker of Tagalog prior to analysis. Interview recordings lasted for a total of 105 minutes, and combined transcripts were approximately 17,000 words in length.

Data Analysis

Analysis Procedure

Informed by the IPA work of Shinebourne and Smith (2009) and Dwyer et al. (2019), the analysis followed multiple stages beginning with an initial idiographic focus before shifting to find patterns of convergence and divergence across interviews. The first stage involved the first and second authors reading the whole transcripts individually several times. Both authors kept detailed and reflective notes during this stage. The second stage involved re-reading the transcripts and beginning to identify evidence from across transcripts of expressions of sense-making and existential reflections linked to identity, breast cancer, and migration. The authors met regularly to discuss emergent concepts and themes. During stage three, emerging concepts were clustered into themes and given labels which developed further through discussion and iterative writing. At stage four, the third author was involved in discussion and demonstration of how themes connected directly with the words of the research participants.

Research Team and Reflective Statement

A key feature of the IPA approach is the acknowledgment of the positioning of the researcher(s) in the processes of analysis and sense-making (Nizza et al., 2021; Smith & Osborn, 2007). This research was a component of a larger project led by the first author which examined the health literacy skills of adult migrant workers in Hong Kong. The rationale for this broader study was derived from the position of Hong Kong as a high-middle-income city and a popular destination for workers from low-middle-income countries such as the Philippines and Indonesia. There are significant disparities between the health systems of these locations which, along with the drivers of migration, create unique challenges for both migrant workers and healthcare providers particularly when an individual has a serious illness like breast cancer. The authors of this article have diverse areas of expertise in qualitative and quantitative health research in Hong Kong which facilitated the development of the iterative and reflective analysis presented in this article.

At the start of the research project, there was no pre-existing personal relationship between researchers, research participants, or the NGOs that facilitated dissemination of project information. The interviewers were not members of the MDW community, and thus the key NGO volunteer who supported recruitment acted as an important facilitator of entry into this subcommunity of Filipino MDWs with breast cancer. Research participants were therefore also members of the strong informal support network which offered companionship, advice, and emotional support on an ongoing basis through face-to-face meetings (including attending weekly church services together and sharing meals) and online communication. These supportive and community-building characteristics are a well-established feature of the Filipino MDW community in Hong Kong (Peralta-Catipon, 2012). This group membership also provided reassurance to the research team that ongoing support was available to the women if they found participation in the interviews exacerbated their levels of distress. Although benefits of participation in the research were not directly evaluated through this project, it is of note that individuals often commented that they wanted to share their stories as a way of helping other MDWs and also expressing their own emotions.

Imbalances in "positionality and symbolic capital" (Abrams et al., 2020, p. 3) are acknowledged within this research and are discussed further in the section on limitations. Following Dwyer et al. (2019) and Smith (2004), participants were not engaged in respondent validity checks. The complexity of the interpretations presented and the potential disparity in literacy skills between researchers and participants were predicted to reduce the scope for disagreement or discussion.

Findings

In this section, we present the results of our analysis and the insights provided into these women's experiences of cancer. Across their diverse stories, the research participants described how and when their cancers were discovered and named as well as how they sought to integrate cancer into their lives as migrant workers. There was divergence in physical experiences but a shared sense of shock, despair, and disappointment in their loss of the physical strength which was key to their livelihood and the future plans for their families. The many layers of these stories are embedded within the context and structures of the women's lives as temporary, transnational migrant workers. Through the processes of analysis, three themes that reflected different stages of ongoing sense-making were identified: (1) discovering and naming the cancer, (2) conflicts between the roles of breast cancer patient and MDW, and (3) tension between the roles of breast cancer patient and family breadwinner in transnational employment. These themes and illustrative quotes are discussed in detail in the following sections.

Discovering and Naming the Cancer

Our interviewees reported a range of diverse experiences in relation to their awareness of the changes in their physical bodies that would later be diagnosed as cancer. All of the women described initially noticing a lump or an abnormality in their breast through self-examination. Their responses to the discovery of the lump diverged in terms of their follow-up actions and the developing realization of what may be happening in their bodies. There was, however, a shared sense of shock that their usually strong and healthy bodies had somehow failed: "I don't know what happened or what is the problem during that time because we don't have the family history" (Doreen, 4 years working in Hong Kong prior to diagnosis). Doreen, Hanna, Moira, and Rennie described a growing awareness that even in the absence of any physical symptoms of illness, the lump was likely to be cancer. These women identified multiple ways in which they searched for information themselves from the Internet, friends, employers, and, eventually, medical practitioners. Rennie, for example, used information sources on the Internet before seeing a doctor and viewed the doctor's diagnosis as confirmation of what she already thought:

> When I discovered that I have a bump in my chest I searched it on YouTube and Google and when I went for a checkup, it ends up being true (. ...) I asked the doctor and he said, ... yeah you are right, it's right because with my age now in the 50s, I am in menopause so it would not be normal for the bump I saw to just be a cyst because of my age, it can turn into cancer so what I searched was correct. (Rennie, individual interview, 5–10 years of work experience in Hong Kong)

In contrast to these women who described taking action to seek out information and help in the process of naming their cancer, Nelly described avoiding diagnosis due to an overriding sense of fear. Nelly said she had come to Hong Kong to work as her husband did not earn enough money in the Philippines to support their family. She had asked about a lump she had noticed in her breast at a routine pre-employment health screening in the Philippines before embarking on her journey to Hong Kong. Nelly said that she was reassured at the time that the lump was likely to be related to breastfeeding her own young child. Nelly described having a continuing awareness of the lump but not understanding what it could be and also not wanting to confront the possibility of it being cancer and the risk of losing her job:

> I don't want to go to the doctor because I don't want to lose my job. So I'm afraid go to the doctor, I'm afraid go to checkup. Even my sister, my two sisters, insist me to go to checkup for your breast because maybe that is a cancer, they said. I was afraid. (Nelly, individual interview, less than 5 years of work experience in Hong Kong)

Despite this encouragement, Nelly did not go to the doctor until she was experiencing great physical pain:

> I told my friend, "Ate [Filipino title for older sister/lady], it's very pain. I cannot." So she told me, "Can you take a picture? I want to show my employer because my employer is a nurse," she said. And then I took picture, and then I took video 14 seconds, and then I show to my friend. And then she show also to her employer. And the employer said to her, "Tell your friend, she need to go to the doctor otherwise she lost her life." This year, she said. So, that's what I was wondering! (. ...) So, in my day off, in my holiday, I need to see the doctor. That's the time, I first time go to check up. And even in the [Queen Mary] the doctor said when the doctor checked my breast "tsk tsk." (Nelly, individual interview, less than 5 years of work experience in Hong Kong)

Like all the other interviewees, Nelly and Moira described being able to quickly access diagnostic and treatment services in Hong Kong:

> So immediately, they asked me to have the mammogram, have the ultrasound, and then they took biopsy, they get tissue from my breast. And it's positive because I have the breast cancer which is stage 4 already, stage 4. (Nelly, individual interview, less than 5 years of work experience in Hong Kong)

> And at the middle of the night, I feel that something happen in my breast, and then I'll go immediately to the Queen Mary and then I, uh, I tell them that I have I have something feel in here, very pain (. …) Yeah. After go back to the Queen Mary, and then, go to the other hospital, to make the mammogram (. …) that is almost one week, and declare I am, I have a breast cancer (.…) my employer told me that "no need the CT scan, you go to the PET scan so that all your body can check it." So … I did that (. …) For the help of my employer, it is very easy to make the surgery, no need wait the wait the time for the surgery. (Moira, individual interview, 5–10 years of work experience in Hong Kong)

This access to diagnostic and treatment services was dependent upon the women maintaining their status as legally employed MDWs. Although the Hong Kong health services were praised by the women, and all reported that they maintained their employment immediately after receiving their diagnosis (although some had subsequently changed employers), a combination of family financial pressures and perceived limited access to care in the Philippines shaped their decision-making and the ongoing prioritization of their employment.

Conflicts Between the Roles of Breast Cancer Patient and MDW

After the initial diagnosis of breast cancer, the research participants described common experiences in relation to how their identities as cancer patients were dominated and shaped by their roles as workers, income earners, and migrants. The need to continually demonstrate their ability or potential to be strong, healthy workers required them to juggle their healthcare needs with the demands of their jobs. These demands were intensified by the domestic location of their work and the almost constant fear of losing their work visa and, thus, access to healthcare in Hong Kong. There was convergence across these aspects of the women's experiences as they sought to integrate cancer into their lives and their work.

An aspect of this juggling of identities is related to the unique work context of MDWs. Unlike other employees who leave their place of work site to go 'home', MDWs in Hong Kong are required to reside in the homes of their employers and, other than a mandated rest day each week, there are no clear or enforced limits on daily work hours. The nature of the demands of domestic work as well as the location in homes increased the structural disadvantages experienced by our research participants after their diagnosis of breast cancer. Our interviewees described trying to balance their health needs and treatments with the work tasks they were assigned. Most of the women continued to work each day after starting treatment for cancer, and some of the women explained that they wanted to continually demonstrate their physical ability to complete their work. Rennie described the ongoing physical and psychological difficulties she experienced as she tried to integrate the demands of her cancer treatment with her work:

> When I undergo my first, second, and third chemotherapy I'm very very weak. Even though I feel dizzy, but I'm still complete and finish my work and sometimes at the middle of the night, she [her employer] will come back late (. …) She will ask you to make her something … even though you're not feeling well (. …). But since it's your work, you just don't care about what you're feeling right (. …) The most important for them is to get your work done before you go to bed. (…) Mentally and physically you are very tired and we cannot avoid it because we are just a helper (. …) It is like she does not care about what you feel even if you are struggling. (Rennie, individual interview, 5–10 years of work experience in Hong Kong)

Rennie's narrative highlights some common issues faced by the interviewees after their diagnosis of breast cancer: (1) they still had to complete physically demanding tasks during their cancer treatments; (2) there were no clear boundaries between their personal and work time/space; and (3) most participants experienced and described a neglect of their health needs by their employers. Rennie's main identity, as stated by her, was of being *just a helper*. Identity is a complex construct that is influenced by multiple factors including the relationships between individuals and their employers. This sense of identity was complicated by the diagnosis of breast cancer and foregrounded tensions between the MDW and employers.

Another participant also reflected how she oscillated between her roles as an MDW and cancer patient by making concessions in relation to her needs as a patient:

> At work yes I am stressed at work because of my employer, I always massage them every day, every night every single night every day. And it is always hard massage. I don't complain to my employer because the house workload is light. Because sometimes I massage three times a day and my vein feels tired. Maybe that is also one of the things that triggers. Because even if my hand hurts a lot I do not complain even if I want to cry because of the pain and I want to say I can't do it anymore but I endure it instead. (Polly, individual interview, 5–10 years of work experience in Hong Kong)

Polly's narrative revealed how she rationalized her "don't complain" attitude by referring to her light workload, and therefore, she was willing to make a concession on her needs even though they were not met ("I endure it instead").

Apart from demanding tasks assigned by their employers, our interviewees also discussed their lack of freedom in terms of food choice due to either the low statutory food allowance paid to them or limitations in food availability if their employers provided food for them:

> Especially with my employer right now, it is always fried noodles because that is the only budget we have which is for lunch. It can only afford that from the free food allowance we receive which is why we always buy fried noodles (. …) My employer giving us food allowance but we cannot question the amount because of course the workload is light which is why we do not demand, we do not act out. (Polly, individual interview, 5–10 years of work experience in Hong Kong)

> Maybe is about the food because we always eat noodles, we always eat the frozen foods. (Nelly, individual interview, less than 5 years of work experience in Hong Kong)

For cancer patients, it is vital for them to receive regular medical checkups, but this did not always happen for the women in our research. For example, Jackie told us she had missed some of her checkups because her employer did not allow her to go to the hospital which was far from their home:

> My boss is not good (. ...) I miss some of my checkup because they did not allow me, very far. (Jackie, group interview, 11–20 years of work experience in Hong Kong)

Hanna considered herself the 'lucky' one because her employer had been considerate and supportive since her diagnosis. However, she said she knew other MDWs who were not able to keep their medical appointments due to their tight work schedule:

> Sometimes, even we have Hong Kong ID, if the employers don't allow us to go (. ...) The quality of medication here is good, but then the quality of our situation, our work, sometimes is not equal. (. ...) If your employers ... could give you a time for your checkup but then for the hectic, um, situation and for the, for the workload, it's very hard for others. I been so lucky, one of the luckiest one, because my employers were so considerate and, um, they are always so quite supportive since the time that I was sick. (Hanna, individual interview, over 20 years of work experience in Hong Kong)

Most of our interviewees described adopting what seemed to be a passive role as employees and were accepting of adversity when tensions arose between their roles as 'patient' and MDW. While many did not confront their employers even though their health needs were not met, some women chose to speak up in cases of abuse. The extract below demonstrates how Iona recognized her health needs as a cancer patient, stood up for herself, and protected her rights as both a cancer patient and MDW:

> Yeah, we need to rest. Like now we have treatment, like me, and then I have several time go to hospital now my employer ask me to do some work before I leave for my holiday and I disagree. Because this is my holiday, and then I said, this is my

> holiday how about my health? (. …) Now I have the illness so I need the health, I need keep my health strongly because I had taken the oral therapy. but she cannot understand (. …) And I uh argue with her in the message from the WhatsApp, because I have right. We follow the instructions from the law, the government, from our contract. And then still yell me, or scolding me that why I need going the hospital, like that, blah blah blah (. …) I have illness so I need completely rest, I need the help from miss, because more important is sleeping. Although we are rich, food is useless if you don't have sleep. (. …) But I pray that one day she will change, and see my thing that we I have right all the time (. …) So I go out early now because I have illness, so I need to take care by myself. Because no one take care me being domestic helper. So we do ourself. (Iona, group interview, did not disclose number of years working in Hong Kong).

These extracts demonstrate the tensions between the roles of these women as both cancer patients and MDWs. After the biomedical diagnosis, they became aware of their health needs and engaged in often tiring and stressful treatment. However, to access this treatment, they needed to maintain their employment and thus sought to fulfill their designated roles as MDWs, which often strained them physically and emotionally.

Tension Between the Roles of Breast Cancer Patient and Family Breadwinner in Transnational Employment

Despite the various difficulties they had encountered as both cancer patients and MDWs in Hong Kong, all interviewees expressed their wish to stay and receive medical treatments in Hong Kong. There was convergence across the rationalizations given for seeking to stay in Hong Kong—treatment in the Philippines was prohibitively expensive and the medical technology in Hong Kong was considered to be more advanced. Eve and Jackie believed that they would have died if they got sick in the Philippines as they did not have money to pay for the treatment they needed:

> In Philippines (…) first I will go to doctor so you need money, big money. The ultrasound you know all the medicine is not free unlike here in Hong Kong (. …) In Philippines, no, different. So you need to check the doctor, then give the prescription and then you go to pharmacy to buy. So if you know no work, you cannot live. (Eve, group interview, 5–10 years of work experience in Hong Kong)

> The treatment here, the modern technology is very innovative. That's it. The technology. That's why if ever I'm in the Philippines maybe I'm not anymore alive, I'm die because my, I'm stage 3 breast cancer, my lump is very big and open the wounds. It was a very critical and, it's so badly. That's why my treatment first is chemo to make small the lump, and then surgery and radiation. If ever I am already in Philippines, maybe I'm not here anymore. (Jackie, group interview, 11–20 years of work experience in Hong Kong)

The interviewees' narratives reflected the ongoing negotiation of identities as breadwinners and cancer patients across Hong Kong and the Philippines. This can be linked with the widely acknowledged importance of family in Filipino culture (Miralao, 1997; Straiton et al., 2017) that influences MDW patterns of work. All the interviewees said they were the key income earners for their families and had to send remittances back home regularly to support the living, housing, and education of their children, spouses, parents, siblings, nephews, and nieces. All interviewees expressed a sense of responsibility and obligation to support their families in the Philippines and, consequently, prioritized long-term family needs over their own short- and medium-term physical and emotional needs. It is also of note that even after years of working in Hong Kong, these financial commitments had limited the accrual of personal savings. Thus, the women said they had no savings to pay for cancer treatment if they returned to the Philippines. The ongoing fear and emotional stress related to keeping their work visas added additional complexity to some women's cancer experiences:

> Some of us some of us, in our group, they lost their visa, they couldn't go for checkup because of their losing the visa here in Hong Kong. I think we can't afford to go to—and I think hospital don't allow us to get into the hospital because of the cost of medication here after, um, losing your visa. It's a big problem. (Hanna, individual interview, over 20 years of work experience in Hong Kong)

> I cannot start it [chemotherapy] here and continue it in the Philippines because the medicine is different between here and the Philippines. That is why right now I don't know if I'll do chemotherapy here or in the Philippines. Even if I can reach out to someone over there I'd still have to spend a huge amount of money right. But I am the only person my family is counting on. (Polly, individual interview, 5–10 years of work experience in Hong Kong)

This fear of unemployment and the potential financial implications for their families influenced the actions some of the interviewees did or did not take as they dealt with breast cancer within the structures of employment and migration. While some interviewees described seeking help from their employers, Nelly, for example, said she was afraid of losing her job and thus delayed seeking help, and when she did, she turned to a friend first. These findings resonate with other research which has described a cancer diagnosis as prompting the sudden and disruptive questioning of "personal identity, autonomy, dignity, life meaning and purpose" as well as an activation of the key social connections that link an individual with those around them (Lee & Loiselle, 2012, p. 124). In our research, however, this disruption was influenced by the nature of the women's transnational employment.

Discussion

This study explored the lived experiences of a group of MDWs from the Philippines who were diagnosed with breast cancer while employed in Hong Kong. This group of women is largely absent from cancer-related literature, and thus the idiographic approach of IPA facilitated an in-depth and exploratory analysis of some of the dimensions of their experiences. Elements of our participants' accounts resonated with those reported in broader cancer-related literature in terms of experiencing shock and a cognitive dissonance or struggle at hearing the news of their diagnosis (Holmberg, 2014) which leads to a broader re-evaluation of life and priorities (Lee & Loiselle, 2012). Some people relate this disruption to life and identity with the initial discovery of symptoms (Liamputtong & Suwankhong, 2015) while others focus on the point of receiving the confirmatory biomedical diagnosis (Holmberg, 2014). The women in our study described a type of biographical disruption that reasserted the priority of their employment over their physical health. Although the interviewees described self-awareness and agency in terms of finding the lumps in their bodies, in contrast to other research on cancer discovery, our research participants framed their breast cancer experience within the broader structures of temporary, transnational migration.

This framing of the experience of breast cancer led to further divergences from breast cancer experiences described elsewhere. Other research has highlighted that the diagnosis of cancer is usually followed by a relatively rapid transition to the role of 'cancer patient' and what is considered to be a legitimate and socially sanctioned "sick role" (Parsons, 1951, as cited in Trusson et al., 2016). That is, once the individual has been (re)named as a cancer patient, they are temporarily released from the constraints and expectations of their usual, healthy life. The 'good' cancer patient is expected to undergo treatment and comply with medical advice—"normal roles and responsibilities are suspended until health is restored" (Trusson et al., 2016, p. 122). In contrast, our research participants described a more complicated navigation of their changing identities that drew on aspects of their transnational migration and employment. These women wanted to keep their jobs for their income as well as their ability to access oncology services in Hong Kong which they felt were more advanced and affordable than the services available to them in the Philippines. The women thus attempted to balance and manage their transnational positioning and work within the structural constraints of their domestic employment to keep their jobs, their income, and their access to low-cost cancer treatment in Hong Kong. The women expressed a desire to prove their ongoing ability to perform their physical labor even when their bodies were weakened by the cancer treatment.

These findings draw attention to some of the inherent flaws within the current structures of this migration system that commodifies the physical strength of women who are tied emotionally and financially to both home and host destinations. Rodriguez (2010) argued that the real-life effects of these policies of transnational migration need to be examined across home and host destinations as both play an active role in the development and maintenance of these systems. In the case of the Philippines, the commodification of the physical labor of women has been widely examined, but limited attention has been directed toward the long-term health needs of these women as they age, develop serious illness, and move through and out of the migration system. Some insights have been gained in relation to influences on MDW uptake of health screening (Jong & Reilly, 2020), but this needs to be expanded further and include a focus on what happens after the diagnosis of a serious illness. This type of research is hard to do as many potential participants may be reluctant to disclose their health conditions as this immediately contradicts the desired impression of being a physically strong worker.

Our findings also highlight the layers of the stories told by MDWs diagnosed with breast cancer in Hong Kong. As we have discussed, previous research has confirmed the magnitude of the emotions and anxiety people may experience after receiving a diagnosis of cancer, and thus some elements of our findings are not unexpected. Despite an increasing focus on the experiences of MDWs in Asia, limited attention has been directed toward considering what happens when these women are diagnosed with breast cancer and the associated multidimensional effects.

Limitations

There are three key limitations to acknowledge in relation to this exploratory study. The first of these relates to our exclusive focus on MDWs from the Philippines. As noted earlier in this article, the population of MDWs in Hong Kong is heterogeneous, and thus the experiences of our interviewees who had stable local social networks are likely to contrast with those of many other MDWs in Hong Kong who may be socially isolated. Local research has identified significant differences in age, education, health, and literacy across MDW groups from the various key sending nations (Cameron et al., 2001; Liao & Gan, 2020). Future research on breast cancer and other serious illnesses in the MDW population could usefully focus on diverse groups.

The second limitation relates to our inclusion of women currently undergoing treatment for breast cancer. Future longitudinal research that considers the experiences of women who have completed cancer treatment and either returned to the Philippines or have continued to work in Hong Kong would add greater depth to this field of work by tracing trajectories of care and recovery. In a related way, expanding the focus beyond breast cancer to other malignancies would give more comprehensive insights into cancer experiences.

The third limitation of this research relates to the use of English as the main language of communication in the interviews. Nine of the 10 participants were interviewed in English, and it was anecdotally observed by the first author that although a Filipino version of the information sheet and consent form was provided alongside the English one, most participants chose to read the English version. Preferences to read and speak in English in this research context may reflect a variety of influences which could be usefully explored. Potential considerations relate to the following factors: all interviewees reported that they had been taught English at school in the Philippines and were regular speakers of English in Hong Kong (no participants described themselves as able to speak Chinese when asked); English is the language used with non-Chinese speakers in the Hong Kong healthcare system (unless translators are requested), and thus the women may be more familiar with discussing cancer and their treatment in English. Additionally, English may be viewed as a higher status language for use in interaction with institutional representatives (such as researchers). In future research, offering a broader range of relevant languages spoken in the home countries or regions of participants for interviews (e.g., Tagalog and Cebuano) may facilitate discussion of diverse aspects of cancer experiences. Although the content of the Tagalog interview was comparable to the content of the English interviews, different language patterns and preferences may be evident in other contexts or in designs that incorporate focus group discussion (Lamb & Cogan, 2016). Future research could consider involving facilitators from NGOs in multilingual interviews.

Despite these limitations, our research aims to take a first step toward addressing the general paucity of literature focused on this group of women who are at great risk of marginalization in both their home countries and host destinations due to their healthcare needs, status as temporary migrants, and transnational positioning.

Conclusion

This article presents an initial exploration of the intersection of breast cancer and temporary migration in Asia. The pressures that drive this movement of thousands of women from the Philippines to higher income destinations like Hong Kong create a unique context in which the identity of the breast cancer patient is shaped by the structures of employment and migration. Migration status (including drivers such as poverty) and family financial responsibilities played a significant role in the decision-making and help-seeking behavior of the MDWs in our research. This is of great concern as rates of breast cancer continue to increase alongside the widening inequality in both health and wealth that drives a significant proportion of global migration. The present study contributes a critical examination of how breast cancer and migration influence the trajectory of these MDWs' lives. Understanding more about their experiences and long-term needs may go some way toward redressing the uneven distribution of the benefits of advances in breast cancer treatment.

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Notes

1. Hong Kong immigration regulations refer to these workers as foreign domestic helpers. However, in this article, we use the term migrant domestic worker which is used in other relevant regions and related literature.
2. Filipino is the standardized written language used in the Philippines. The most used spoken languages are Tagalog and Cebuano. After discussion with research participants, in this article, we refer to the written version of the language as Filipino and the spoken language as Tagalog.

References

Abrams, J. A., Tabaac, A., Jung, S., & Else-Quest, N. M. (2020). Considerations for employing intersectionality in qualitative health research. *Social Science and Medicine*, *258*, 113138. https://doi.org/10.1016/j.socscimed.2020.113138

Amrith, M. (2021). Ageing bodies, precarious futures: The (im) mobilities of 'temporary' migrant domestic workers over time. *Mobilities*, *16*(2), 249–261. https://doi.org/10.1080/17450101.2021.1885834

Boersma, M. (2019). Filipina domestic workers in Hong Kong: Between permanence and temporariness in everyday life. *Current Sociology*, *67*(2), 273–293. https://doi.org/10.1177/0011392118792928

Bray, F., Ferlay, J., Soerjomataram, I., Siegel, R. L., Torre, L. A., & Jemal, A. (2018). Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA: A Cancer Journal for Clinicians*, *68*(6), 394–424. https://doi.org/10.3322/caac.21492

Brunet, J., Sabiston, C. M., & Burke, S. (2013). Surviving breast cancer: Women's experiences with their changed bodies. *Body Image*, *10*(3), 344–351. https://doi.org/10.1016/j.bodyim.2013.02.002

Burke, N. J., Villero, O., & Guerra, C. (2012). Passing through: Meanings of survivorship and support among Filipinas with breast cancer. *Qualitative Health Research*, *22*(2), 189–198. https://doi.org/10.1177/1049732311420577

Cameron, L. A., Malcolm Dowling, J., & Worswick, C. (2001). Education and labor market participation of women in Asia: Evidence from five countries. *Economic Development and Cultural Change*, *49*(3), 459–477. https://doi.org/10.1086/452511

Cao, B., Bray, F., Ilbawi, A., & Soerjomataram, I. (2018). Effect on longevity of one-third reduction in premature mortality from non-communicable diseases by 2030: A global analysis of the Sustainable Development Goal health target. *Lancet Global Health*, *6*(12), e1288–e1296. https://doi.org/10.1016/S2214-109X(18)30411-X

Cheung, J. T. K., Tsoi, V. W. Y., Wong, K. H. K., & Chung, R. Y. (2019). Abuse and depression among Filipino foreign domestic helpers. A cross-sectional survey in Hong Kong. *Public Health*, *166*, 121–127. https://doi.org/10.1016/j.puhe.2018.09.020

Christie-de Jong, F., & Reilly, S. (2020). Barriers and facilitators to pap-testing among female overseas Filipino workers: A qualitative exploration. *International Journal of Human Rights in Healthcare*, *13*(3), 275–288. https://doi.org/10.1108/ijhrh-01-2020-0006

Dee, E. C., Ang, C. D. U., Ting, F. I. L., Tangco, E. D., & Eala, M. A. B. (2022). Improving cancer care in the Philippines: The need for deliberate and careful implementation of the National Integrated Cancer Control Act. *The Lancet regional health. Western Pacific*, *28*, 100615. https://doi.org/10.1016/j.lanwpc.2022.100615

Dwyer, A., Heary, C., Ward, M., & MacNeela, P. (2019). Adding insult to brain injury: Young adults' experiences of residing in nursing homes following acquired brain injury. *Disability and Rehabilitation*, *41*(1), 33–43. https://doi.org/10.1080/09638288.2017.1370732

Eatough, V., & Smith, J. A. (2017). Interpretative phenomenological analysis. In C. Willig & W. S. Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 193–209). Sage.

Fong, E., & Shibuya, K. (2020). Migration patterns in East and Southeast Asia: Causes and consequences. *Annual Review of Sociology*, *46*(1), 511–531. https://doi.org/10.1146/annurev-soc-121919-054644

Garabiles, M. R., Ofreneo, M. A. P., & Hall, B. J. (2017). Towards a model of resilience for transnational families of Filipina domestic workers. *PLoS One*, *12*(8), Article e0183703. https://doi.org/10.1371/journal.pone.0183703

Ginsburg, O., Bray, F., Coleman, M. P., Vanderpuye, V., Eniu, A., Kotha, S. R., Sarker, M., Huong, T. T., Allemani, C., Dvaladze, A., Gralow, J., Yeates, K., Taylor, C., Oomman, N., Krishnan, S., Sullivan, R., Kombe, D., Blas, M. M., Parham, G., & Conteh, L. (2017). The global burden of women's cancers: A grand challenge in global health. *The Lancet*, *389*(10071), 847–860. https://doi.org/10.1016/S0140-6736(16)31392-7

Holmberg, C. (2014). No one sees the fear: Becoming diseased before becoming ill—Being diagnosed with breast cancer. *Cancer Nursing*, *37*(3), 175–183. https://doi.org/10.1097/NCC.0b013e318281395e

Hong Kong Immigration Department. (2023). https://www.immd.gov.hk/eng/services/roa/term.html (Accessed 23.11.03).

Islam, M., Rezaul, & Cojocaru, S. (2015). Migrant domestic workers in Asia: Transnational variations and policy concerns. *International Migration*, *54*(1), 48–63. https://doi.org/10.1111/imig.12201

Kerr, A., Ross, E., Jacques, G., & Cunningham-Burley, S. (2018). The sociology of cancer: A decade of research. *Sociology of Health and Illness*, *40*(3), 552–576. https://doi.org/10.1111/1467-9566.12662

Kim, Y., Yoo, K.-Y., & Goodman, M. T. (2015). Differences in incidence, mortality and survival of breast cancer by regions and countries in Asia and contributing factors. *Asian Pacific Journal of Cancer Prevention*, *16*(7), 2857–2870. https://doi.org/10.7314/apjcp.2015.16.7.2857

Lagarde, J. B. B., Laurino, M. Y., San Juan, M. D., Cauyan, J. M. L., Tumulak, M.-A. J. R., & Ventura, E. R. (2019). Risk perception and screening behavior of Filipino women at risk for breast cancer: Implications for cancer genetic counseling. *Journal of Community Genetics*, *10*(2), 281–289. https://doi.org/10.1007/s12687-018-0391-3

Lamb, D., & Cogan, N. (2016). Coping with work-related stressors and building resilience in mental health workers: A comparative focus group study using interpretative phenomenological analysis. *Journal of*

Occupational and Organizational Psychology, *89*(3), 474–492. https://doi.org/10.1111/joop.12136

Le Boutillier, C., Urch, C., King, A., Barry, C., Mansfield, L., & Archer, S. (2022). 'Still living with it even though it's gone': Using interpretive phenomenological analysis to explore shared experiences of living with and beyond breast, prostate, and colorectal cancer. *European Journal of Oncology Nursing*, *56*, 102067. https://doi.org/10.1016/j.ejon.2021.102067

Lee, V., & Loiselle, C. G. (2012). The salience of existential concerns across the cancer control continuum. *Palliative and Supportive Care*, *10*(2), 123–133. https://doi.org/10.1017/S1478951511000745

Liamputtong, P., & Suwankhong, D. (2015). Therapeutic landscapes and living with breast cancer: The lived experiences of Thai women. *Social Science and Medicine*, *128*, 263–271. https://doi.org/10.1016/j.socscimed.2015.01.031

Liao, T. F., & Gan, R. Y. (2020). Filipino and Indonesian migrant domestic workers in Hong Kong: Their life courses in migration. *American Behavioral Scientist*, *64*(6), 740–764. https://doi.org/10.1177/0002764220910229

Lu, Y., & Zhang, A. T. (2016) The link between migration and health. In F. Thomas (Ed.), *Handbook of migration and health* (pp. 19–58). Edward Edgar Publishing.

Luo, D., Eicher, M., & White, K. (2020). Individual resilience in adult cancer care: A concept analysis. *International Journal of Nursing Studies*, *102*, 103467. https://doi.org/10.1016/j.ijnurstu.2019.103467

MacLennan, S. J., Cox, T., Murdoch, S., & Eatough, V. (2022). An interpretative phenomenological analysis of the meaning of work to women living with breast cancer. *Chronic Illness*, *18*(3), 503–516. https://doi.org/10.1177/1742395320987883

McGeechan, G. J., McPherson, K. E., & Roberts, K. (2018). An interpretative phenomenological analysis of the experience of living with colorectal cancer as a chronic illness. *Journal of Clinical Nursing*, *27*(15–16), 3148–3156. https://doi.org/10.1111/jocn.14509

Mendoza-Dreisbach, S., & Dreisbach, J. L. (2018). Female breast cancer as taboo: Cultural factors and awareness amongst patients and their families in the Philippines. *Geografia*, *14*(4), 201–211. https://doi.org/10.17576/geo-2018-1404-16

Miralao, V. A. (1997). The family, traditional values and the sodocultural transformation of Philippine society. *Philippine Sociological Review*, *45*(1/4), 189–215.

Molassiotis, A., Yates, P., Li, Q., So, W. K. W., Pongthavornkamol, K., Pittayapan, P., Komatsu, H., Thandar, M., Yi, M., Titus Chacko, S., Lopez, V., Butcon, J., Wyld, D., & Chan, R. J., STEP Study Collaborators. (2019). Mapping unmet supportive care needs, quality-of-life perceptions and current symptoms in cancer survivors across the Asia-Pacific region: Results from the International STEP Study. *Annals of Oncology*, *30*(3), 493–493. https://doi.org/10.1093/annonc/mdy094

Nizza, I. E., Farr, J., & Smith, J. A. (2021). Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology*, *18*(3), 369–386. https://doi.org/10.1080/14780887.2020.1854404

Ortiga, Y. Y. (2014). Professional problems: The burden of producing the "global" Filipino nurse. *Social Science and Medicine*, *115*, 64–71. https://doi.org/10.1016/j.socscimed.2014.06.012

Parsons, T. (1951). *The social system*. Routledge and Kegan Paul.

Patel-Kerai, G., Harcourt, D., Rumsey, N., & Naqvi, H. (2015). Exploring the lived experience of breast cancer diagnosis and treatment amongst Gujarati-speaking Indian women. *Diversity and Equality in Health and Care*, *12*(1), 9–17. https://doi.org/10.21767/2049-5471.100024

Peng, I. (2017). *Transnational migration of domestic and care workers in Asia Pacific*. International Labour Organization.

Peralta-Catipon, T. (2012). Collective occupations among Filipina migrant workers: Bridging disrupted identities. *OTJR: Occupation, Participation and Health*, *32*(2), 14–21. https://doi.org/10.3928/15394492-20110805-01

Philippine Statistics Authority. (2022). *2021 overseas filipino workers (Final results)*. https://psa.gov.ph/content/2021-overseas-filipino-workers-final-results (Accessed 2023 06 10).

Piper, N. (2017) Global governance of labour migration: From 'management' of migration to an integrated rights-based approach. In P. Drahos (Ed.), *Regulatory theory: Foundations and applications* (pp. 375–392). Australian National University Press.

Rodriguez, R. M. (2010). *Migrants for export: How the Philippine state brokers labor to the world*. University of Minnesota Press.

Samarasekera, U., & Horton, R. (2017). Women's cancers: Shining a light on a neglected health inequity. *The Lancet*, *389*(10071), 771–773. https://doi.org/10.1016/S0140-6736(16)31798-6

Schwartz, N. A., & von Glascoe, C. A. (2021). The body in the mirror: Breast cancer, liminality and borderlands. *Medical Anthropology*, *40*(1), 64–78. https://doi.org/10.1080/01459740.2020.1775220

Sharma, R. (2021). Global, regional, national burden of breast cancer in 185 countries: Evidence from GLOBOCAN 2018. *Breast Cancer Research and Treatment*, *187*(2), 557–567. https://doi.org/10.1007/s10549-020-06083-6

Shilling, C. (2003). *The body and social theory* (2nd ed.). Sage.

Shinebourne, P., & Smith, J. A. (2009). Alcohol and the self: An interpretative phenomenological analysis of the experience of addiction and its impact on the sense of self and identity. *Addiction Research and Theory*, *17*(2), 152–167. https://doi.org/10.1080/16066350802245650

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*(1), 39–54.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage.

Smith, J. A., & Osborn, M. (2007). Pain as an assault on the self: An interpretative phenomenological analysis of the psychological impact of chronic benign low back pain. *Psychology and Health*, *22*(5), 517–534. https://doi.org/10.1080/14768320600941756

Soerjomataram, I., & Bray, F. (2021). Planning for tomorrow: Global cancer incidence and the role of prevention 2020–2070. *Nature Reviews Clinical Oncology*, *18*(10), 663–672. https://doi.org/10.1038/s41571-021-00514-z

Spitzer, D. L., Thambiah, S., Wong, Y. L., & Kaundan, M. K. (2023). Globalization and the health and well-being of migrant domestic workers in Malaysia. *Globalization and Health*, *19*(1), 29. https://doi.org/10.1186/s12992-023-00925-w

Straiton, M. L., Ledesma, H. M. L., & Donnelly, T. T. (2017). A qualitative study of Filipina immigrants' stress, distress and coping: The impact of their multiple, transnational roles as women. *BMC Women's Health*, *17*(1), 1–11. https://doi.org/10.1186/s12905-017-0429-4

Trusson, D., Pilnick, A., & Roy, S. (2016). A new normal?: Women's experiences of biographical disruption and liminality following treatment for early stage breast cancer. *Social Science and Medicine*, *151*, 121–129. https://doi.org/10.1016/j.socscimed.2016.01.011

Turnbull, M., Ching, T., & Yu, C. (2023). Perceptions of health and coping strategies among temporary migrant workers in East and Southeast Asia: A systematic review. *International Journal for Equity in Health*, *22*(1), 1–17. https://doi.org/10.1186/s12939-023-01840-7

Ugalde, A., Haynes, K., Boltong, A., White, V., Krishnasamy, M., Schofield, P., Aranda, S., & Livingston, P. (2017). Self-guided interventions for managing psychological distress in people with cancer: A systematic review. *Patient Education and Counseling*, *100*(5), 846–857. https://doi.org/10.1016/j.pec.2016.12.009

World Health Organization. (2021). *Breast Cancer*. https://www.who.int/news-room/fact-sheets/detail/breast-cancer (Accessed 23 06 01).

World Health Organization. (2022). *Cancer*. https://www.who.int/news-room/fact-sheets/detail/cancer (Accessed 23.06.10).

Zanotto, A., Goodall, K., Ellison, M., & McVittie, C. (2023). 'Make them wonder how you are still smiling': The lived experience of coping with a brain tumour. *Qualitative Health Research*, *33*(7), 601–612. https://doi.org/10.1177/10497323231167345