UNIVERSITY OF GHANA
COLLEGE OF HUMANITIES

CULTURE AND HEALTH CARE PLURALISM AMONG AKAN CANCER PATIENTS IN GHANA

BY

PATIENCE GYAMENAH

THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL AFRICAN STUDIES DEGREE

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DECLARATION

I hereby declare that this work, *Culture and health care pluralism among Akan cancer patients in Ghana*, is the result of my own research undertaken under supervision, except for references made to other people's work which have been duly acknowledged. Also, this work has neither in part nor whole been presented for another degree elsewhere.

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ABSTRACT

Cancer has become a major public health problem worldwide. In sub-Saharan Africa and in Ghana in particular, the considerable increase in cancer incidence has become an issue of great concern. However, cancer research in developing countries has been scanty, with most of these researches being quantitative and biomedical in nature, and focusing on treatments. This research examines the behavioural perspective of cancer patients regarding their choice of health care. This involves their conceptualization of their illness with respect to illness causation, reasons for and implications of their choices. This study is based on the theory of illness causation advanced by Foster (1979) and Murdock et al. (1976) which indicates that belief about illness causation, as embedded in people's culture, is fundamental to understanding the health care patterns and attitude of the sick in any given society.

Focused ethnographic approach was used to collect in-depth information for this study. After obtaining institutional ethical approval, purposive sampling technique was used to recruit 35 patients with varied types and at different stages of cancer from the Komfo Anokye Teaching Hospital in Kumasi. Semi-structured interviews were conducted through face to face interactions with patients to explore their beliefs on illness causation and how these influence their choice of health care. Also, two (2) medical doctors, four (4) nurses, managers of three (3) herbal centres and one (1) herbal/spiritual centre were interviewed. Fifteen (15) family members of cancer patients who were at the hospital were also interviewed. All interviews were audiotaped and transcribed for thematic content analysis.

The study revealed that cancer patients ascribed both physical and spiritual causality to their illness. As such, they combined orthodox treatment with spiritual healing, in essence, "giving to Caesar what is Caesar's and to God what is God's". Regarding the order of

therapeutic search, patients reported to herbal and spiritual centres before coming to the hospital, a phenomenon which accounts for the late reporting and diagnosis as well as bad prognosis of cancers in Ghana. The findings of this research elucidate on the relationship between culture and health care choices of cancer patients in Ghana.

This work is dedicated

To

My wonderful parents,

Mr. Philip A. Gyamenah and Madam Dora Obeng;

my beloved husband,

Mr. Michael Okyere Asante;

and my supportive siblings,

Linda, Padmore, Prince, Pius and Patrick Gyamenah

ACKNOWLEDGEMENTS

This work has seen successful completion not only by my effort, but also through the direct and indirect support of several people, many of whose names I cannot mention for lack of space. I am indeed grateful to my supervisors, Prof. K. Awedoba and Dr. Deborah Atobrah for painstakingly directing the progress of this work, providing supervision and referring me to relevant sources for this work.

I would also like to express my gratitude to Dr. Baafo Awuah, Medical Director of Komfo Anokye Teaching Hospital without whose permission I could not interview any patient. He took time off his busy schedule to supervise my field work. My heartfelt gratitude goes to Dr. Osei Bonsu, Head of the Oncology Unit, who shared his insights on my work and gave approval letter for registering this research with the Research and Development Unit of the Komfo Anokye Teaching Hospital. The contributions of Dr. Frimpong and Dr. Sam cannot be underestimated. They introduced me to the patients and took time to respond to my interviews. Mr Kwaku Duah and Mrs Vivian Della Atuwo-Ampoh of the Radiology Unit were very instrumental in recruiting patients and providing a room for the interviews.

I am grateful to the Ghana Studies Association for the research grant they offered me, which was useful in making this research a success as far as data collection was concerned. My appreciation also goes to Dada Thomas Amoah, Dr. Owusu Gyante, Kobby Sarpong and Micheal Osei for their support during my field work in Kumasi. I am indebted to Newlove Owusu, Gladys Owusuaa and my husband Michael Okyere Asante for their emotional support and encouragement in the course of writing this thesis.

Above all, I couldn't have completed this work without good health and a sound mind; for these I am forever grateful to God, for He is my constant source of strength.

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CHAPTER ONE

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 Background to the study

Health has significant implications on family life, community development and nation building. When my uncle died of cancer, the entire family was shattered. He was the bread winner for the entire family. The company in which he worked grieved over the loss of his contribution towards the growth of the company. His church mourned over him as they remembered the melodious songs he taught them as a choir master.

The world and for that matter Africa is increasingly losing her human resource to chronic non-communicable diseases such as cancer, diabetes, stroke, hypertension, coronary heart diseases, to mention but a few (de-Graft Aikins, Agyei-Mensah & Agyemang, 2013). These diseases have increasingly become major public health problems worldwide with implications for affected individuals, their families, health care providers as well as the state (de-Graft Aikins, Agyei-Mensah & Agyemang, 2013).

Rapid urbanization, ageing population, weak health system, poverty, and globalization play complex roles in the rising chronic burden in Ghana and less industrialized countries at large (Kanavos, 2006; de-Graft Aikens et al., 2013). Tobacco and alcohol consumption, obesity, unhealthy diets, and sedentary lifestyle are contributing factors leading to the rising incidence of such chronic illnesses (Kanavos, 2006; Awuah & Afrifa-Anane, 2013).

Research on chronic non-communicable diseases in Ghana from the 1920s to the 1980s were mainly bio-medical science research with a limited number of in-depth anthropological studies (de-Graft Aikins et al., 2013). However, anthropological work provides "important socio-

cultural context for understanding medical trends" (de-Graft Aikins et al., 2013, p. 6). Among the few anthropological studies which bring to fore the socio-cultural dimensions of such illnesses in Ghana include Atobrah (2012) on Ga cancer patients, Amoah et al, (2002) on diabetes, Biritwum et al., (2006) on diabetes. There is however need for more insights into chronic illnesses to ensure health care policy that will reduce the chronic illness burden, hence this study. I adopt focused ethnographic method to interrogate the health care choices of Akan cancer patients in Ghana.

This chapter presents the study background, problem statement, study objectives, research questions and significance of the study. It also presents background information on the study area as well as the organization of chapters of the entire study. Key terms used in this study are also defined in this chapter.

1.1.1 Global cancer statistics and the rising burden of cancer in less industrialized countries

Cancer has increasingly become a major public health problem worldwide. Global cancer statistics show that there were 14.1 million new cancer cases, 8.2 million cancer deaths, and 32.6 million people living with cancer within 5 years of cancer diagnosis in 2012 worldwide. Out of this global cancer statistics, 57% (8.0 million) of new cancer cases, 65% (5.3 million) of the cancer deaths and 48% (15.6 million) of the 5-year prevalent cancer cases occurred in less industrialized regions (GLOBOCAN, 2012; Cancer Research UK, 2015).

According to the International Agency for Research on Cancer (hereinafter, IARC), the recorded cancer deaths of 8.2 million in 2012 makes it one of the leading causes of death worldwide (GLOBOCAN, 2012). It is predicted that by 2020, the number of new cancer cases in the world will increase to more than 15 million, with deaths increasing to 12 million per year.

Globally, more than half of cancer incidence and over 6 in ten cancer deaths occur in less industrialized regions (Cancer Research UK, 2015), as anticipated by Kanavos (2006).

Although the cancer burden is high in affluent societies, Kanavos (2006) notes that less industrialized countries are closing the gap rather rapidly. This results partly from the fact that developing societies are copying to a large extent lifestyles similar to those of the advanced societies, as observed by IARC and Cancer Research UK (2014) in their *World cancer factsheet*:

> As low HDI [Human Development Index] countries become more developed through rapid societal and economic changes, they are likely to become "westernized". As such, the pattern of cancer incidence is likely to follow that seen in high HDI settings, with likely declines in cervix uteri and stomach cancer incidence rates, alongside increasing incidence rates of female breast, prostate and colorectal cancers. This "westernization" effect is a result of reductions in infection-related cancers, outweighed by an increasing burden of cancers more associated with reproductive, dietary and hormonal risk factors.

Kanavos (2006) notes regretfully that the increased prevalence and incidence of cancer in developing countries reflect a wider transition in the global burden of disease from infectious diseases towards a greater frequency of non-communicable, chronic illness. He adds that even though cancer affects communities worldwide, there are marked differences in the prevalence, cause, as well as types of cancers in various societies. This is reflected in the global statistics for cancer (see Appendix I).

Genetics, environment, lifestyles, socio-cultural and behavioural factors, as well as economics have been identified as accounting for the differences in the incidence, pathology, mortality, and clinical characteristics of cancers globally (Kanavos, 2006; Cancer Research UK, 2015). Nevertheless, the enormous disparities in wealth between developing and developed countries may also be relevant in the types, frequency, and outcomes of cancer that occur in these settings. Globally, lung, female breast, colorectal and stomach cancers are said to account for over 40% of all cancers diagnosed in 2012. While lung cancer remains the most common of

all new cases in men (16.7%), breast cancer is the dominant of all new cancer cases in women (25.2%). Table 1 shows the most common cancers worldwide based on 2012 data.

Table 1: Most common cancers worldwide, 2012

Cancer type	Cases per year (thousands)
Lung	1,825
Breast	1,677
Bowel	1,361
Prostate	1,112
Stomach	952
Liver	782
Cervix	528
Osophagus	456
Bladder	430

Source: Cancer Research UK, Worldwide Cancer Incidence, 2014a

It has been projected that the global cancer burden will increase to 23.6 million new cases each year by 2030 representing an increase of 68% compared with figures for 2012 (66% in countries with low and middle Human Development Index (HDI) and 56% in countries with high and very high HDI) (IARC and Cancer Research UK, 2014).

Early detection and access to advanced diagnostic modalities and cancer therapies, which have led to declines in the incidence and mortality of certain cancers in developed countries, are not seen in less industrialized countries (Kanavos, 2006). There is inadequate epidemiological data in developing regions due to lack of mechanisms for comprehensive data collection. Meanwhile, international efforts to gather data on cancer incidence and mortality depend largely on local surveillance, pathology and staging which varies across regions (Kanavos, 2006; Laryea

et al., 2014). In their analyses of cancer data provided by the IARC, for instance, Cancer Research UK (2014a; 2014b) reports that "the reliability of cancer statistics available for each country varies." Kanavos (2006) calls for improved cancer surveillance and data collection which are critical to the implementation and evaluation of prevention programmes and measuring outcomes.

1.1.2 Cancer incidence in Africa

In Africa and in Ghana in particular, the considerable increase in cancer incidence has become an issue of great concern. In Africa breast cancer is the most prevalent of female cancers, closely followed by cervical cancer; prostate cancer is the most prevalent of male cancers accounting for more than 50%. This is followed by bowel cancer (most prevalent in Northern Africa), bladder (mostly common in Northern Africa) and Kaposi Sarcoma, a cancer of the skin, mucus membrane and blood vessels (Lesotho, Mozambique, Swaziland, Zimbabwe, Malawi and Zambia) (IARC and Cancer Research UK, 2014).

In West Africa, the most prevalent male cancer is prostate cancer; cervical cancer is the most prevalent cancer in females, followed by breast cancer (IARC and Cancer Research UK, 2014). In Ghana, Laryea et al. (2014) report that out of all cancer cases registered in Kumasi in 2012, 69.6% were recorded among females, with the commonest cancers in females being cancers of the breast (33.9%), cervix (29.4%), ovary (11.3%) and endometrium (4%); among males, the commonest cancers were liver (21%), prostate (13.2%), lung (5.3%) and stomach (5.3%).

Although most cancers are treatable when detected early, in sub-Saharan Africa and in Ghana there is usually late diagnosis of cancers. This results from limited biotechnology and socio-cultural factors including inadequate awareness on cancer, high rates of illiteracy, limited

access to biomedical infrastructure, and poverty. Late reporting and diagnosis has led to high and early cancer death rates in Ghana (Wiredu & Armah, 2006; Clegg-Lamptey, Dakubo & Attobrah, 2009).

1.1.3 Culture and health-seeking behaviour

Helman (2000), points out that a "society's health care system cannot be studied in isolation from other aspects of that society, especially its social, religious, political and economic organizations" (p.50). Research has widely confirmed that meanings ascribed to illness by patients and their broader society are deeply rooted and influenced significantly by beliefs, norms and practices (Twumasi, 2005; Gyapong, Adjei, Vlassoff & Wise, 1996; Atobrah, 2012). Thus, health and help-seeking behaviours of individuals are cultural. Helman explains that beliefs and practices related to ill-health are a central feature of a people's culture. As Van der Geest (2004) notes, "…all medical beliefs and practices are embedded in broader social and cultural forms" (p. 1996). In essence, what individuals view as the cause of their illness influences the kind of health care they seek. Beliefs about illness causation determine the choice of treatment applied to restore health. Kirmayer (2004) in his work, *The cultural diversity of healing: Meaning, metaphor and mechanism*, establishes this point by stating that,

> Where illness is understood as the result of mechanical or physical injury, specific physical measures may be taken. Where illness is attributed to spirit attack, shamanistic practices involving communication with or journeying to the spirit world and enlisting the aid of spirit helpers are employed. When the spirit comes to dwell within or possess the afflicted person, it must be exorcized. Where spirits or ancestors are offended, they must be propitiated through sacrifices and offerings. Where illness reflects an imbalance, efforts are made to restore balance by supplying the missing element or augmenting the appropriate process, which may be physiological (e.g. humoural systems, hot/cold), or involve various subtle energies (pp. 34-35).

Medical systems are not only embedded in a people's belief but also mirror the relationship between individuals, their society and culture as a whole. Van der Geest (2004)

establishes that "…in situations and processes of illness and recovery, people's true values, convictions and moral rules become most clearly visible" (p. 1996). Fainzang (2001) also argues that "…illness is a paradigmatic example of misfortune, which reveals the nature of social relationships" (cited in Van der Geest, 2004, p. 1996). In essence, in traditional societies, health and illness are important means for detecting social unity and harmony. Twumasi (2005) therefore emphasizes that the diagnosis of illness is viewed broadly as the diagnosis of a social offence. In the same way, treatment of an illness is considered as the restoration of normal social relationships (Twumasi, 2005). Disease causality, as embedded in a people's culture, is said to be key to understanding the health care patterns and attitude of the sick.

1.2 Problem statement

The most important reaction and pursuit of cancer patients is to find cure and medical treatment for their condition. The desperation, fear and anxiety of patients and their families usually cause them to resort to multiple sources of medical care (Atobrah, 2012). These include herbal medicine, spiritual healing, and Chinese medicine, among others. This phenomenon has contributed to the late reporting of cancer patients to hospitals leading to late detection and diagnosis (Clegg-Lamptey et al., 2009). Clegg-Lamptey et al. (2009) interrogated the reasons why breast cancer patients reported late for treatment at the hospital as well as why some patients defaulted on their treatment regimen and returned when their conditions grew worse. Clegg-Lamptey et al. (2009) indicated that about 60% of patients with breast cancer in Ghana report with Stage III and IV diseases, and 8 to 10 months duration of symptoms. A questionnaire survey was used to interview sixty-six (66) newly-diagnosed breast cancer patients aged between 20 and 84 years and 35 previous absconders aged 20 to 74 years. They reported that factors that accounted for delayed presentation of cancer included; previous medical consultations 26

(39.4%), ignorance 19 (28.8%), fear of mastectomy 16 (24.2%), herbal treatment 13 (19.7%), prayer/prayer camps 13 (19.7%) and financial incapability 12 (18.2%). Reasons for absconding included fear of mastectomy 20 (57.1%), herbal treatment 13 (37.1%), financial incapability 11 (31.4%) and prayers/prayer camps 10 (28.6%) (p. 127). Little is however known about how cancer patients make their choice of health care and what influences their choice of treatment. Also, the use of quantitative approach as applied in the above study does not explain adequately cancer patients' actions and choices regarding their health care. This is because it does not explore deeper underlying factors such as patients' beliefs that influence their attitude towards their health care. There is the need for more social science research especially ethnographic ones to augment biomedical research into cancer. This will ensure a holistic understanding into the cancer menace as well as a holistic approach to finding remedies to combat the situation. The qualitative approach to research enables researchers to explore the depth, richness, and complexity inherent in a phenomenon as opposed to the quantitative approach that focuses on testing relationships, describing, examining cause and effect relations. This study fills in the gap by adopting qualitative ethnographic research approach to explore cancer patients' underlying beliefs about cancer causation and how these beliefs influence their choice of health care.

In her study of young adults with chronic illnesses, Atobrah (2012) indicates that most young patients and their families ascribe supernatural meanings to the cause of ailment which influence their "course of treatment as they [combine] orthodox medicine with other forms of therapy, including spiritual healing and herbal medicine" (Atobrah, 2012, p.52). In essence, what people perceive as the cause of their illness influence their choice of health care, and what people conceptualize as the cause of their illness is usually rooted in their beliefs and practices which are entrenched in their culture. It can therefore be said that culture plays a very significant

role in how people conceptualize diseases and illnesses in general. These conceptualizations are heavily influenced by practices, beliefs and norms and have themselves greatly influenced the choice of health care by patients, their families and society at large. This study, therefore, builds on the Clegg-Lamptey et al. (2009) findings by seeking explanations to the attitudes and behaviours of cancer patients towards health care by exploring their beliefs about the causes of cancer as well as their local conceptualization of cancer. The study interrogates the therapeutic options available to cancer patients as well as what influences their health-seeking behaviour.

1.3 Research questions

The study will be guided by the following research questions:

1. What major therapeutic options are available to cancer patients in Ghana and which ones do they resort to?
2. How do cancer patients conceptualize their illness causation and how does that influence their choice of health care?
3. What are the implications of cancer patients' choice of therapeutic options on their recovery process?
4. What behaviours and attitudes do cancer patients adopt in response to their illness condition?

1.4 Research objectives

In order to address the questions posed above, the study will be driven by the following objectives:

1. To explore the major therapeutic options available to cancer patients in Ghana and to discover which ones they resort to.

2. To investigate how cancer patients conceptualize their illness causation, and how these conceptualizations influence their choice of health care.
3. To examine cancer patients' views on the implications of their choice of therapeutic options on their recovery process.
4. To interrogate the behaviours and attitudes cancer patients adopt in response to their illness condition.

1.5 Significance of the study

The increasing prevalent rate of cancer in developing regions calls for more research. However, cancer research in developing countries has been scanty, with most of these researches being quantitative and biomedical in nature. Atobrah (2013) in her review of cancer studies in Ghana found out that of the cancer research conducted in Ghana, 89.5% of them were biomedical in nature. Only 4.8% were from a social science perspective and 3.8% were multidisciplinary research-based. This research will fill the gap by adopting a qualitative approach in interrogating the health care choices as well as attitudes and behaviours of cancer patients from the lens of the changing cultural context. Unlike other studies which have focused on people's perception about cancer, the study provides detailed examination of the lifestyle of cancer patients by interrogating their beliefs and worldviews, their conceptualizations of illness and wellness, their health and help-seeking choices, attitude and behaviours.

1.6 Background to the study area[1]

The study was based in Kumasi, Ghana, specifically the Komfo Anokye Teaching Hospital. Kumasi is the capital city of the Ashanti Region and the ancient capital of the Ashanti Kingdom.

[1] Information on this section was collected from KATH website (http://www.kathhsp.org/about.html) and KMA website (http://www.kma.ghanadistricts.gov.gh/).

It is located at the south central part of Ghana, about 250km from Accra, the capital city of Ghana. Kumasi is the second-largest city in Ghana in terms of land area, population size, social life and economic activity. The city is noted for its vibrant commercial activities, and its beautiful layout and greenery has accorded it the accolade of the "Garden City of West Africa". Tradition is held very high in Kumasi and has a good blend with modernity. Kumasi has a wide range of attractions which include the Manhyia Palace, the Kumasi Zoo, the large Kumasi Central Market, National Cultural Centre, the Okomfo Anokye Sword among others.

The Komfo Anokye Teaching Hospital (hereinafter, KATH) situated in Kumasi is the second-largest hospital in Ghana, and the only tertiary health institution in the Ashanti Region. The geographical location of KATH, coupled with the road network of the country and commercial nature of Kumasi make the hospital accessible to all the areas that share boundaries with Ashanti Region and others that are farther away. As such, referrals are received from all the northern regions (namely, Northern, Upper East and Upper West Regions), Brong Ahafo, Central, Western, Eastern and parts of the Volta Regions.

KATH was built in 1954/55 to cater for the health needs of the growing population of Kumasi and its environs. It was known as the Kumasi Central Hospital until it was later changed to its present name in honour and memory of the powerful and legendary fetish priest, Komfo Anokye. The hospital became a Teaching hospital in 1975 for the training of medical students in collaboration with the School of Medical Sciences of the University of Science and Technology, Kumasi. The 1000-bed KATH has got the mission of providing quality services to meet the needs and expectations of all its clients through well-motivated and committed staff.

KATH is one of the two major hospitals with oncology units (apart from the Korle-Bu Teaching Hospital located in Accra) and as such handles cancer cases. Most of the patients interviewed in this study hail from the Ashanti, Eastern, Brong Ahafo and Central regions. Some of them lived in Kumasi and so Komfo Anokye Teaching Hospital was the first hospital they reported to. The majority however were referred from various hospitals in the regions aforementioned.

1.7 Definition of terms

Health care pluralism as used in this study basically means the existence of multiple healing systems and options within a society, including orthodox (scientific-biomedical) health care and unorthodox ones such as herbal medicine, spiritual healing among others. Pluralism has always existed in health care systems; there have always been multiple practitioners to choose from and multiple ways of understanding health and healing. People are predisposed to combining two or more health systems rather than sticking to one (Farooqui et al., 2014)

Culture in the context of this research is explained as a people's way of life with particular reference to their conceptualizations of illness, health and health care which include their knowledge, religion, beliefs, norms, and practices about illness causation, diagnosis and treatment (Tylor, 1871; Keesing, 1997). In this study, the peculiar culture of the Akan people of Ghana is interrogated regarding their beliefs and norms regarding illness causation, particularly cancer.

Disease and illness are used synonymously in this study. The usual distinction made by anthropologists where disease refers to "abnormalities in the structure and function of body organs and systems" and illness refers to "experiences of disvalued changes in states of being

and in social function" (Eisenberg & Kleinman, 1981, p. 13 cited in Ventevogel, 1996, p. 6) does not apply in this study. Disease and illness have been loosely and interchangeably used.

1.8 Organization of the Study

The study is organized into five chapters. The first chapter presents the background to the study, statement of the problem, the research questions and objectives, conceptual framework, background to the study area, the significance of the study, and the organization of the study.

Chapter Two follows with the review of relevant literature. Topics such as disease etiology, medical pluralism, culture and illness are discussed under literature review as they serve as the backdrop for this study (Twumasi, 2005; Helman, 2000; Foster, 1976; Murdock, Wilson & Frederick, 1976; Gyapong et al., 1996).Various works conducted on cancer in Ghana are also reviewed (Clegg- Lamptey et al. 2009; Atobrah, 2012; Opoku, Benwell & Yarney, 2012).

Chapter Three presents in detail the methodological approach used in conducting the study. The sources of data, data collection strategy, sampling procedure, ethical consideration and data analysis procedure are highlighted under this chapter.

Chapter Four sets forth the data presentation and analysis and discusses specific findings and observations of the study. Finally, chapter five outlines the conclusions, challenges and recommendations for further research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Cancer has increasingly become a major health challenge in the world and for that matter in sub-Saharan Africa and Ghana (Kanavos, 2006; Laryea et al., 2014). In as much as a lot is being done in the biomedical science to find means to alleviate the menace and to save lives, it is very critical that the social and cultural dimensions be thoroughly investigated too. This will allow a holistic approach and understanding of cancer. Cultural, social insight and understanding are essential to the pursuit of cancer remedy.

This chapter discusses relevant literature in relation to this study. Literature on disease etiology, illness and culture, Akan conceptualization of illness, religion and health care, cancer research in Ghana and other work have been discussed.

2.2 Conceptual framework

2.2.1 *Disease aetiologies*

The main theory that will be used for this work is the theory of illness or disease causation. Various authors have propounded theories of illness causation. Foster's (1976) work on "Disease etiologies in Non-Western Medical Systems" and Murdock et al.'s (1976) work on "World Distribution of illness" are classical works on disease etiologies. Their main thesis is that what people believe to be the cause of their illness influences the other elements of their medical system. Foster puts it simply that if we are given a clear description of what a people believe to

be the cause of illness, then we can fill in the other elements of that medical system. He indicates that "the first task of the anthropologist concerned with medical systems is to find the simplest taxonomy for causality beliefs" (Foster, 1976, p. 775).

Cultural evolutions have occurred and so have health systems. Glick (1967) has argued that,

> [t]he most important fact about an illness in most medical systems is not the underlying pathological process but the underlying cause. This is such a central consideration that most diagnoses prove to be statements about causation and most treatment responses directed against particular causal agents (p. 36, cited in Foster, 1976, p. 775).

Foster (1976) adds that "kinds of curers, modes of diagnosis, curing techniques, preventive acts and the relationship of all these variables to the wider society of which they are part derive from beliefs about illness causality" (p. 775). Scholars have used two main broad explanations to illness causation. While Foster (1976) classifies them into personalistic and naturalistic explanations to illness causation, Murdock et al. (1976) refer to theories of supernatural and natural causation.

Personalistic or supernatural theory of illness causation, according to Foster, is more ancient of the two theories of illness causation. Under this theory, disease is explained as due to the active purposeful intervention of an agent who may be human (witch, sorcerer, or other) or non-human/supernatural (ghost, ancestor, a deity or some powerful being). It is explained that the sick person is a victim who suffers aggression or punishment. Personalistic/supernatural theory of illness causation gives little room for accident or chance. Illness and death are believed to stem from acts of an agent. For instance, Harley (1941), practicing medicine among the Mano of Liberia for 15 years, recorded that "death is unnatural, resulting from the intrusion of an

outside force" usually directed by some magical means (cited in Foster, 1976, p. 775). In the same way, Alland (1964) explains that people get sick and die because some power has acted against them, according to the Abron of Ivory Coast (cited in Foster, 1976, p. 775). Under theories of personalistic or supernatural causation, Murdock et al. have sub-theories such as mystical, animistic, and magical causation. Mystical causation includes fate, contagion, ominous sensations and mystical retribution. Under animistic causation there are soul loss and spirit aggression. Theory of magical causation consists of sorcery and witchcraft.

Naturalistic theory of illness causation on the other hand accounts for illness as a physiological consequence of the victim in a manner that seems reasonable to medical science (Foster 1976; Murdock et al., 1976). It explains illness in an impersonal, systematic way. Disease is thought to stem from natural forces such as cold, heat, winds, dampness, and above all, an upset in the balance of the basic body elements (Helman, 2000). In the naturalistic system of Chinese medicine, health conforms to an equilibrium model, where the *yin* and the *yang* are in a balance appropriate to the age and condition of the individual in his natural and social environment. It is the upset of this balance that triggers illness. Naturalistic explanations represent popularized legacies from the great traditional medicine of the ancient classical civilizations particularly those of Greece, Rome, India and China (Helman, 2000).

Contemporary description of naturalistic causation frequently deal with the hot-cold dichotomy which explains illness as due to excessive heat or cold entering the body with treatment targeted at restoring the proper balance through hot and cold foods as well as herbs that are thought to withdraw excess heat or cold from the body. Murdock et al. (1976) have explained naturalistic causation in terms of infection, stress, organic deterioration, accident and overt human aggression. Young (1976) outlined a broad classification of medical systems as

internalizing or externalizing. Young's classification focuses on where the illness resides in an individual's body—inside or outside the body. He explains that,

> [i]nternalizing systems locate the causes, mechanisms and solutions to affliction inside the individual—although these processes may be bodily, psychological or metaphysical: something bad has gotten inside the person and must be neutralized, destroyed or removed (toxins, germs, traumatic memories, evil spirits); something is missing or depleted inside the person and must be added (vitamins, blood, vital energy); something is blocked inside the person and must be unblocked and allowed to flow (energy, wind); something is out of balance within the person (yin/yang, dosas) and must be brought back into balance. Externalizing medical systems, in contrast, locate the origins and resolution of affliction in processes outside the individual, and these are often interpersonal, social or spiritual. In consequence, they usually involve rituals in which the patient's family, entourage or communities are engaged and the healing transformation may take place in the group rather than the individual (Cited in Kirmayer, 2004, p. 36).

Helman (2000) highlights lay theories of illness causation. Illness causation may lie within the individual, the natural world, the social or the supernatural world. At the individual level, illness is explained in a more naturalistic way, where there is a malfunction of the body. Here responsibility of illness falls mainly, though not completely, on the patients themselves. Illness is blamed on negligence—not taking care of one's diet, hygiene—on sexual behaviour among others. Christman's (1977) categorization of etiologies falls under individualistic explanation including debilitation, degeneration, invasion, imbalance, stress, mechanical cause, environmental irritants and hereditary proneness. With the natural world, climatic conditions, colds or chills, excessive heat, natural disasters, viruses, germs and bugs are blamed to cause illnesses. Where interpersonal conflicts are frequent, illnesses are blamed on witchcraft, sorcery, evil eye, jealousy, poisoning, and battle wounds. These are considered as social causes of illness. Direct actions of supernatural entities in the supernatural world such as gods, spirits, and ancestral shades are blamed for causing illnesses. Individuals may face ill-health as a punishment for sinful behaviour or a reminder for behaviour lapses (Christman, 1977 cited in Helman, 2000).

In sum, societies interpret their universe in two (but not mutually exclusive) ways and on the basis of their interpretation of occurrences. It is based on this interpretation that they choose certain patterns of behaviour. Naturalism and supernaturalism are both ways in which people adjust to the universe (Hsu, 1952 cited in Twumasi, 2005).

2.2.2 *Culture and illness*

As dynamic as culture is, so is its definition. Culture has been defined in several ways by various scholars. Tylor (1871) sees culture as "that complex whole which includes knowledge, beliefs, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society" (cited in Helman, 2000, p. 2). Keesing (1997) also defines culture as a "system of shared ideas, systems of concepts and rules and meanings that underlie and are expressed in the ways that human beings live" (cited in Helman, 2000, p. 2). Culture can be said to be an inherited lens through which individuals perceive the world. It sets out the rules for individuals and groups interacting with other individuals and groups, and with the natural and supernatural environment.

In this study, the "significance of culture and social factors in illness and in health, in preventive medicine and health education and in actual delivery of health care" is highlighted (Helman, 2000, p. 11). Helman indicates that beliefs about anatomy and physiology which involves the optimal shape, size of the body including the clothing and how the body functions are influenced by social and cultural backgrounds and have significant effects on the individual. It is however important to note that cultures are not static but dynamic and so may change along the line. Cultures are also not homogeneous. Moreover, individual factors such as age, sex, educational background, socio-economic status among other factors may influence the way people behave in a particular cultural setting. In any particular case, all these factors will play

some role and thus in certain situations, depending on the context, some people will act more culturally than others.

To ensure a potent health care, there is the need to take into account the specific needs and circumstances of every community as well as their social, economic and cultural backgrounds. Their beliefs about their own health needs are fundamental to any meaningful interventions. For instance, Gyapong et al. (1996) conducted a study in the Kassena-Nankana district in the Upper East region on the cultural beliefs and practices and their implication for disease control on filariasis. The authors indicated that filariasis was perceived to be caused by spiritual and supernatural factors in rural communities in Northern Ghana. They therefore indicated that the importance of social and cultural perception of a disease and its relevance to control (care and cure) cannot be overemphasized. Gyapong et al. (1996) also asserted that disease control programmes in developing countries are often unsuccessful and unsustainable because strategies pursued are inappropriate for the community or incompatible with traditional perceptions of etiology, prevention and control.

Gyapong et al. (1996) therefore argued that feasible interventions to treat and prevent filariasis require a broad understanding of traditional perception of the disease, its cause and consequence and means of prevention. Same can be said of cancer which is on the ascendency now. People have formed their perceptions of the illness. This is true for individuals and the society at large. Akan societies for instance have labeled a number of chronic illnesses as *abonsam yadeɛ* (literally satanic or evil disease). Through interviews with cancer patients, I realized that most people consider cancer to be *abonsam yadeɛ*. Such can be said of other chronic conditions like HIV/AIDS and Tuberculosis. Not only are they considered evil but are believed to have supernatural or spiritual causes. For a long time, people in some communities in Ghana

and elsewhere have believed that HIV/AIDS has a spiritual cause. Such chronic conditions have also to a large extent been stigmatized; for instance people living with HIV/AIDS have been and remain stigmatized in spite of all the sensitization and educational campaigns (Kwansa, 2013). People living with onchocercal skin disease in countries like Ghana, Nigeria, Uganda and Sierra Leone experience stigma (Vlassoff et al., 2000). The fact is that perceptions of disease and its management are usually linked with cultures, social organization and religion. These perceptions are therefore deeply rooted in the culture of local communities and more so in their religion. Also since perceptions vary from place to place, there is the need to carry out in-depth studies of the social, cultural and economic aspects of a disease like cancer before embarking on control measures. However, health workers have argued that it makes no sense to suspend their work while anthropologists search for cultural explanations. It is for this reason that focused ethnographic studies have been suggested in the past.

Gyapong et al. (1996) in their study noted that people in their study area were mainly traditionalists who revered their ancestral gods. They consulted soothsayers and traditional healers for health care. They attributed supernatural causes to their illness. They attributed the causes of filariasis to juju and spiritual medicine thrown to the ground by powerful juju men during war dances; walking on herbs poured on the ground by herbalists who were considered powerful people; walking on grounds in the forest where dwarfs inhabit, among other factors. From Foster's classification, the Kassena-Nankana society from my own judgment will fall in a personalistic society which explains most phenomena from the spiritual point of view.

Gyapong et al. (1996) also indicated the challenge filariasis patients had in accessing modern facilities due to the long distances and cost involved in travelling from local communities to urban places to seek medical attention. Moreover, there was the challenge with

access to means of transportation such as vehicles. Patients had to ride bicycles which worsened their conditions. They also indicated that filariasis patients were afraid of surgery which could be used to treat the disease. People feared that they would die from surgical operations and leave their families behind with no one to care for them. Same can be said of cancer patients who were interviewed in the work of Clegg-Lamptey et al. (2009). They (especially breast cancer patients) were afraid of surgery. Some of them who were told to prepare for surgery refused to do so. They suspended their treatment and came back later when the illness was getting worse. Filariasis patients, according to the study, resorted to self-medication. They bought analgesics and antibiotics from drug peddlers in the market places. Some also applied Chinese Robb to the leg and hydrocele. Some cancer patients applied herbs to the affected parts, for instance on the breast. They believed that by applying some herbal medicine on the breast, the cancerous lump would dissolve. Also, for financial reasons some cancer patients suspended their treatment regimen at the hospital. Regarding attitude of families and the general community towards filariasis patients, Gyapong et al. (1996) reported that it was that of acceptance. Affected people were generally accepted and could attend social gatherings unless the disease got to the advanced level where they were uncomfortable moving about. Cancer patients also received general acceptance and support from their immediate families.

Gyapong et al. (1996) however reported that people were reluctant to marry someone with filariasis. Women were afraid to marry men with hydrocele because of the fear that they may not be able to give birth by such husbands. In the same way men were reluctant to marry women with filariasis because they may be a burden rather than helpmates. Filariasis is said to have negative impact on people's work as they could work only few hours. They had to take time

from work because of the discomfort they suffered which made them tire easily (Gyapong et al., 1996).

2.3 Religion and health-seeking behaviour

In the course of this study, I found out that with the advent of Christianity, most people may not go to the shrine or pour libation when they are sick as their Christian belief prohibits that. However, the belief in the supernatural cause of illness is still valid in their Christian faith. Therefore, instead of consulting soothsayers, people rather consult pastors or visit prayer camps, and instead of praying to the deities, people pray to the Almighty God or Allah. Instead of trusting smaller gods for ultimate healing, people believe the Almighty God for their healing. People pray over medicine before they take it and do all manner of rituals to invoke God for their healing.

Bohmig (2010) conducted a study exploring the notions of care and religion at a medical ward at Korle-Bu Teaching Hospital from 2004 to 2007. She indicated that both nurses and patients subscribed to a set of cultural norms; they based their expectation and decisions on a mixture of professional information and traditional beliefs. She added that religion played an important role, shaped perspectives and offered possible reactions to disease and death, and influenced social behaviour.

She reported that nurses prayed for strength for themselves and cure for their patients. They also found fulfillment in the work they did as they considered it as service to God. They believed they got blessings from serving their patients. Even though Bohmig's (2010) work focused more on nurses, it emphasized how deeply culture is rooted in people's attitude and behaviour even in their profession. Patients alike hold on strongly to religious beliefs as a coping

strategy in their suffering. Geertz (1973) indicates that Christianity delivers coping perspectives to people who face the suffering, bafflement and injustice of a life-threatening disease (cited in Bohmig, 2010). Bohmig concluded that the hospital is not a culturally neutral biomedical institution but is embedded in the Ghanaian culture as a place of medical treatment, social encounter and defined rituals.

2.4 The Akan notion of religion, health and disease

Ghana's population is made up of ethnically diverse societies. About 47% of the population belongs to the Akan subgroup. The Akans are found in the southern part of Ghana including Western, Ashanti, Eastern, Central, Brong Ahafo regions and some parts of Ivory Coast (Ventevogel, 1996). According to the 2010 population census, the ethnic group composition of Ghana is made up of Akan (47.5%), Mole-Dagbon (16.6%), Ewe (13.9%), Ga-Dangme (7.4%), Gurma (5.7%), Guan (3.7%), Grusi (2.5%), Mande-Busanga (1.1%), and others (1.4%) (Ghana Statistical Service, 2012, p. 34).

The Akan people are made up of sub-ethnic groups such as the Ashanti, Fanti, Akuapem, Kwahu, Akyem, Bono, Wassa, Nzema, Ahanta, Sefwi, Brussa, among other groups. The Akan society places premium on good health. Illness is considered as a social deviation that needs restoration. People who were to be in leadership positions needed to be healthy thus without any blemish and evidence of ill-health such as madness, chronic illnesses among others. The said leader could be disqualified if he got sick along the line. In marriage also, people looked out for the family background of a prospective spouse to be sure if there were no traces of certain chronic diseases. If any such illnesses were found, the marriage plans could be aborted. Twumasi (2005) indicates that the Akan people, like other societies, have a special system for detecting and restoring health. He posits that if a person got sick, he was expected to inform others about

his condition for necessary action to be taken. People who were sick were relieved temporarily of their social responsibilities, say of providing for their family, while they sought restoration of their health.

Yadeɛ is the Twi term for illness. It is derived from *ɔyaw* (pain) and *adeɛ* (thing). It implies that illness is a painful thing (Ventevogel, 1996). Akans see illness as physical, mental, social and spiritual disturbance of an individual's well-being. The Akans believe that illnesses can originate from the *yafunu* (stomach), or *efi* (dirt) that accumulates in the body. Cleanliness through personal hygiene, keeping water sources clean, and tidying the environment are fundamental to illness prevention (Warren, 1982; Ventevogel, 1996).

The Akans believe that a person is made up of the *mogya*, *ɔkra*, and *sunsum.* They believe in the *Onyame* (supreme God) whom they worship through *abosom* (smaller gods). They also believe in *Asase Yaa* (Mother Earth) and river gods who offer spiritual protection. Akans believe that *bayi* (witchcraft) is an evil force that causes illnesses, harm and ill luck for people. They believe that *aduto* (bad medicine) can also be used to cause illness on their victims. People could also become sick when they angered their ancestors or deities (Warren, 1982; Ventevogel, 1996).

Even though some anthropologists (Rattray 1927; Field, 1960; Sarpong 1985; Twumasi 1975) have suggested that every disease among the Akans is considered to be spiritually based, Warren and Ventevogel have disputed this fact by indicating that illnesses are categorized into both physically and spiritually caused with majority of illnesses among the Bono assigned physical causation such as worms, bad food or water, too much heat among others. "When an illness is unexpectedly severe, or when the symptoms are difficult to interpret, people can

suspect that maybe there is 'something' more. They consider whether a witch or another evil person has caused this disease" (Ventevogel, 1996, p. 18). Warren in his study of the ethnomedical system of the Techiman-Bono people indicates that some diseases can be classified as either naturally or spiritually caused depending on the circumstances surrounding the onset or development of the disease. He gave an example that Gonorrhea contracted after a visit to a prostitute would be classified as naturally caused. However, the case of a patient who breaks the social norm against adultery and contracts Gonorrhea will be classified as spiritually caused by a spell placed on the sufferer by the offended spouse (Warren, 1982).

Warren indicates that diseases among the Bono are also classified into intermediary categories such as contagious and non-contagious, mortal and non-mortal, severe and minor, male and female, adult and children. Other classifications are based on specific causation and on anatomical location (for example, diseases of the skin, head, stomach, blood and bone). Warren indicates that all Bono, regardless of age, religion or educational background, use both spiritually and naturally caused categories (Warren, 1982). Ventevogel (1996), in his study of the Bono-Takyiman, noted that both Christians and Muslims adhere to original Akan beliefs. However, the categorization into physical and spiritual causation is rarely mutually exclusive.

Regarding the choice of health care, Akans combine traditional and orthodox medicines (Twumasi, 1975; Warren 1982; Ventevogel 1996). Some illnesses are treated with traditional healers while others are treated at the hospital. Ventevogel indicates that the Bono's choice of health care is based on the kind of illness. Diseases such as impotency, stroke, barrenness, mental illness, bad boil are considered to have spiritual cause and are treated with local healers, while illnesses such as high fever, malaria, measles, snake and dog bites, high blood temperature are treated at the hospital. Apart from illnesses with spiritual causation, traditional healers are

noted to be the best healers for certain kinds of illnesses such as piles, fractures and cataracts. These illnesses are preferably treated with traditional healers rather than at the hospital.

2.5 Medical systems around the world

Healing systems have evolved over time in different cultures and parts of the world. Kirmayer (2004) presents a review of diversity of healing practices found around the world. He highlights different healing systems such as described below (p. 35).

The practice of Urani medicine in the Indian subcontinent and the Middle East explains illness as imbalance in humours or life force. In this system, health is restored through herbal or mineral medicine. In the practice of Ayurveda medicine in Indian subcontinent, illness is seen as an imbalance in humors or elements (body, mind, and spirit). In this practice, health is restored through diet, purification and medicines. Similarly, traditional Chinese medicine practised in East Asia explains illness as an imbalance in energy (yin/yang) or five phases (air, earth, wind, fire, and water). Healing is acquired through herbal and other medicines, diet, moxibustion, and acupuncture. New age healing system such as aromatherapy, crystal healing, light therapy, also explains illness as "energy imbalance" and uses materials and manipulations to "rebalance energy".

The practice of homeopathy, which originated from Northern Europe, explains illness as a system of health care which uses very small doses of substances to trigger the body to heal itself. Naturopathic medicine practised in Europe and North America sees illness as a "weakened state of the body". Health is restored by strengthening the body through different methods like diet, cleansing and natural remedies that help the body to naturally heal itself. Psychotherapies which originated from Europe explain illness as "psychological conflict or maladaptive

learning". Chiropractic medicine practiced in Europe and North America explains illness as "misalignment of spinal column". Healing practice involves physical manipulation (Kirmayer, 2004).

On the religious side, Islamic medicine originated from the Middle East and explains illness as "disturbance of heart" as a centre of spiritual, emotional and physical experience. Healing is acquired through the recitation of the Quran (Kirmayer, 2004). Christian healing practiced in the Americas explains illness as a "moral error, sin, demonic possession". Healing involves prayers, restitution, and demonic exorcism. Possession cult which is widespread in Africa, Asia and South America explains illness as offending spirits or ancestors. In this practice, possession by spirits allows propitiation. Shamanism, on the other hand, explains illness as caused by offence against spirits, magical attack, or accident. Restoration of health is acquired when the "shamanic healer travels to the spirit world and with the aid of spirit helper (usually an animal) redresses wrong" committed by the sick person (Kirmayer, 2004).

2.6 The Akan medical system

It has been stated that beliefs and attitudes of a given social group towards disease are held with tenacity. In his work on Akan medical systems, Twumasi (2005) distinguishes between traditional medical system and orthodox medical system, naming the former as the older of the two systems. The traditional medical system was the only form of medical system before the advent of the scientific medical system. The traditional health practitioner was then the only practitioner of medicine. The traditional healer employed magico-religious acts to treat illnesses until orthodox medical system was introduced by missionaries through colonialism. Orthodox medicine uses scientific methods and medicine. Both medical systems deal with illnesses but

with different, though not mutually exclusive, world views. Twumasi indicates that any conflict between the two medical systems has disruptive effects on those who need medical care.

Twumasi (2005) categorizes traditional practitioners into faith healers, traditional birth attendants, spiritualists/diviners, and traditional herbalists, all of which adhere to traditional principles. He indicates that in traditional society, traditional medicine is much more than an art of curing illness. But it is also integrative as the traditional practitioner performs social analysis to restore harmony to the individual and the group. The explanations of many illnesses are found in some antisocial behaviour on the part of either the victim or a close relation. To cure an illness requires correcting social wrong. Twumasi adds that health and illness become the means for detecting threats to the social unit of the group and for the restoration of harmony.

Twumasi is quick to add that there have been significant changes in the Akan social organization in the face of colonialism, formal education, economic changes, rural-urban migration as well as changes in extended family system. These factors in their individual unique ways have made it easier for individuals to lean more towards the use of the orthodox system of health care. Twumasi asserts that formal education has helped alienate the youth from the traditional society leading to a gradual breakdown of traditional cosmology. In the same way urban residence has led to changes in family structure of authority resulting in its weakening. As more people become wealthy and gain education and new job opportunities, they become influential and begin to question and challenge certain norms. And as they are exposed to modern facilities of scientific health care, they rely less on traditional practitioners for their health care needs. The question however is whether people ignore completely the traditional practitioners as they place their trust in orthodox medicine. In the case of cancer patients, what

are their preferences? Do cancer patients patronize traditional practitioners or orthodox medicine, or do they combine both?

2.7 Cooperation between herbal medicine and Western health care

There has been much debate about the possibility and desirability of cooperation between Western health care system and non-Western health care system since the 1970s. This debate was heightened when the World Health Organization (WHO) advocated for "primary health care strategy" that will make health care available to all (WHO, 1978 cited in Ventevogel, 1996, p. 41; Van der Geest, 1995). This implied a shift from hospital-based health care to community-based health care; curative care to giving more attention to prevention and health education; training of few medical doctors to retraining of many local health workers with more focus on socio-cultural factors in health care (Ventevogel, 1996).

WHO saw traditional healers as important contributors in achieving the set goal considering the role they played in providing primary health care in local communities. WHO therefore prescribed a greater collaboration between medical officers and traditional healers by retraining them through the organization of short-term courses. The short courses were meant to provide knowledge on "detection and diagnosis of disease; prevention and public health activities; basic hygiene; family planning; immunization; diarrhea control; and, possibly, in simple surgery" (WHO, 1985 cited in Ventevogel 1996, p. 42). WHO's proposition called for a lot of debate among scholars, Western medical practitioners and health care planners. Antagonists of the cooperation have argued that it is undesirable because traditional medicine consists of superstitions and irrational beliefs and as such cannot improve the health care system. However, idealists have argued that both Western and herbal medicine have got positive aspects

that can be harnessed through cooperation. They highlight the strengths of traditional medicine that can be incorporated into Western medicine for improved health care. Traditional medicine provides psychological therapy to patients through informal, warm and close relations that heals the fears and anxiety of patients; social support as it restores disturbed social relations; cultural and spiritual support through shared beliefs with patients (Twumasi, 2005; van de Geest, 1995; Ventevogel, 1996; Warren, 1982).

Even though this move faced a lot of challenges, some form of collaboration has been achieved in Ghana. One significant initiative is the Ministry of Health's project of attaching herbal clinics to various regional hospitals in Ghana. These clinics are manned by health professionals who are equipped with both western and herbal training. The herbal clinic shares facilities such as laboratories with the regional hospital. One of these clinics—Kumasi South Herbal Clinic—was visited during fieldwork. The initiative offers patients the avenue to choose between orthodox or herbal medication for their illness condition. The doctors interviewed at the Kumasi South Herbal Clinic indicated that patients are, in some peculiar circumstances, referred to herbal treatment when they do not respond well to orthodox treatment. They indicated that patients request to use herbal medication for the treatment of chronic illnesses such as stroke, hypertension, and diabetes. Other illness conditions such as fibroids, piles and menstrual disorders, and infertility cases are sometimes referred to the herbal clinic. Medications are well calibrated with standard prescription of dosages for patients so that they are not abused. In instances where patients need to combine both herbal and orthodox medicine, they are guided by prescription to ensure effective outcome.

Regarding the factors that influence the choice of herbal medication, the doctors mentioned that some patients seek herbal medicine as an alternative when they do not respond

well to orthodox medicine or when they suffer some negative side effects. There are also cost imperatives to their choice as the cost of herbal medicine is, comparatively, lower than orthodox medicine. However, Ghana's Health Insurance Scheme does not support herbal treatment at the herbal clinics. There is the need for the extension of the Health Insurance Scheme to cover treatment cost at these herbal clinics attached to regional hospitals. This will enable patients use these facilities without being hindered by financial challenges.

In relation to cancer treatment, the Kumasi South Herbal Clinic had not received any cancer cases. However, the other three herbal centres (Champion Divine Clinic, Top Herbal Clinic, and Jonart Herbal and Spiritual Centre) visited during fieldwork indicated that they had received and handled cancer cases including breast, prostate and cervical cancers.

In their study, *Traditional Herbalists and Cancer Management in Kumasi, Ghana*, O'Brien et al. (2012) sought to explore the role traditional herbal practitioners' play in cancer management in Ghana. Forty-two (42) traditional medical practitioners were interviewed about their knowledge and practices regarding cancer management. The study found out that traditional medical practitioners identified cancers as diseases of visible masses, fungating lessions, ulcerations and bleeding. Traditional medicine practitioners also believed that they could treat and prevent cancer. O'Brien et al. (2012) concluded that traditional medical practitioners constitute a significant health service delivery resource and called for dedicated efforts to further integrate traditional medical practitioners into the overall health care system.

Considering the fact that there is evidence that herbal practitioners handle cancer cases, there is the need for health training and education on cancer for herbal medicine practitioners on the causes of the various types of cancers, their symptoms and treatments. This will enable them

to possibly identify and refer cancer cases to the appropriate places like oncology units for treatment.

2.8 Cancer presentation and diagnosis in Ghana

Zelle et al. (2012) have stated that breast cancer control in Ghana is characterised by low awareness, late-stage treatment and poor survival. In Clegg-Lamptey and Hodasi's (2007) work, *A Study of Breast Cancer in Korle Bu Teaching Hospital: Assessing the Impact of Health Education*, they studied the history of breast cancer patients referred to the Korle Bu Teaching Hospital (KBTH) for a three-year period to determine any changes in breast cancer presentation. 158 patients were included in the study consisting of 156 women and 2 men with ages between 24 and 75 years (mean age of 48 years). At the end of the study they indicated that the majority of the patients were in the fifth decade (40-49) of their lives. They also stated that breast cancer patients report late to the hospital. They proposed that initial counselling and education aimed at dispelling misconceptions about mastectomy should be offered to breast cancer patients. Also, surgeons should offer breast construction to patients who are afraid of deformity. This may reduce the number of patients who stop their treatment. They also proposed highly personalized approach to follow-up using breast care nurses and counsellors to address patients' concern, especially the fear of mastectomy. They called for further studies to determine why patients present late breast cancer cases to the hospital.

In a follow-up study conducted by Clegg-Lamptey, Dakubo and Attobrah, (2009), they interrogated the reasons why breast cancer patients report late or abscond during treatment. They highlighted that newly diagnosed patients had symptoms lasting from one week to five years (mean=46 weeks) a little different from an earlier study in 2007 of 2 weeks to 5 years (Clegg-

Lamptey & Hodasi, 2007). They specified that even patients whose lumps were found by clinical breast examination during community breast screening exercises took between six weeks to two years (mean=47 weeks) to report to the hospital for treatment. They pointed out that married women were more likely to abscond. They stated that it will be more important to deal with the causes of delayed presentation than attempt to do breast screening since even patients identified through community screening still present late to hospital. They called for counselling for patients at the time of diagnosis. Also, they urged that factors leading to late presentation and absconding must be addressed during outreach programmes.

Wiredu and Armah (2006) did a retrospective review of 3,659 cancer deaths at the KBTH over a 10-year period. They collected data on autopsy records of Department of Pathology and medical certificates from all the wards of the Korle-Bu Teaching Hospital (KBTH) Accra, Ghana from the period 1991 to 2000. They found out that the commonest causes of cancer death in females were malignancies of the breast, closely followed by cancer of the haematopoietic organs, liver and cervix. In males however, the highest mortality was from the liver disease, followed by prostate cancer, hematopoietic organs and stomach.

2.9 Cancer causation

The Merch Manual (1992) defines cancer as a "Cellular malignancy whose unique trait—loss of normal controls—result in unregulated growth, lack of differentiation, and ability to invade local tissues and metastasize" (p. 1263). They specify that cancer can develop in any tissue in any organ at any age even though age is the most significant impact on incidence and mortality. Mercola (2015) states that as one ages, there are more opportunities for genetic mutations (damage) which the body is less capable of repairing. Cancers such as prostate, stomach and colon reach their peak at ages 60 to 80. Others like leukemia reach their peak from birth to age

10. The oldest and effective form of cancer therapy has been surgery. Radiation and drugs have been used to treat various cancers.

Tobacco is the single most important risk factor for cancer. It caused 22% of cancer deaths and 71% of lung cancer deaths worldwide. It has been established that it is responsible for other cancers like head and neck, nasopharynx, esophagus, stomach, pancreas, liver, kidney, bladder, leukemia, and cervix (Cogliano et al., 2011; Lee & Hashibe, 2014). Certain specific infections contribute to cancer risk factors. Out of 12.7 million new cancer cases recorded in 2008, 16.1% (representing around 2 million new cases) were attributable to infectious agents. *Helicobacter pylori*, hepatitis B and C viruses, human papillomaviruses are together responsible for 1.9 million cases of gastric, liver and cervix uteri cancers respectively (De Martel et al., 2012). Reproductive behaviour such as giving birth later in life, the use of birth control pills, oral contraceptive and hormone replacement therapies containing estrogen and progestin are noted to cause breast cancer (Mercola, 2015). Alcohol consumption is a risk factor for cancers of the neck, esophagus, liver, colorectum, and breast for women only. Dietary behaviour, particularly consumption of red and processed meat, is also a risk factor. Genetic determinants are established as the cause of prostate cancer. Obesity and excessive exposure to sunlight are also cancer risk factors (Cogliano et al., 2011; IARC and Cancer Research, UK, 2014).

Apart from the factors mentioned, Hashin and Boffetta (2014) indicate that less industrialized countries are exposed to occupational and environmental carcinogens that contribute to cancer burden. They report that factors such as asbestos and arsenic exposures through mining and manufacturing cause lung, liver, bladder and kidney cancers.

Unfortunately, cancer patients in my study had very little knowledge regarding scientific explanations to cancer causation. They expressed general exasperation about the unknown cause

of cancer and as such ascribed supernatural causation to their cancer conditions. Atobrah (2012), in her study on young patients' perceptions and meanings of chronic illness and their implication for medical care, used in-depth interviews, narratives and observation to interrogate 24 young patients who were diagnosed of cancer, renal disease and stroke. She interrogated patients and their relatives' perception, causal explanations, meanings ascribed to diagnosis and search for treatment and cure. She found out that most young patients and their families ascribed supernatural meanings to the cause of ailment which influenced their "course of treatment as they combined orthodox medicine with other forms of therapy, including spiritual healing and herbal medicine" (Atobrah, 2012, p. 52). It is important that cancer awareness messages and prevention massages should include in-depth education on cancer causation. Correct knowledge about cancer causation has positive influence on coping and prevention strategies (Rodríguez et al., 2015).

2.10 Cancer awareness in Ghana

One prominent challenge that demands remedy in cancer discourse is ignorance, something which can be done with only through awareness creation. In Ghana several attempts have been made to create cancer awareness. Attempts have been made by government, health professionals as well as non-governmental organizations in this regard. Various media platforms such as television and radio have been utilized in sensitizing Ghanaians about cancer. Messages that have been sent across to the Ghanaian populace have included various symptoms of the individual cancer types. Over the past years much sensitization has been made especially about breast, cervical and prostate cancers as they are the leading kinds of cancers in Ghana. People have been educated on how to conduct Breast Self-Examination (BSE) in the case of breast cancer.

Taking a step further, organizations and individuals has adopted initiatives to conduct free breast cancer screenings to the Ghanaian populace. For instance, Breast Care International (BCI), a non-governmental organization whose vision is to promote early detection of breast cancer in local communities, has been phenomenal in creating cancer awareness in Ghana. It organizes educational campaigns and breast screening exercises in local communities (Mena et al., 2014). Since 2011, the Breast Care International organizes annual walks meant to create awareness on cancer. On October 28, 2014, a walk for cure was organized in the Brong Ahafo region with about 35,000 people taking part of the walk (Myjoyonline.com). Such initiatives have proved useful in encouraging people to report early to the hospital upon seeing any signs of symptoms of cancer.

Mena et al. (2014) conducted a cross-sectional survey to assess the impact of Breast Care International's programmes on knowledge, attitudes and practices toward breast cancer among women from rural communities in Ghana. Out of the total of 232 women who participated in the study, 131 (intervention group) were from a community that received the prior breast cancer education from Breast Care International. The remaining 101 participants (referent group) were from another community that had not received any prior breast cancer education. At the end of the survey, Mena et al. (2014) found out that knowledge about breast cancer among participants who received prior breast cancer awareness was significantly better than among those who did not. Only 53.5% of participants from the referent group knew that breast cancer usually appears as painless breast lump when compared to 82.3% from the intervention group which was also more likely to practice breast self-examination.

Another study conducted by Opoku, Benwell, and Yarney (2012) in Accra and Sunyani on *Knowledge, Attitudes, Beliefs, Behaviour regarding Breast Cancer Screening Practices in*

Ghana aimed at exploring breast cancer related knowledge and practices in order to develop an appropriate socio-economic and cultural specific model to improve breast cancer care in Ghana. They found out that respondents displayed knowledge deficit about breast cancer. However, high educational level of the respondents was very significant for breast cancer screening practices. Opoku, Benwell, and Yarney (2012) found out that Breast Self-Examination was 32%, Clinical Breast Examination was 12% and mammogram use was 2%. Also, the respondents' attitudes towards breast cancer included fear of the disease which was linked to death in most cases, denial and guilt, as well as supernatural attributes to cancer causation.

Asobayire and Barley (2014) conducted another study to investigate problems confronting breast cancer awareness in the Kassena-Nankana district of Northern Ghana. They reported that lack of biomedical terminology in the local language posed a challenge to breast cancer awareness creation and recommended the need to incorporate indigenous languages in public health educational materials for breast cancer in remote communities of deprived districts of Ghana. They also recommended adequate numbers of specialized health personnel and breast cancer screening facilities in the Kassena-Nankana district.

2.11 Complementary and alternative medicine

In the same way as different societies have different explanations to illness causation, so have healing systems and beliefs evolved over time in different cultures and parts of the world. Some examples are Ayurvedic medicine from India, emphasizing balance among body, mind, and spirit; Chinese medicine, which is based on the view that health is a balance in the body of two forces called yin and yang; acupuncture, a common practice in Chinese medicine that involves stimulating specific points on the body to promote health; homeopathy, a system of health care which uses very small doses of substances to trigger the body to heal itself; and naturopathic

medicine, which uses different methods that help the body to naturally heal itself (U.S. Department of Health and Human Services, 2005).

Regarding cancer treatment, there are various therapeutic options available worldwide. Some are considered as conventional as they have been scientifically proven. These include orthodox treatments such as surgery, chemotherapy, radiotherapy, hormone therapy, and brachytherapy. There are other treatments for cancer which have not been scientifically proven known as Complementary and Alternative Medicine (CAM). Studies have shown that a variety of complementary and alternative medicines have been used by cancer patients around the world (Farooqui et al., 2014). A study by Farooqui et al. (2014) on the use of Complementary and Alternative Medicine among cancer patients in Malaysia revealed that the use of CAM has been rapidly increasing among cancer patients.

Complementary and alternative medicines used by cancer patients include mind-body medicines which are based on the belief that one's state of mind is able to affect the body. Some examples of mind-body medicines are meditation, biofeedback, hypnosis, yoga, and imagery. There are also creative outlets methods such as art, music, or dance used in treating cancers. Manipulative and body-based Practices such as Massages are also available to cancer patients. Biologically based practices which include dietary supplements and herbal products have also been used. Spiritual healing cannot be overemphasized when talking about Complementary and Alternative Medicine (U.S. Department of Health and Human Services, 2005).

Regarding reasons for the use of complementary and alternative medicine, research has proven that patients take alternative and complementary medicine for immediate relief and to reduce the side effects of their orthodox scientific treatments. Also, patients feel a sense of

responsibility when they use alternative medicine. Patients feel the need to be actively involved in their health care. By taking complementary and alternative medicine, they have the feeling that they are playing a role in their health care (Farooqui et al., 2014).

CHAPTER THREE

METHODOLOGY

3.1 Introduction

As a methodology chapter, this section consists of my research strategy, sources of data, data collection procedures and sampling procedure. Interview procedure, ethical consideration, data analysis procedure as well as challenges in data collection are also discussed.

3.2 Research strategy

This study adopts a qualitative approach in investigating the health care choices of cancer patients. The majority of cancer research conducted in Ghana have mainly been quantitative in nature giving figures and statistics of cancer cases in Ghana (see Wiredu & Armah, 2006; Clegg-Lamptey & Hodasi, 2007; Laryea et al., 2014) with little reference to the lived experiences of cancer patients. However, a qualitative study like this affords us the opportunity to gain insights, meanings and access to the experiences of cancer patients which cannot be expressed in numbers.

A focused ethnographic approach was adopted in this study. Focused ethnographies have proved very suitable for healthcare research as they have "meaningful and useful application in primary care, community, or hospital healthcare practice, and are often used to determine ways to improve care and care processes" (Higginbottom, Pillay & Boadu, 2013, p.1). Ethnographic studies have for instance been found useful in explaining illness in Ghanaian cultures, for example, among Kasena-Nankana filariasis patients (Gyapong et al., 1996), Ga cancer patients (Atobrah, 2012) and patients with onchocercal skin disease (Vlassoff et al., 2000).

Also, focused ethnography is problem-focused and context-specific (Higginbottom, Pillay & Boadu, 2013). Considering the short time frame of a year within which this research had to be carried out as well as the demand of understanding the beliefs and conception of illness as a whole of a people, no other approach was more appropriate than focused ethnographic method. It allowed the researcher to emerge herself into the culture of the study group (Akans) regarding their general beliefs about illness causation. At the end of the study, the beliefs cancer patients held regarding the cause of their illness was ascertained as well as the influence that they had on their health care choice.

Face to face interviews with semi-structured questions were used to ascertain the lived experiences of cancer patients. In a study like this, semi-structured interviews with open ended questions allowed cancer patients to give narratives of their health care experiences.

Purposive sampling method was used in selecting cancer patients, family members actively involved in their health care, health workers, and herbal practitioners for the study. These participants had specific knowledge and experience which were considered to be of interest to the investigation.

3.3 Sources of data

This research made use of both primary and secondary data. Secondary data was collected from books and journal articles in medical anthropology relevant to this study. Primary data was collected through qualitative ethnographic methods of data collection, specifically in-depth interviews, narratives and observation.

3.4 Data collection strategy

Cancer patients were recruited from the oncology unit of the Komfo-Anokye Teaching Hospital. There are only two hospitals with oncology units in Ghana. Cancer cases from across the country are therefore referred to these hospitals. KATH receives referrals from the Western, Eastern, and Brong Ahafo Regions, and sometimes from the Central Region, all of which are predominantly Akan. This enabled easy access to more Akan patients who are the target of this study.

Semi-structured interviews were used to collect data for this study. Three different interview guides were prepared for cancer patients, hospital staff and herbal/spiritual centres respectively. Interviews were recorded with the consent of respondents and transcribed. The study involved medical doctors, nurses as well as patients who had come to the hospital for treatment. These people are busy people. As such semi-structured interviews were more appropriate in saving time unlike unstructured interviews. The use of semi-structured interviewing in the study allowed the researcher to lead the discussion to avoid deviations as well as allow reliable, comparable data as topics and questions were covered in a particular order as opposed to unstructured interviews (Russell, 1994). Also, semi-structured interviews allow the interviewer to "[elicit] answers fully from the perspective of the study participant, and … gain a greater understanding of the context and meaning of those responses through various forms of probing" (Whitehead, 2005, p.17). Thus, the use of an interview guide helped draw patients who digressed from the discussion back to the question under consideration.

3.5 Sampling Procedure and background data of respondents

A purposive sampling technique was used in recruiting adult cancer patients who constituted the main participants in this study. A total of thirty-five (35) adult cancer patients were interviewed on their beliefs, perceptions, attitudes and practices on illness causation and how these influenced their choice of health care. The study was opened to patients with all kinds of cancers. However only those who gave their consent to participate in the study were interviewed. Out of this number (35), fifteen (15) were breast cancer patients, five (5) cervical cancer patients, four (4) patients had prostate cancer, four (4) others were head and neck cancer patients−three (3) of whom suffered from nasopharyngeal cancer while one (1) had melanoma cancer. One (1) patient had lung cancer, one (1) had uterus cancer and one (1) had cancer of the penis and the last patient (1) had cancer of the rectum.

Out of the 35 cancer patients interviewed, ten (10) were males and the remaining twenty-five (25) were females who were registered at the oncology unit of the Komfo Anokye Teaching hospital. Majority of the females reported of breast cancer cases. As a result, the final sample included more women than men and more breast cancer patients than other types of cancers. This is consistent with the cancer statistics in Ghana (see Wiredu & Armah, 2006). Table 2 (p. 44) shows the breakdown of patients by cancer type and sex.

Table 2: Breakdown of patients by cancer type and sex

Cancer type	Number	Percentage	Sex
Breast cancer	15	42.9%	Females
Cervical cancer	5	14.3%	Females
Prostate cancer	4	11.4%	Males
Melanoma	1	2.8%	Female
Nasopharyngeal cancer	3	8.6%	Males
Leg cancer	1	2.8%	Males
Cancer of the Rectum	1	2.8%	Female
Leukemia	1	2.8%	Male
Cancer of the Lung	1	2.8%	Female
Cancer of the Penis	1	2.8%	Male
Uterus	1	2.8%	Female
Total	**35**	**100%**	

Source: Author's data, 2015.

The study focused on Akan cancer patients. The Akan people of Ghana are a very heterogeneous group with several ethnic groups. The whole of southern Ghana is more or less Akan, except for the Volta and parts of the Eastern Region. Brong Ahafo and the Western Regions comprise of a number of ethnic groups including Fanti, Wassa, Nzema, Ahanta, Sefwi, Brussa. Most of these groups have their own peculiar languages, though they speak and understand Twi. Most Akan groups share a similar culture though there are some divergences. The sample for this study included five (5) Fantes, nine (9) Bonos, fourteen (14) Asantes, three (3) Akuapems, two (2) Wasa and two (2) Kwahus. Even though the findings of the study may not apply to all Akans, the broader word Akan was used in this work. Table 3 (p. 45) shows the breakdown of patients by ethnicity.

Table 3: Breakdown of patients by ethnicity

Ethnicity	Number of patients	Percentage
Fante	5	20.0%
Bono	9	25.7%
Ashanti	14	40%
Akuapem	3	8.6%
Wasa	2	5.7%
Kwahu	2	5.7%
Total	**35**	**100%**

Source: Author's data, 2015.

The majority of the patients who were interviewed were traders and farmers; the others were teachers, civil servants, students and a secretary, as shown in Table 4 below.

Table 4: Breakdown of patients by profession

Occupation	Number of patients	Percentage
Farming	11	31.4%
Trading	15	42.9%
Teaching	2	5.7%
Civil servants	3	8.6%
Secretary	1	2.9%
Student	3	8.6%
Total	**35**	**100%**

Source: Author's data, 2015.

The patients fell within the age range of 18-65 with the following breakdown. The majority of patients (31.4%) fell within the age range of 50-59 followed by the age range of 60-69 (28.6%). 25.7% of patients fell within the age range of 30-49, 11.4% fell within 18-29, and 2.8% of patients fell within the 29-30 age range. Table 5 (p. 46) shows the breakdown of patients by age.

Table 5: Breakdown of patients by age

Age range	Number of patients	Percentage
18-29	4	11.4%
30-39	1	2.8%
40-49	9	25.7%
50-59	11	31.4%
60-69	10	28.6%
Total	**35**	**100%**

Source: Author's data, 2015.

All but two patients were Christians attending various orthodox and charismatic churches, as shown in Table 6.

Table 6: Breakdown of patients by sex and religion

Sex	Number of patients	Percentage	Religion	Number of patients	Percentage
Males	10	28.6%	Christians	33	94.3%
Females	25	71.4%	Muslims	2	5.7%
Total	35	100%	Total	35	100%

Source: Author's data, 2015.

The majority of the patients had basic education (34.3%); 20% had no education at all; 14.3% had secondary education; 22.9% had middle school education and 8.6% had tertiary education. This is illustrated in Table 7 below.

Table 7: Breakdown of patients by educational background

Educational level	Number of patients	Percentage
Tertiary education	3	8.6%
Middle school	8	22.9%
Secondary education	5	14.3%
Basic education	12	34.3%
No education	7	20.0%
Total	**35**	**100%**

Source: Author's data, 2015.

3.6 Key informants

Managers of three (3) herbal centres and one (1) manager of a centre that combines both herbal and spiritual methods were interviewed on their conceptualization of the causation of cancer and the therapeutic services they provided at their facilities. Two (2) medical doctors and four (4) nurses from the oncology unit at Komfo Anokye Teaching Hospital were interviewed about their views on the use of alternative health care by cancer patients and implications on the recovery process of patients. Fifteen (15) family members of cancer patients were also interviewed. These included husbands (5) who had brought their wives to the hospital; children (5) who were responsible for the care needs of their parents as well as siblings (5) of some cancer patients.

3.7 Interview procedure

Interviews with patients were conducted at the oncology unit of the Komfo Anokye Teaching Hospital. A room was made available for the interviews. This allowed patients to talk freely as they had the privacy they needed. However, the fact that patients were not interviewed in their natural environments could affect their responses especially regarding their use of alternative medicine. Some casual conversations and observations were also made with patients while they were in the queue to see the doctor.

I was amazed at the extent to which patients opened up to me. Initially I was a little anxious about talking to patients as I felt they may not open up to me. I had a challenge when I realized that most of the patients had been referred from hospitals in other regions and did not live in Kumasi. This is because the original methodology was to interview patients in their homes. I felt they may open up and talk more freely when they were in the comfort of their homes.

However, the hospital premises provided a more comfortable zone as far as talking about their cancer condition was concerned. They felt there was no need to look around them to see who was listening to their conversation. After all, everyone in the oncology unit knew about their condition. They did not have to worry about health workers or patients eavesdropping. This atmosphere made patients relaxed enough to talk about all manner of issues regarding their health care.

The kind of rapport built with patients also enabled them to talk freely. After I had obtained permission from the medical director to conduct the study at the hospital, he gave me a note to be given to the acting head of the oncology unit and the head of the nurses who introduced me to the patients. I was therefore not seen as someone who had sneaked in for information. In spite of the introduction by the health personnel, I took time to introduce myself to patients. Before I started, I greeted the patient and asked how he/she was feeling to which there was always a courteous response. I mentioned my Akan name (Nana Amoa) to them and where I came from (Sefwi Wiawso); that way they understood I was an Akan too. I told them I am a student from the University of Ghana, that I was concerned about the increasing incidence of cancer cases in Ghana and that I was conducting a study into it. I added that if they gave me permission I would like to hold conversations with them to know how they felt, the places they sought health care from and how helpful or otherwise their choices had been to them. They were glad to know that about this particular study. They shared their own concerns about the inadequate information about cancer, the rate at which people were getting cancer, even young people, and worst of all, the unknown cause of cancer. They said they were glad and privileged to provide any information they could. A patient who had prostate cancer remarked as follows:

> *I am glad to know that cancer is a concern to other people and studies are being done about it. It is much of a worry to us especially when we don't know what causes it. I have always been looking for opportunity to share my experience of cancer with someone, especially the youth. So go ahead and ask me the questions if I have the answers why not, I will gladly provide them.*

This patient was a 55 year-old prostate cancer patient. He was very instrumental in providing responses except that he talked about other issues that were not relevant to the study. I however listened attentively and brought him back on track from time to time.

Patients were generally very responsive. They asked questions and made appeals to government for financial support, details of which are given in the data presentation in Chapter Four. The health workers were also helpful in recruiting patients and providing vital information needed about patients and for the study in general. Same can be said of the herbal and spiritual centres visited except that they could not provide reliable statistics on the patients they mentioned they had treated.

3.8 Ethical considerations

This research involves human subjects (sick people as well as health workers). Strict adherence to ethical principles is of fundamental importance to ensure that no physical or psychological injury is caused to the research participants. As a result, an ethical clearance was sought by the researcher from the Ethics Committee for Humanities of the University of Ghana, which ensures that research conducted does not pose a threat to research participants as well as to the researcher by reviewing necessary documents like questionnaires and interview guides among others.

Permission was sought from patients before any interview began. Participants were asked for permission to digitally record the interviews for the sake of reporting. Almost all participants gave their consent, except one patient who said she did not want the recording to be played on television or radio. She was assured that the recording would be handled with confidentiality.

There was the need to build rapport with participants in order to gain their confidence to allow responsive interaction. Participants were assured of confidentiality and anonymity. This was done by assuring them that any information given would be used for research purposes only. Participants were assured that pseudonyms would be used instead of their actual names to hide their identity during data presentation. Participants were also informed that their involvement or otherwise in the study was purely voluntary and that they were not under any obligation to participate in the research. In the same way they were free to opt out of the study at any point without any adverse consequences.

The researcher ensured that the research process did not create any physical discomfort or stress to patients. For instance, there was a patient who had throat cancer; when I started the interview I realized she liked to talk a lot. She spent about five minutes on the first question asked. Realizing that proceeding with the interview would worsen her condition, the interview was terminated. I ended with the first question, thanked her for her contribution and left. Some interviews were paused and continued another time whenever I noticed any signs of fatigue in patients.

3.9 Challenges with data collection

A major challenge faced was "defensiveness of hospital authorities and their hesitation in allowing observers to enter their workplace" (Van der Geest, 1989, p. 1996). It was difficult gaining entry into Komfo Anokye Teaching Hospital as the hospital staff were uncertain about any negative impact the work might have on patients. I was made to go through a number of procedures to register the study. Even though I had acquired an ethical clearance certificate from

the University of Ghana Ethical Committee for Humanities, I was told that it was not applicable at Komfo Anokye Teaching Hospital. I was made to register my study with the Research and Development Unit of the hospital. I also had to seek permission from the Medical Director of the Hospital and obtain a letter from the head of the oncology unit. Van der Geest (2004) has indicated that some social scientists who had tried to do hospital research had faced similar challenges. However, after I had taken the pains to go through the procedures to register the research, and gained permission, the patients opened up to me and responded to all my questions as they knew that I had gone through the right procedure to be able to interact with them.

3.10 Data analyses procedure

Interviews and conversations produced data in the form of notes and summaries. Transcripts were produced from audiotaped interviews verbatim. Each respondent was given an ID number such as CP1–cancer patient 1, CP2–cancer patient 2, HC1–Herbal Clinic 1, FM1–Family Member 1. Each taped interview was transcribed and tagged with the ID numbers of respondents. Certain quotations were highlighted during transcription to be presented as evidence in data presentation. As a way of ensuring confidentiality, patients were assigned fictitious names for the purposes of data presentation.

Some themes were prepared based on the research objectives before data collection took place (preset themes). Various questions were raised under each theme. These were the questions that were used in preparing the interview guides. These themes were helpful as they provided direction for data collection. Data gathered were therefore categorized to match these themes. However, there were a number of emergent themes that came up in the course of fieldwork. The data gathered produced certain recurring themes and ideas that had not been thought of earlier.

These were added to the themes that were preset. For instance the issue of stigma and disclosure was not part of the preset themes. However patients mentioned it a lot. It was therefore added to the preset themes (Bryman & Burgess, 1994).

Sub-themes were also generated under the major themes to allow some differentiation and nuances in the data. Connections between themes were also highlighted with several themes combined to create larger ideas and concepts for discussion. A few cause and effect relationships were established where necessary to help explain findings of the study. Responses that were counter to the themes were also discussed for a nuanced understanding of the data (Miles & Huberman 1994; Pope & Mays 2000).

CHAPTER FOUR

DATA PRESENTATION, FINDINGS AND ANALYSIS

4.1 Introduction

This chapter highlights the data gathered in the course of the fieldwork. Here, relevant data and findings are presented, analyzed and discussed.

The objective of the study was to interrogate the beliefs of cancer patients about their illness causation and how that influences their choice of health care, as well as their behaviours and attitudes towards their illness condition. Data was gathered to this effect at the Komfo Anokye Teaching Hospital (KATH), 3 herbal centres, and one spiritual and herbal centre all at Kumasi in the Ashanti Region of Ghana.

A total of thirty-five (35) cancer patients were interviewed on their beliefs about the cause of their illness and the places they seek treatment.[2] Two (2) medical doctors and four (4) nurses at the oncology unit of KATH were interviewed. Interviews were also conducted at Champion Divine Clinic, Top Herbal Centre and Jonart Herbal and Spiritual Centre and the herbal centre of the Kumasi South Hospital. These herbal centres were registered with the Ministry of Health and had their drugs approved by the Food and Drugs Board. They had medicine for various illness conditions including diabetes, hypertension, stroke, fibroid, typhoid, malaria, infertility, waist pains among others. Even though they claimed to have treated people with cancer, they could not provide any records to that effect. One centre gave the excuse of confidentiality of the records of patients. The herbal centre at the Kumasi South Hospital is one opened by the government. It is attached to the hospital and shares facilities with the entire hospital. This is part of an initiative by Ghana's Ministry of Health to attach herbal clinics to

[2] See section 3.5 under Chapter Three for breakdown.

every regional hospital. In Kumasi alone there are four of these centres—Tafo, Obuasi, Suntreso and Kumasi South hospitals. There are professional doctors and nurses who man the herbal centres.

4.2 Data Presentation, findings and discussion

Data presentation, analysis of findings and discussion are done thematically. While some major themes were raised from the research objectives, others emerged in the course of the fieldwork through interactions with patients, which added a new perspective to the study. For instance, the theme of disclosure and stigma came out during interviews with patients. Based on the research questions and fieldwork, six major themes have been selected for analysis. These include disease discovery and diagnosis, indigenous conceptualization and beliefs about cancer causation, treatment choices, efficacy of treatment, stigma and disclosure, and coping strategy. Disease discovery covers narratives about how patients got to know about their cancer condition. Indigenous conceptualization and beliefs of cancer causation highlights what cancer patients perceive as the cause of their cancer condition, based on their societal beliefs. Treatment choice covers the therapeutic options available to and used by cancer patients. Under the theme of efficacy of treatment, issues of treatment regimen and side effects of medication are discussed. Knowledge of cancer patients' condition by family and friends and fear of mastectomy are highlighted under the theme of disclosure and stigma. Finally, issues of religion, care and support will be deliberated under the theme of coping strategy.

4.3 Disease discovery and diagnosis

Narratives were taken from patients on how they discovered their cancer conditions. Most patients had long narratives of their disease discovery. They indicated that it took time before

they were diagnosed of cancer. Some patients were wrongly diagnosed by doctors especially in the local hospitals. Some were diagnosed of typhoid, pneumonia, hypertension, and diabetes. This happened with patients who had cancers of the rectum, lung, blood and cervix. Breast cancer patients were however diagnosed more easily than the other types. An eighteen year old leukemia patient reported that he had been wrongly diagnosed with pneumonia for a very long time. He had received several blood transfusions at different hospitals. It was at KATH that the final diagnosis of leukemia was made.

Most of the patients (80%) studied reported that their first point of call when they first noticed the symptom of ill health was not necessarily the hospital but herbal centre. About 70% of the patients interviewed stayed outside Kumasi, specifically in places like Sunyani, Berekum and surrounding areas. The first hospital of contact was their local hospitals where they reported with various symptoms before they were finally referred to KATH. Some of these patients were diagnosed of cancer at their local hospitals while others were referred to KATH for further investigations. Papa Opoku, a 63 year old man who was diagnosed of head cancer narrated:

> *I was getting out of a car when I hit my head on the car. After about four months I saw a swelling on my head, it was painful sometimes but then the pain died at a point in time. The pain was on and off until the swelling grew bigger and very painful. That was when I went to my local hospital. The swelling was removed but it grew back and I went back to the hospital; that was when I was referred to KATH for another surgery.*

Papa Opoku is a farmer who has middle school certificate and a Christian. He added that he had also been to herbal centres for medication since he felt his situation had nothing to do with biomedical treatment. Agya Oppong, 55 lives in the Brong Ahafo region; he has middle school education and is a farmer. He has been diagnosed of prostate cancer and recounts his experience:

> *I had difficulty passing urine so I went to my local hospital. They placed a tube in my genital to help me in passing urine and scheduled me for surgery in two*

months' time. The doctors said it was urine retention. I was later transferred here (KATH) where the doctors diagnosed that it was prostate cancer.

Patients who fell under this category were mainly those who stayed outside of Kumasi. Local hospitals may not have the necessary machines and technology needed for the early detection of certain types of cancers. Distance and cost also deterred some patients from coming to Komfo Anokye Teaching Hospital which is the closest hospital with an oncology unit. Some patients added that even after they had received referral letters from their local hospitals, it took them some time to gather funds to come to Komfo Anokye Teaching Hospital. A cervical cancer patient from Sunyani indicated that it took about a month for her to finally come to KATH after she had been referred. She explained that she did not have any relative in Kumasi. She was also in pain; to sit in a vehicle from Sunyani to Kumasi was therefore a challenge to her. She had to wait till she was better and had some money before she came to KATH.

There were however about 20% of patients who lived in Kumasi and had easy access to the Komfo Anokye Teaching Hospital. Most of the patients who indicated that they had reported early to KATH with their case actually stayed in Kumasi or close to Kumasi. For instance Benewah narrated thus:

I saw a blood stain in my brassiere one Friday after work. I examined my breast and realized that the blood was coming from it. It was not much but I got alarmed and went to KATH the following week. I was made to do several medical examinations and I was told it was cancer. I had heard of breast cancer on the radio so that influenced my decision to report early to the hospital.

Benewah is a 32 year old breast cancer patient. She has secondary education and is a trader.

About 60% of the patients testified that determining their exact health condition had been a difficult one. Maame Kesewaa, a 60 year old patient with lung cancer indicated that she had

been to various hospitals and had been diagnosed of ulcer. However, the medications were not working on her because she was getting worse. She stated thus:

> *When I was diagnosed of lung cancer, I could just not believe it. How was it possible? I don't drink or smoke. I was in a state of shock. I was however grateful that at long last I knew exactly what was wrong. I decided to fight it with a positive attitude and not that of fear.*

The doctors and nurses from their point of view stated that the diagnosis usually came late. They indicated that most of the patients reported late and so at the time of diagnosis the cancer would have advanced leading to bad prognosis. Most patients reported late. They did not report at the time they would have wished them to report. They stated that the stage at which patients report and diagnosis is made determines whether their condition could be treated or managed.

A medical doctor (Dr. Asante) who was interviewed explained that cancer patients are categorized into two; those who are for palliative care and those are for cure. Radical measures including high radiation and surgery are used against early detected tumors to eliminate them. But once the cancer spreads to other parts of the body it becomes difficult to cure. He added that the local site where the cancer develops (for instance the breast) does not kill. However, when cancer metastasizes—spreads to other parts of the body such as the lung, liver, spine, marrow—it becomes difficult to cure as it becomes terminal. The doctors indicated that cancers at the early stages have cure but late stages are for palliation. They also explained that palliative care is meant to reduce the aggression rate at which the cancer spreads, reduce their pain and sleepless nights. Palliative care also helps patients live comfortably until they die. The doctors indicated that the most effective way of handling cancer mortality is early reporting and diagnosis.

The doctors added that early cancers were sometimes not symptomatic. Thus Patients might not see the symptoms until the tumor had developed. For instance, one may not find a little lump in the breast problematic until the lump had developed. If patients do not have prior knowledge of cancer they would not report early. Some patients also consulted and started treatment at other places before reporting to the hospital. The delays meant that by the time they reported to the hospital little could be done about it since the cancer had become untreatable. Doctor Asante recounted:

> *A very rich man came here a year ago with prostate cancer which had spread to the spine, bones. His condition was very bad. He died not long after he was brought here. Apparently he had been at a prayer camp for a long time. He was brought in here when it was too late for cure.*

Madam Sarah, a senior nurse added her voice by indicating that the major challenge health workers face at the oncology unit is the late reporting of cancer patients. Majority of patients report with advanced tumors which are difficult to treat.

4.4 Indigenous conceptualization and belief about cancer causation

Patients were asked about the Akan term and local conceptions of cancer. There were no names for different types of cancers. Patients lump the different types of cancers together. They made reference to cancer in general instead of different types of cancer like prostate cancer or cervical. They regarded it as the same illness condition which could occur in different organs in the body. In the Twi language cancer is referred to as *akisikuru a ɛyere honam mu baabi* (a gangrene fixed in a particular place in the body), but *kokoram* is the generic Akan term used to refer to all kinds of cancer (Basel Missionary Society, 1909, pp. 30, 83). It is more of a descriptive terminology than a name, hence may refer to sore (*ekuru*) especially in the head or neck or an ulcerous condition (*ekuru a etu*) (Basel Missionary Society, 1909, p. 177). Most of the patients

interviewed mentioned *kokoram* when they were asked about the Akan term for cancer. Majority of them however came to know the Akan name after they had cancer. Health workers also made reference to *kokoram* as the Akan term for cancer. Patients attested to the fact that *kokoram* was not a common illness in the past as one hardly heard of it. They also indicated that it was very difficult to treat cancer (*εyε yadeε koankrɔ*). Patients indicated that cancer is conceived as an evil illness (*abonsam yadeε*). It is believed that cancer could be caused by a witch or a spiritual enemy. People think that cancer can be bought for someone (*yetumi tɔ ma obi*). That is cancer could be placed on its victim through *juju*. Cancer is also considered as terminal (*owuyadeε*) and for that matter has no cure. It is believed that a person who has cancer will eventually die. These beliefs accounted for some of the reasons why a lot of cancer patients were hesitant to disclose their illness condition to people. Ampomaa, a 27 year old patient who had breast cancer stated:

> *You know people look at cancer like it is HIV. Because a lot of people do not know much about it, they think when you have it you are going to die or you have been cursed. So I don't tell people I have cancer. They know I am not well and I come to the hospital but they do not know exactly what it is.*

The local conceptualization, to a very large extent, influences people's beliefs about the cause of their illness and the places they seek health care. People in the local communities, including family members and friends, suggest places of treatment to cancer patients based on local conceptions.

Patients were asked what they believe was the cause of their illness condition. They responded in various ways. Some believed their illness had a spiritual cause. Others ascribed causation to physical conditions. There were some patients too who thought their illness could have both physical and spiritual causes. There were still others who at first said they did not

know but as the interview progressed, their comments pointed to either one of the two main beliefs.

71.4% (25) of patients studied believed that the cause of the illness is spiritual. Their beliefs were built on what their local communities perceive as the cause of cancer. A few others also formed their perception based on what they have been told by people with spiritual authority such as pastors and diviners. For instance, Agyeman, who has been taking care of his 60 year old mother with Melanoma cancer, stated that:

> *When my mother got sick, I called all the partners she does business with to ask if she owes anybody or if she had had a quarrel with anybody. I thought someone might have cursed her. But everybody said she was a good person and did not owe them or have a grudge with them. So I don't know what caused the sickness. But it could be from one of the women my mother used to trade in the market with who bought it for her.*

Agyeman believed that someone bought the cancer through *juju* for his mother because she was successful at her trade. As a result, he reported that he sent her to spiritual places for healing as well as herbal centres. He brought her to the hospital because she was still not getting better.

Maame Aya, a 58 year old patient who had cervical cancer also believed that her condition was spiritual. She reported that:

> *I woke up one night to urinate when something hit me from my back. From that time I experienced a burning sensation when passing urine, the colour of my urine also changed. I also bled. As for me I believe that it has spiritual cause but I don't know who is responsible for that. I have visited a prayer centre where they told me that there is a spirit behind the sickness (honhom taa yadeɛ n'akyi).*

This patient had her belief confirmed by a spiritual person. Her belief therefore became firmer because it was not only based on indigenous conception but was actually confirmed.

The remaining 10 patients (28.6%) however ascribed physical causation to their illness. Birago, a 32 year old young lady who had breast cancer stated her belief about cause of her cancer not necessarily being spiritual. She pointed to some possible physical causes of her condition based on her own lifestyle. She pointed out:

> *I don't know what caused it but when I came to the hospital the doctors asked me a lot of questions. They asked whether I had used contraceptives before. I tend to believe that contraceptives may be a contributing factor because I have used some before. I also got pregnant but I aborted it. I seriously think these may be contributing factors.*

This patient did not attribute any spiritual causation to her condition because she could find a cause which may not necessarily be proven, but it saved her from wandering and searching for what caused her cancer condition. Papa Opoku quoted above explained that because he knows the genesis of his condition he does not blame it on any spiritual causation. He feels he had been negligent by not reporting early to the hospital when he hit his head in a car. People tend to read spiritual meanings into their illness if they fail to find any physical causation.

Although some patients believe to some extent that cancer may have a spiritual cause, they nevertheless prefer to seek treatment at the hospital while they also seek spiritual cure from a spiritual source. Almost every patient interviewed believed in the power of God to heal, even though their conceptualization of God may not necessarily be the same. They also attested to the fact that God has given doctors the wisdom and grace to heal and so they stick to hospital treatment. Some have also heard or seen people who did not take their treatment seriously or who have used herbal drugs or been to prayer camps resulting in worsening of the conditions or even death. Maame Anima, a 57 years old woman who had breast cancer, stated:

> *As for what caused the illness I don't know, even the doctors say they do not know what caused it. People say it is an evil disease but if you think that way and you*

> *go to some prayer camps or some other place, you may end up getting worse and then die. As for me I have brought it to the professionals who have knowledge about cancer while I trust God to take care of any spiritual issues. I ignored the advice of all those who scared me by saying that if I came to the hospital and had the surgery I would die.*

People's perception in the local communities and what they tell patients have very strong influence on their decision. This patient was told by some lay people (friends) around her that if she did surgery she would die.

It was observed that cancer patients communicated among themselves. They shared their health care experiences with each other, including their experiences with herbal medicine and spiritual healers. Some also spread false information and thereby transferred their ignorance, fear and panic to others through their interaction. Papa Kwaakye, who has prostate cancer stated:

> *I can't tell what brings cancer but I have heard that it may come from having had many sexual partners. As for me I don't believe mine has a spiritual cause. Even though Akans believe cancer may be caused by witches and other things like ghosts, I don't believe any of them have power over me. I do not pay attention to these things.*

Even though this patient was aware of the local conception of cancer, he rejected it. He rather blamed it on lifestyle and environmental factors. He added that the kinds of food we eat these days are not free of chemicals. There is water and air pollution. All these contribute to the prevalent rate of cancer these days. He advised that precautionary measures be taken regarding diet and lifestyle.

Mr. Asiedu, 55 with prostate cancer ascribed the condition to naturalistic cause of cancer and stated:

> *As for me I have not been faithful to my wife. When I came to the hospital the doctor asked me if I have multiple partners and I said yes. I think that could be a*

cause. Also my grandfather and my father died of cancer. I think it may be hereditary too. I don't think it is a spiritual illness as people say.

This patient could also pinpoint physical contributing factors that were responsible for his condition. He did not ascribe spiritual causation to his illness. It can be said that circumstances leading to cancer can influence to some extent the interpretation patients make regarding causation of their illness. Patients whose relatives had ever had cancer bought into the idea that cancer can be hereditary. A patient who had had some kind of accident in the past traced the causation of cancer to the accident. For instance, a female patient in narrating her case remarked that it began with a boil on her breast. She suspected that probably the boil did not heal well. When she gave birth to her second child, she recalled that the child had refused to suckle one of her breast, perhaps because it was affected. She regretted that she did not do anything about it. She lamented that she could have identified her cancer condition earlier if she had been attentive.

Even though these categories of patients are also aware of the indigenous conceptualization that ascribes spiritual causation to cancer, they are able to refute or reject it. These patients are more proactive in seeking orthodox treatment than the other category of cancer patients who subscribe to spiritual causation. They also have more trust in their hospital treatment regimen. On the other hand, patients who could not point to any tangible physical cause resorted to spiritual interpretation. Table 8 below illustrates the breakdown of patients by beliefs about illness causation.

Table 8: Breakdown of patients by beliefs about illness causation

Beliefs about illness causation	**Number of patients**	**Percentage**
Physical causation	10	28.6%
Spiritual causation	25	71.4%
Total	**35**	**100%**

Source: Author's data, 2015.

4.5 Treatment choices and options available to cancer patients

Narratives were taken from patients regarding the therapeutic options available to them, the therapeutic options they have actually explored, the efficacy of their treatment choices as well as the factors that influenced their choice of treatment.

4.5.1 *Therapeutic options available to cancer patients*

When asked what therapeutic options were available to cancer patients they reported that they knew about *abibiduro* (herbal medicine), *aborofoduro* (hospital treatment), *sunsum aduro* (spiritual healing) and *Chinese aduro* (Chinese medicine). Patients were asked which of the treatment options they had used before. It was found out that even though a few of them had heard of Chinese medicine on television or radio none of them had used that option for curing cancer. 28 patients (80%) had used herbal medicine at one point in time during their illness. More than half of this category of patients had used the herbal medicine before coming to the hospital. The rest stopped their hospital treatment midway to seek alternative treatment but resumed when they found it unhelpful. Only 8.6% (3) of patients interviewed continue to use herbal medicine alongside their hospital medication. Most of the patients indicated that soursop (*aluguntugui*) a local fruit had been very useful to them. It was recommended either by nurses or friends. They had found it very useful as it improved their appetite and gave them energy. Some of the patients ate the fruit while others boiled its leaves and drank from it.

In response to the therapeutic options available to cancer patients, Auntie Kumiwaah, a 47 year old breast cancer patient, stated:

> *Apart from the hospital treatment, I know that some cancer patients use herbal medicine because I have used some before. Some also go to prayer camps for*

> *spiritual healing. Others use Chinese medicine. I have not used Chinese medicine or been to any prayer camp before but I have friends and family members who pray for me.*

Madam Doris, A nurse at the oncology unit explained that:

> *Before patients come to the oncology unit for treatment, they consult their friends and family for views on places they can seek help. They are directed to spiritual and herbal centers for treatment.*

4.5.2 *Therapeutic options used and their efficacy*

Many of the patients interviewed (80%) had resorted to herbal medicine first before reporting to the hospital for treatment. They had been treated for different illnesses altogether as the cancer diagnosis came later. Patients were asked how efficacious their treatment choice had been to them. Maame Kyerewa, a 50 year old woman suffering from rectal cancer, reported:

> *I was treated for hypertension and then typhoid at the herbal centre but I was not getting well so I went to my local hospital. They could not find what was wrong so I was referred to KATH where I was made to do various scans which led to the final diagnosis of cancer.*

A lot of the patients who had used herbal medicine reported that it was not helpful to their condition. Some of these patients actually stated clearly that it made their condition worse. They explained that they believed in herbal medicine. Some had resorted to herbal medicine in treating different illness conditions in the past but this time they did not get better. Papa Opoku, a 63 year old patient who suffered from cancer of the head stated:

> *I visited a lot of herbal places; I was given medication to apply on the growth on my head. They tied it and did a lot of other things but none was helpful so I finally brought it to the hospital. It was at KATH that they saw that it was cancer.*

Papa Kwaakye, a patient with prostate cancer (mentioned earlier) recalled:

> *I have used herbal medicine but it did not help me. I may even say it worsened my situation. The herbalist charged so much, about Ghc500, but as the medicine did not work I did not pay the money. Some of the drugs may be good but one has to be careful of those quack (nkwankyɛn) herbal drugs.*

Amoah, a 27 year old student with melanoma cancer, stated:

> *It has been about four years now. I had continuous headache. I went to various herbal places to seek help but I got worse. In the beginning we thought it was ulcer and hypertension so I was given herbal medicine for those illnesses but when it did not help me I stopped. I keep to my hospital treatment now.*

Majority of patients responded that their hospital treatment had been helpful to them. They recounted the improvement they had experienced since they commenced their hospital treatment regimen. Maame Esi, a 57 year old breast cancer patient, reported as follows:

> *The hospital treatment has been very helpful to me. After mastectomy the pain I felt in my breast vanished. I am strong now and go about my normal duties. I think I am very fortunate because I saw the signs early and reported early so once the lump was removed, I was alright.*

Maame Esi was among the few patients who detected the lump in her breast early and reported immediately to the hospital. She was also serious with treatment and did not break her treatment regimen. She was determined to go through mastectomy in spite of all the discouragements she encountered from friends and family.

Three cancer survivors were interviewed. They had gone through the complete course of their hospital regimen. They were doing very well, they looked strong and healthy. They reported that they saw the symptoms early and reported immediately to the hospital. They had heard of cancer on radio and television so they went to check when they saw the symptoms.

Sister Agyeiwaa, one of the breast cancer survivors indicated that she saw a small lump in her breast and informed her husband who sent her to the hospital the next day. She stated that:

The doctors had difficulty locating the lump but I insisted that there was a lump. Several doctors were made to examine me but they could still not find it. When I kept insisting that I found a lump, they agreed that I should do mammography which revealed the lump. The doctors congratulated me for my bravery and persistence. The lump was removed and I went through radiotherapy and chemotherapy. I am doing very well now. The doctors told me that the cancer had not spread to other parts of my body because I reported early.

Sister Agyeiwaa, 40, is a trader and has middle school education. She had learnt about how to do breast self-examination on television. She reported that she found a lump in her breast one evening when she was bathing and tried breast self-examination. Sister Agyeiwaa indicated that she has taken it upon herself to encourage other women who have breast cancer to take their treatment seriously, especially mastectomy. Table 9 shows a breakdown of patients by treatment choice.

Table 9: Breakdown of patients by treatment choice

Choice of health care	**Number of patients**	**Percentage**
Patients who had used herbal medicine	28	80%
Patients who had not used herbal medicine	7	20%
Patients who had used spiritual healing (prayers, faith, anointing oil)	33	94.3%
Patients who had not used spiritual healing (prayers, faith, anointing oil)	2	5.7%
Patients who had used hospital treatment	35	100%
Patients who had used Chinese medicine	-	-
Patients who had combined spiritual, herbal, and hospital treatment	3	8.6%
Patients who had used only hospital treatment	2	5.7%

Source: Author's data, 2015.

4.5.3 *Decision making on health care choice*

Families and friends as well as the local communities of patients played an important role in the choice of health care. A lot of narratives were given by patients on suggestions people gave

regarding places to seek help. Some of the contributions were positive, others were negative. Some husbands played a very important role in observing the signs and symptoms of breast cancer and taking their wives to the hospital for treatment. A patient recounted:

> *It was my husband who drew my attention to changes in my breast. One of my nipples had grown a little bigger. It was not painful so I ignored it. When I came back from the market one day, my husband told me to go to the hospital because he had listened to a programme on Peace FM where they were talking about symptoms of breast cancer. He persisted until I went to the hospital where they diagnosed me of breast cancer. He was with me throughout my treatment and never stopped encouraging me.*

Ameade et al. (2014) in their study in Tamale, Ghana on the role of male partners in reducing breast cancer menace in Ghana reported that the majority (92.0%) of the five-hundred (500) people involved in the study agreed that men can assist in early breast cancer detection. Majority of male partners were also willing to assist in early breast cancer detection if provided with the necessary skills. Ameade et al. (2014) also stated that breast cancer awareness programmes should not only focus on women but men as well. Asobayire & Barley (2014) in the study, *Women's cultural perceptions and attitudes towards breast cancer: Northern Ghana* recommended that education and awareness campaigns targeted at male spouses and their respective community compound heads would lead to improvement in knowledge, awareness and attitudes towards breast cancer.

In my study I came across husbands who came to the hospital with their wives and waited while they (wives) received their treatments. A few female cancer patients mentioned that their husbands had generally been supportive as far as their health care was concerned. Even though these husbands may be in the minority considering the general attitude of male spouses towards their sick spouses, it is commendable and worthy of emulation by other male spouses.

Some patients who had seen other relatives suffer from cancer were more proactive in reporting to the hospital upon noticing signs and symptoms. Maame Esi, a 57 year old woman with breast cancer who happened to report early to the hospital upon seeing a lump in her breast stated:

> *I saw a lump in my breast so I brought it to the hospital. I did not stay at home because I have seen two of my sisters who died from cancer so I don't play with my treatment. Now I feel very strong, I can walk very long distances. My faith in God has helped me. Even though it killed my sisters, I can rest assured that I will be well. My sisters were using herbal drugs until it was too late and they died.*

Patients are influenced a lot in their choice of health care by family and friends. Upon diagnosis of the disease, a patient admitted that she was advised by her sister to seek spiritual help from a pastor as the disease could be spiritual but she did not really do so because she did not believe that her disease was caused by spirit agents.

4.5.4 *Cost of treatment*

The cost of treatment for cancer is very high. The processes of treatment include surgery in some cases, chemotherapy, radiotherapy and other treatments that cost a lot of money. A cancer patient, depending on the kind of cancer he/she has, may go through all of these treatments. Most of the patients interviewed had had surgery, chemotherapy and radiotherapy. Each stage of treatment was expensive. Patients' major challenge as far as their hospital treatment was concerned, was financial. Some patients had to sell land and other property to fund their expenses. Others had gone for loans to cater for their bills. Papa Kyereh, a 55 year old prostate cancer patient, stated:

> *The amount of money I have spent on this illness, only God knows. The amount can buy two cars. When I exhausted my coffers my children came in to support me but still we are not done yet. It is not easy.*

Papa Nyarko, a 63 year old patient who had cancer of the penis, also indicated:

> *The treatment is expensive. I am on chemotherapy now and each time I come I spend about Gh¢1,800 and sometimes it is not even enough. I have gone through three sessions of the chemotherapy already. This is my third one. I have been told I will do eight sessions in all. I have spent all my life's savings and I am currently depending on a loan. This is my third year of treatment.*

Aboagye, the brother of Amoah (a nasopharyngeal cancer patient) who always comes to the hospital with him indicated that:

> *We have been here for just 3 months but we have spent about Gh¢ 2,500 already. It is only our parents who pay the bills. In fact we need government support because the treatment is very expensive. If it has not been that the herbal medicine was not helpful we would have stuck to it.*

Even though the National Health Insurance Scheme covers breast and cervical cancers, the doctors and patients reported that it is not effective anymore. They explained that the drugs needed for patients are not available so patients buy them. When the doctors and nurses were asked why some of the patients were not consistent in their treatment regimen, they attested that financial constraints was one major restraining factor. Doctor Mensah noted:

> *Financial constraints is a major challenge to patients as far as their treatment is concerned. It is one of the main reasons why patients default on their treatment. They however come back when they are able to raise some money. Most of our patients are farmers and traders. They are low and middle income earners. Cancer treatment is very expensive and most of them struggle to buy the drugs and pay for their chemotherapy and radiotherapy. The National Health Insurance scheme is no longer effective.*

The high cost of treatment placed a great burden on patients. It affected their businesses and careers. Cancer Statistics UK indicated that 169.3 million healthy years of life were lost to

cancer in 2008 globally with colorectal, lung, female breast and prostate cancers as the main contributors in most regions (IARC & Cancer Research UK, 2014).

42.9% (15) of patients in my study did not work because of their cancer condition. Those who were still working indicated that they had reduced the number of hours they worked because they did not have the strength to do so. Their doctors had advised them not to work as they used to do as that could affect their health negatively. Family members (husbands, children and siblings) reported that supporting their relatives in their treatment had negative financial implications on them. Some of them had to leave their personal businesses to attend to their sick relatives. Some of them had to quit their jobs altogether to be able to live up to their task. They also spent huge sums of money on medication. Agyemang (mentioned earlier) noted:

> *For about four years since my mother got sick, my business has been badly affected. I do not work full time anymore because I have to attend to her. Her illness has not only caused me financial drain but has also taken a lot of my productive hours.*

The battle of treating cancer can disorganize family arrangements and plans. Maame Mansa, a breast cancer patient indicated:

> *When my daughter completed senior high school, I could not let her further her studies because I did not have money. I have channeled my funds into funding my cancer treatment. If she has to go to school, it will mean there will be no money for me to pay my bills. So I have asked her to wait for me to get well then I can work and let her go to school.*

4.6 Challenges cancer patients faced

Cancer patients faced a number of challenges in the course of health care. A few of these challenges that came to fore in the course of the study have been discussed below.

4.6.1 *Stigma and disclosure*

Patients were asked about the people (friends and family members) who knew about their illness and how they felt about letting other people know about their illness condition. Some patients did not have any difficulty letting trusted friends and very close family members know about their illness condition. They were also free to let the spiritual leaders such as pastors and other people who pray for them know. Some of this category of patients felt that they needed the support of these people and they could only receive this help if they disclosed their condition. An example was Papa Agyapong who suffered from prostate cancer. He stated that:

> *I don't have problems so much with being sick with cancer. As for sickness it can happen to everyone, besides I didn't call it on myself. So I don't have a problem if people know about my cancer condition. My family members and close friends know that I have cancer and they support me a lot.*

Papa Agyepong conceived cancer like any other illness that could affect anybody. He was not hesitant therefore to let other people know about their condition.

However, other cancer patients were hesitant in letting friends and family members know. Some patients could actually even keep it from their spouses for some time. Sister Takyiwa, a 49 year old breast cancer patient and a successful trader, hid her diagnosis from her husband until it was time for her to go for surgery. When asked why she did that she responded that she did not want to bother her husband as he was the type who got very worried about issues. She also refused to tell other close family members. She indicated that:

> *People talk a lot and can discourage you. They will even spread the information to other people if they know about your condition. By God's grace I can afford my treatment and my husband supports me so why should I 'sell' my illness condition. I prefer to pray to God about it and trust him for healing.*

Only very close family members knew about Sis. Takyiwa's condition. Sister Kyerewaa, a 42 year old breast cancer patient, specified:

> *Some people knew that I was sick and had a surgery but they did not know it was cancer. I didn't tell them it was cancer because when you talk of cancer people see it like HIV/AIDS. They also think you will die and they may discourage you. When I was coming for surgery I did not tell people. Even my church members did not know. It was after it that they heard that I had done an operation. I did not want anybody to scare or discourage me.*

Even though some people knew that sister Kyerewaa was sick, they did not know she had cancer because she refused to disclose details of her illness.

Aunty Ohenewaa, a 45 year old breast cancer patient who did not disclose her illness condition stated:

> *I have not told anybody I have cancer. It is only my brother and sister who know. Why should I disclose my sickness? It is between me and God, he is the only one who can help me. So the doctors help me physically and God takes care of me spiritually. I pray a lot, I am part of the Bible study and prayer group in my church. They visited me when I had the surgery but they don't know it is cancer.*

Benewa who brought her mother who has breast cancer to the hospital and was responsible for her upkeep specified:

> *We have not informed our extended family members about my mother's cancer condition. They know she is not well but they do not that it is cancer. They do not show much concern about her so we do not see any reason why we should give details about her condition to them.*

Patients experience stigma differently based on the kind of cancer they have, their gender and age. The same is true for disclosure. Young breast cancer patients (below 55 years) tend to conceal their breast cancer status compared to older breast cancer patients (55 years and above). Males are more likely to disclose their cancer condition than females in general. In a study to find out whether cancer patients experience stigma, Label and Devins (2008) found out that

people who were purported to have engaged in a behaviour that is perceived to have contributed to their cancer condition faced increased negative attitudes and more severe consequences of stigma compared with those who are not perceived to have contributed to their disease. In my study, it came to the fore that prostate cancer patients were reluctant to disclose their cancer condition because prostate cancer is associated with promiscuous lifestyle.

4.6.2 *Deterioration of physical outlook*

One challenge that cancer patients reported they battled with was the deterioration of their bodies. They gave narratives of how they had suffered physically. Some lost weight while others went through immense pain. A common saying that ran through the narratives was, "If you had seen me at that time, you will cry." Others said, "You would not be able to talk to me if you had seen me in my condition." The side effects of drugs also took its toll on patients. Chemotherapy resulted in darkening of palms and body, nail removal, weight loss, loss of hair, among others.

These side effects were very visible and many patients indicated that they had been a challenge to them. All the patients I interviewed dressed in a way to conceal the side effects of their treatments. Patients reported that they went to great extents to conceal these visible manifestations of the side effects of their treatment to avoid raising suspicion among friends and family members whom they did not want to know about their condition. They had to dress in a way to cover the physical changes as much as possible. The women wore wigs or headgear to conceal their hair loss. Some also wore shoes to cover their darkened feet. But there were other things they could not conceal no matter how hard they tried. For instance, they could not conceal their weight loss and darkened palms. Some patients indicated that they found excuses for people at church or other social gathering who asked them about their darkened palms.

4.6.3 *Fear of death*

The fear of death is another issue of concern to cancer patients. Even though the researcher did not ask any question on death, patients brought up the issue on their own accord, an indication that it is an issue they grappled with. In our interaction they were quick to indicate how fortunate and grateful they were to be alive. One cancer patient reported:

> *It is by God's grace that I am alive and I am very grateful to God. I have heard about some patients who are already dead. In the theatre where I had my surgery, we were 15 in all. All of them are dead except just two of us. I know about this because we became like a family; we took each other's contact and called each other. You will be there and this one will call and ask whether you had heard about the death of so and so. It will make you sad and afraid all together.*

Some patients were however positive about the subject of death. One retorted that as for death, everyone will die and that they were not afraid of death. A patient remarked thus:

> *Well, people board vehicles and they have accidents and die. They die unprepared so if I am fortunate not to have been involved in any such thing. Why will I not be glad and thank God? Even if the doctors tell me that I have 3 or 6 months or a year more to live, is it not enough time for me to meet my Maker? I am 60 years old and I thank God because other people die at younger ages.*

4.6.4 *Distance and cost*

Distance and cost deterred some patients from coming to KATH when they were referred by their local hospitals. Some patients had no relatives in Kumasi or nearby that they could reside with as they sought treatment at KATH. This made it difficult for them to seek treatment at KATH. There was a patient on radiotherapy from the Brong Ahafo Region who did not know anybody in Kumasi, so she begged someone to be allowed to sleep in her kitchen. She came to the oncology unit early morning for her radiotherapy and went back in the night after evening meals, cleaned the kitchen and then spent the night there.

4.6.5 *Fear of surgery*

Fear of surgery was a major deterrent to a lot of cancer patients, especially breast cancer patients. Mastectomy is one of the last things breast cancer patients wished to hear. The idea of having one or both breasts removed is an issue breast cancer patients grapple with. There are a lot of dilemma breast cancer patients have regarding mastectomy. When patients were interrogated, they reported that they were afraid of losing their husbands, if they lost their breasts. Moreover, they had issues of identity to grapple with; for example, would they feel like 'women enough' should they lose one or both breasts? The Akan society has expectations of health and identity for both males and females. The male must be muscular and physically well-built to be able to work hard to take care of his family and dependents. In the same way, the female is expected to be well-built with all the feminine features. She is expected to be beautiful with developed breasts and pelvis to support the demands of childbirth and motherhood. During the performance of puberty rite ceremonies, the young adult woman went half naked to expose her mature breasts—a true sign of her femininity. It was after this had been done that she had suitors and was subsequently given out for marriage. Also, the representations of women by the media in adverts and other commercials portray women in a particular way. Women must be slim, busty, with large and curvy hips. These representations to a large extent affect women's identity. It is not surprising, then, that a woman who has breast cancer would refuse to have her breasts cut as she sees it as a sign of deformity and the tampering of her feminine identity.

4.6.6 *Issues of childbirth*

There was the issue of childbirth to contend with, in the case of women who were still at the childbearing stage. Breast cancer patients wondered if they would be able to give birth and breastfeed after they had gone through mastectomy. In my interview with the doctors, they

indicated that a patient who had undergone mastectomy could still conceive, give birth and breastfeed with one breast. However, a young lady of 27 who had undergone mastectomy and radiotherapy complained that her menses had ceased. She reported that after the mastectomy the menses continued to flow until she was done with the radiotherapy and then she experienced that for over three months the menses was not flowing anymore.

4.7 Coping strategy

Patients were asked how they managed through their difficult times. They gave narratives of what they lean on for support. Patients mentioned that their trust in God, support from family and friends, counselling from health workers as well as personal determination have been useful to them.

4.7.1 *Belief in God as the ultimate healer*

All the patients interviewed believed in God for their healing. All patients interviewed were Christians with the exception of two who were Muslims. The Christians believed in spiritual healing and trusted in God, the ultimate healer. Birago, a 32 year old breast cancer patient who had no support from family because they were not in the position to help, stated:

> *As for me I don't worry at all. When I look left or right I don't see any helper. I hold on to God through faith. If I want to think, worry and cry then I will even die out of that than the cancer itself. I encourage myself, dress and eat very well so that I can have energy to sell and make money for my treatment. When I come to the hospital I tell people who have been crying and thinking to stop because it will not help them.*

Her absolute trust in God and her personal determination and resilience had been her coping strategy. Papa Kyereh, a 55 year old prostate cancer patient indicated:

> *As a coping strategy, I refuse to worry about my condition. The illness came by itself so it will go by itself. If you worry you will die before the cancer kills you. I encourage myself and others not to worry too much about the sickness but while we take our treatment we should continue to pray. God has not left us alone in this. I am an elder in church; I pray a lot and rely on God for my healing. My family members, especially my children, have been very supportive.*

Papa Kyereh relied on God for his ultimate healing while he took his hospital treatment seriously. He had enjoyed financial and emotional support from his family, especially his three children.

One very important coping strategy for patients was the feeling that on comparison with others, they had been fortunate. A lot of patients had reason to count their blessings and be thankful and hopeful. I found in the narratives comments such as *"As for me I was fortunate to have seen it earlier and had it removed. Others report very late when the cancer has spread to other parts of their bodies."*

Other patients said:

> *I am very fortunate because at least I have given birth to all my children and I have a supportive husband unlike others whose husbands leave them because they have lost one breast. My children also support me a lot.*

4.7.2 *Family support*

Most of the patients interviewed (94.3%) indicated that support from family and friends was a great source of strength to them. Their family supported them financially, emotionally and psychologically. Family support has been a very strong comfort to cancer patients. A lot of patients had their family members help foot their bills. Regarding family support, Papa Opoku indicated:

> *My family members have been supportive financially and in advising me. When I had to come for the last surgery, I had no money because I had spent all my money on the previous surgeries, so they came in to support financially.*

There were some people who had no financial support at all. Even though they had family members, these were not in the financial position to support them. Benewah, a young breast cancer patient is an example. She stated:

> *I have absolutely no financial support from anybody. Even though I have siblings, they do not have much money to support me. It is very difficult taking care of my bills. Even though I trade, the profit is not enough to take care of the bills. The treatment is very expensive. When I came for the radiotherapy and they told me the amount, I stayed at home for a week before coming because I did not have money. But when I came back, I was told we could pay in installment, so I have made part payment. I am praying that I will get money to pay the rest before I finish the treatment. It has affected my business because I end up using the money for medication.*

A lot of the patients called for help from government and non-governmental organizations. Most patients lamented:

> *The treatment is too expensive, no wonder some people can't afford it and they resort to herbal medicine or they eventually die; if you don't have money you will die. In fact, government has to pay special attention to cancer because the prevalence rate is very high these days. Even little children and young people are developing cancer.*

Mr Amakye the husband of a breast cancer patient indicated:

> *I bring my wife to the hospital every time she has to come for her treatment. I pay the bills and support her emotionally. This is because I know that she would have done same if I were the one who was sick.*

Agyeman, who was always with his mother at the hospital stated:

> *I have been taking care of my mother since she felt sick about a year ago. Even though it cost me a lot of money, time and effort, I feel it is my responsibility to take care of her. She catered for me when I was young. Now it is time for me to do same for her.*

Reciprocity is eminent when it comes to taking care of a sick relative. I noticed that relatives did not make sacrifices for their sick just because they are their kin but also because of the peculiar relationship that exists between the two parties involved (the sick and the caregiver). More so, caregiving responsibility as well as financial support fell on nuclear family relatives like spouse, sibling, parent and children than on extended family members such as uncles or aunties. The same applied when it came to disclosing one's cancer condition to relatives. Most people disclosed to their nuclear families rather than to the extended family. Sister Asantewaa who brought her mother with nasopharyngeal cancer reported that,

> *We have not informed any of our extended family members about her condition. The point is that nobody really shows much concern and is ready to support in any way, so there is no need to inform them. There are five of us her children who contribute to fund her bills. I am responsible for her daily upkeep and supervising her treatment. I come to the hospital with her every time. Even though it affects my work, I have no choice because I am the last born and the only one who stays with her.*

4.7.3 *Role of counselling*

The advice and counsel given by doctors and nurses helped patients relax as their fears were abated by these health workers. Patients reported that the doctors and nurses advised them on a number of issues. They were told not to combine their medication with herbal medicine, an advice some took seriously, but others did not. They stated that the fears and misconceptions some people exposed them to were abated by the counselling doctors and nurses gave. Madam Mercy, a nurse indicated:

> *Patients hold a lot of misconceptions about their illness. Lay people who have little knowledge about cancer give them false information about their situation as well as*

> *places they should seek help. So we take it upon ourselves to give them counseling to debunk any wrong information patients hold on to.*

Patients reported that the doctors and nurses informed them ahead of time of the side effects of their medication. This made it easier for them to cope when the side effects manifested. Patients also specified that the doctors and nurses listened to their complaints and advised them. This was important to patients because they could not freely talk about their cancer condition with everyone except the few family members and trusted friends. Even with that, they did not get professional advice. A prostate cancer patient indicated:

> *When my diagnosis proved that I had prostate cancer I was very distressed. I did not want to tell anybody because it has been said that if you are promiscuous, that is when you get prostate cancer. But when I came, the doctors educated me and asked certain questions which pointed to the fact that cancer could be hereditary. It was then that I realized that mine could be hereditary since my father and grandfather died from cancer. It was after that that I was able to tell my family and friends about my condition.*

4.7.4 *Individual's outlook*

Individual attitude to cancer was essential in their treatment procedure. Some were very positive about their situation and treatment. Others were anxious and pessimistic. They worried about what caused the illness, how they were going to find money to fund their treatment. Others had very strong belief in God, much more than the other patients. Some of them dressed nicely and looked cheerful but others were worried. This showed in the interaction and the way they carried themselves about.

4.8 Conclusion

The data gathered shows that cancer patients lack adequate knowledge on biomedical causes of cancer. As such, they lean towards their indigenous perceptions of cancer as an evil disease, incurable, caused by evil forces, among others. These beliefs influence cancer patients to seek spiritual and herbal medicine instead, or in addition to biomedical treatment.

In relation to therapeutic options available to cancer patients in Ghana, there are a range of choices. These include biomedical treatment which involves surgery, chemotherapy, radiotherapy, brachytherapy, hormone therapy, among others. There are herbal treatments available to cancer patients as well as spiritual healing which involves prayers, exercise of faith, the use of holy water, and anointing oil. Cancer patients combined these therapeutic options available to them.

Cancer patients face challenges with the use of biomedical treatment including high cost of treatment, and side effects of drugs which led to deterioration of their bodies. Cancer patients also battled with whether or not to disclose their cancer condition to family members and friends. About 30% (25% males) of patients however stated that they did not care if other people knew that they had cancer. The remaining 60% of cancer patients stated that only their nuclear family members and trusted friends knew about their cancer condition. Even so, these people were those who played active role in their health care—financially, spiritually or providing domestic care.

In sum, the data gathered throws some light on the beliefs of cancer patients on what caused their cancer condition and how their beliefs influence their health care choices. It also highlights how patients handle the challenges that come with their illness condition. The result of the study is in conformity with the theories of illness causation discussed earlier in the literature

review. The study also confirms the theory that meanings ascribed to illness by patients and their broader society are deeply rooted and influenced significantly by beliefs, norms and practices (Twumasi, 2005; Gyapong, Adjei, Vlassoff & Wise, 1996; Atobrah, 2012). Patients who believed their illness had spiritual causation resorted to spiritual healing while those who believed that their illness was caused by physical factors sought help from places such as the hospital. However it came to the fore that cancer patients combined health care choices rather than resort to just one source of health care. Their belief about the cause of their illness however determined the order in which health care was sought.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the study as well as conclusions arising from its findings. It also includes recommendations for policy intervention.

The study focused on the therapeutic options available to cancer patients. It also investigated the beliefs and conceptualization of cancer patients about their illness causation and how it affects their health care choices. Attitudes and behaviours cancer patients adopt in response to their illness condition were also explored.

5.2 Summary of conclusions drawn from the study

Various conclusions have been drawn from the study based on the data gathered from the fieldwork. These are heighted below:

5.2.1 *Belief about cancer causation*

Cancer patients bought into their indigenous conceptualization of cancer causation. The Akan people attribute spiritual implication to health and well-being. As such they see illness as a breach in the social order that calls for attention (Twumasi, 2005). The Akan people explain most phenomena from the spiritual perspective and as such fall under personalistic society according to Foster (1976) and Murdock et al.'s (1976) classification of society. In the same way, chronic illnesses including tuberculosis, stroke, and diabetes have been attributed to

spiritual causation. Cancer has also been attributed to spiritual causation. Patients gave narratives about what people in their societies conceive as the cause of cancer. Cancer was seen as evil disease (*abonsam yadeɛ*) that is meant to kill and not to cure (*yadeɛ koankrɔ*) which calls for spiritual remedy.

Cancer patients bought into this conceptualization. In cases where patients did not believe in these conceptions, family members and friends flagged it at them. Because cancer is regarded to have a spiritual cause, it calls for spiritual remedy. This to a large extent influences the health care choices of patients. They are encouraged to seek treatment from a spiritual source, be it a fetish priest, a malam or a pastor.

Apart from seeking spiritual source of cure, cancer patients were also encouraged to seek herbal treatment, a therapeutic practice that is not alien to the indigenous Akan. Twumasi (2005) indicates that the traditional practitioner in the Akan society did not only apply spiritual healing but also prescribed herbs some of which have spiritual potency. In the course of interviews, patients reported the belief of people in their communities that if you have cancer and you report to the hospital you will have to go through surgery. Here again surgeries are associated with death and deformity. Patients indicated that they grapple with these perceptions in their search for therapeutic options for the treatment of their cancer condition. They reported that several suggestions are thrown at them from friends and family members when they get to know of their illness. Patients also indicated that they were sometimes helpless in resisting some of these suggestions thrown at them by friends and family members who play active role as far as their health care is concerned.

5.2.2 *Pluralism of health care choices*

Research has shown that the choices cancer patients make has a relationship with their gender, level of education, economic status, type of employment among others (Farooqui et al., 2014). Farooqui et al. report that cancer patients in Malaysia had access to information about therapeutic options from the internet, magazines, family members and friends, adverts on television and radio among others. Due to low literacy rate, cancer patients in my study had limited access to information on cancer. Their means of access to information was limited to family members and friends as well as radio and television. None of them accessed the internet or read magazines for information on treatment choices. Although there is a wide variety of alternative and complementary medicine available to cancer patients around the world, cancer patients in this study had limited access to information on complementary and alternative medicine. When asked about the therapeutic options they knew about, 95% mentioned orthodox (hospital) treatment, herbal medicine and spiritual healing. Only about 5% mentioned Chinese medicine.

The study revealed that respondents have a good knowledge of different sources of health care. About 80% of patients reported that they had used herbal treatment and spiritual healing before resorting to orthodox treatment. They however added that their conditions did not get better and as such they ended up at the hospital. Once they reported to the hospital, they hardly used herbal medicine as they had been counselled against it by the doctors and nurses. However, they still believed in spiritual healing coupled with hospital medication. They however combined it in a way that did not interfere with the hospital treatment. In essence they "give to Caesar what is Caesar's and to God what is God's" with Caesar representing their orthodox treatment and God representing spiritual healing. Religion and belief in spiritual healing was a strong theme

that ran through the interviews as far as patients coping strategies were involved. About 95% of patients combined some aspects of spiritual healing with their orthodox treatment.

The data gathered and literature reviewed in this study reveals that Akan's read both physical and spiritual meaning to various illness conditions and as such practice health care pluralism (Twumasi, 1975; Warren 1982; Ventevogel 1996).

5.2.3 *Late reporting and defaulting on treatment*

It came to fore in the course of this study that cancer patients report late to hospital leading to late diagnosis of cancer. The study confirmed assertions by earlier research that cancer patients report to herbal and spiritual healing centres before reporting to the hospital (Clegg-Lamptey et al., 2009). The challenge is that apart from breast cancer that may be easy to diagnose, to some extent, patients are treated for other illnesses before they are finally diagnosed of cancer at the hospital. Within the time period of the search of diagnosis, they are treated for other diseases they do not have and as a result their conditions become worse. For instance, a patient had lung cancer but was treated for ulcer and it got worse (see chapter four for more examples). The doctors and nurses however indicated that with the increase in awareness, breast cancer patients have started reporting earlier than before.

There is still the issue of defaulting on treatment. Even though some patients default on their treatment based on reasons such as the fear of surgery, their main challenge at the time of the study was financial. Most of the patients who were at the hospital were those who had already experimented with other therapeutic options such as herbal medicine and reported that they had found it unhelpful. They were therefore committed to their hospital treatment regimen. Most of these patients had also received counselling and had corrected some, if not all of the

myths and misconceptions they had previously held about cancer. However, they faced financial constraint which sometimes forced them to put their treatment on hold. The doctors indicated that it was mostly due to financial reasons that patients defaulted on their treatment. Some of them however came back when they got the money. Patients stated that the education given by the doctors and nurses on cancer had been very helpful because they became aware of the consequences of not completing their treatment.

5.2.4 *Cancer awareness and early reporting*

Patients were asked if they had heard of cancer before their diagnosis. Most patients had heard of the disease called 'cancer' prior to having been diagnosed of cancer, but they did not have much knowledge about it. Most of them did not know what caused cancer. The media was the source of information on cancer to many of the patients. Maame Mansa, a 56 year old cervical cancer patient responded that, *"I have heard of cancer on the radio but the only type I knew was breast cancer. I did not know that one could get it in the cervix until my own diagnosis."* The more people were aware of cancer, the more likely they were to report early to the hospital. People who had had knowledge about the disease reported earlier to the hospital than those who had no such knowledge.

5.2.5 *Efficacy of orthodox treatment of cancer*

Cancer patients reported that hospital medications had been more helpful to them compared to herbal medicine. Patients reported that it seems that there is no herbal medicine that is efficacious in treating cancer yet, and called for more research into herbal medicine. All patients involved in the study indicated that they had experienced significant change in their health condition since they started their orthodox treatment.

5.2.6 *Support system for cancer patients*

The study proved that family support has been of valuable use to cancer patients. Patients narrated how various individuals commended their families for the tremendous support. For some it was their parents, for others it was their spouse, and for the rest it was their children and siblings. These people supported in various ways—some financially, some emotionally, others physically and spiritually. It was the immediate family rather than the extended family that respondents credited for the support received. This is an indication of the gradual breakdown of the extended family system and heavy reliance on the nuclear family system.

Spiritual support from friends, pastors, church members, and church groups proved to be one of the recurring themes in conversations with cancer patients. They recounted the people who prayed with and for them. They indicated how helpful such support had been to them in coping with their condition. They reported that these people also counselled and encouraged them with the word of God, giving testimonies of miraculous healings and urging them to believe in God for their ultimate healing.

5.3 Challenges of the study

There were a number of challenges encountered in the course of the study. The first had to do with gaining entry into the study site which has already been stated in the methodology session. Even though an Ethical Clearance Certificate was obtained from the Ethics Committee of the Humanities, University of Ghana, before the onset of the study, it was not enough to gain entry into the research site. The study had to be registered with the Research and Development Unit of Komfo Anokye Teaching Hospital. Obtaining a letter of acceptance from the oncology unit was difficult as the hospital staffs were hesitant to allow the study to be conducted at the unit, citing

the safety of their patients. However, once the Medical Director of the hospital granted permission, the doors opened.

I could not travel to visit patients at their homes as proposed due to time constraints and also because most of the patients stayed outside the Kumasi metropolis which was the study site.

5.4 Recommendations

Various recommendations can be made based on the findings of the study. These have been discussed below.

More awareness on cancer

There should be more societal awareness on cancer as this can make a difference and even save lives. Many of the patients who were interviewed indicated that they had heard of cancer on the radio or television. If more public education is done, people would be better informed about cancer and would report early to the hospitals.

The hospital staff served as the major source of correct knowledge regarding biomedical explanations to cancer causation. It is recommended that they keep explaining the pathological causes of cancer to patients. This is fundamental in helping patients overcome their anxiety and fear regarding their illness. It also helps to debunk myths that cancer patients hold on to from their communities, some of which could be detrimental to their treatment and recovery process.

Establishment of special counselling units for cancer patients

During the study, it came to the fore that there is no established counselling unit at the oncology unit. Rather, patients received counselling as part of their consultation process. It would be

beneficial to have a special counselling unit at the oncology units manned by qualified staff with special counselling sessions held for patients and their primary caregivers on specific days. This would provide emotional and psychological support to patients. It will also ensure that cancer patients and their primary caregivers are better informed about cancer and would also be in a better position to resist false advice and information from outsiders.

Moreover, doctors and other health care providers including nurses and pharmacists should engage cancer patients in an open non-judgmental dialogue about the alternative medicine they use. This will enable them advise patients appropriately on the dangers or otherwise of the treatment. Open discussion without judgment will enable cancer patients open up and disclose the kind of alternative treatments they use to their health care providers.

Financial assistance

Financial support from government would do a great deal of good to cancer patients as they have financial challenges due to the high cost involved in their treatment. There are some of them who default on their treatment regimen solely for financial reasons. Patients reported that even though the National Health Insurance Scheme (NHIS) covers breast cancer and cervical cancer, there are shortages in drugs, and the support is not forthcoming. Patients are therefore expected to take care of their bills on their own, something they are unable to do due to the expensive nature of the treatment. There should be the strengthening of the National Health Insurance Scheme to cover the costs of cancer treatments.

Cancer support unit

There should be more cancer support units formed by individuals and non-governmental organizations with the aim of raising awareness as well as funds to support cancer patients.

Herbal research

There should be more research on herbal medicine to help find cure for cancer as some patients prefer it to orthodox treatment due to a number of reasons. Patients reported that it has fewer side effects, is less expensive and readily available to them. Osseo-Asare (2014) indicates that traditional healers, rural communities, chemists and drug companies have all contributed to the shaping of scientific knowledge on healing plants. She highlights cases where African traditional remedies have helped inspire new pharmaceuticals. Vigorous research into plant medicine might lead to the possibility of finding cure for cancers in plants medicine.

Cancer registry

The sad thing is that Ghana does not yet have a national cancer registry that takes records of all cancer related disease, something that health workers talked about and was reiterated by Prof. Clegg-Lamptey (Quicou-Duho, 2015, May 5). Currently, researchers only rely on institutional registries from KBTH and KATH in Accra and Kumasi respectively. A national cancer registry will ensure effective data on cancer related cases.

5.5 Gap for future research

This study was mainly hospital-based. As a result, cancer patients were not visited in their homes to know how they behaved at home and in their various communities due to limited funds and resources. More in-depth study of cancer patients' attitude outside the hospital especially at their homes and work places would enable us have a holistic knowledge of cancer patients' health care practices as well as their attitudes and behaviours in response to their illness condition. Also, prayer camps could not be visited as proposed due to financial and time constraints. Further studies can be conducted in this area.

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APPENDIX I

GLOBAL CANCER INCIDENCE AND MORTALITY BY REGION[3]

Region	Cancer Incidence Cases per year (thousands)	Four Most Common Cancers	% of Cancer Incidence in Region	Deaths per year (thousands)	Four Most Common Causes of Cancer Deaths	% of Cancer Mortality in Region
Eastern Asia	4,145	Lung Stomach Liver Bowel (inc. anus)	19 13 11 10	2,758	Lung Liver Stomach Oesophagus	26 16 14 8
Northern America	1,786	Prostate Breast Lung Bowel (inc. anus)	15 14 13 9	692	Lung Bowel (inc. anus) Breast Stomach	27 9 7 7
South-Central Asia	1,514	Breast Cervix Lip, oral cavity Lung	15 10 7 7	1,023	Breast Lung Stomach Cervix	10 9 9 8
Western Europe	1,110	Prostate Breast Bowel (inc. anus) Lung	16 15 12 11	483	Lung Bowel (inc. anus) Breast Stomach	21 11 8 7
Central & Eastern Europe	1,037	Bowel (inc. anus) Lung Breast Stomach	13 13 12 7	638	Lung Bowel (inc. anus) Stomach Breast	19 13 9 8
South America	808	Breast Prostate Bowel (inc. anus) Lung	14 14 8 8	440	Lung Bowel (inc. anus) Stomach Prostate	13 8 8 8
South-Eastern Asia	786	Breast Lung Liver Bowel (inc. anus)	14 13 10 9	529	Lung Liver Bowel (inc. anus)	18 14 8

[3] Figures represent 2012 data. Reliability of cancer statistics varies across countries (Cancer Research UK, 2014a, 2014b).

					Breast	8
Southern Europe	769	Bowel (inc. anus) Breast Lung Prostate	14 13 12 12	390	Lung Bowel (inc. anus) Prostate Breast	20 11 7 7
Northern Europe	526	Prostate Breast Bowel (inc. anus) Lung	16 15 12 11	245	Lung Bowel (incl. anus) Prostate Breast	21 11 7 7
Western Asia	318	Breast Lung Bowel (inc. anus) Prostate	13 12 9 7	189	Lung Bowel (inc. anus) Breast Stomach	18 8 8 8
Eastern Africa	287	Cervix Breast Kaposi Sarcoma Oesaphagus	16 12 11 6	208	Cervix Kaposi sarcoma Breast Oesophagus	14 10 8 8
Northern Africa	221	Breast Liver Lung Bladder	18 9 7 6	143	Liver Breast Lung Bowel (inc. anus)	13 11 9 6
Central America	196	Breast Cervix Prostate Stomach	13 10 10 7	111	Stomach Lung Liver Prostate	10 9 8 8
Western Africa	182	Breast Cervix Liver Prostate	22 15 13 10	131	Liver Breast Cervix Prostate	18 16 13 11
Australia/ New Zealand	143	Prostate Bowel (inc. anus) Breast Melanoma of skin	18 13 12 10	52	Lung Bowel (inc. anus) Prostate Breast	19 11 8 7
Caribbean	91	Prostate Breast Lung Bowel (inc. anus)	21 12 11 9	53	Lung Prostate Bowel (inc. anus) Breast	17 15 9 7
Southern Africa	83	Breast Prostate	12 12	51	Lung Cervix	13 9

		Cervix Lung	10 9		Breast Oesophagus	8 8
Middle Africa	74	Cervix Breast Prostate Liver	16 15 9 8	57	Cervix Breast Prostate Liver	14 11 10 10
Melanesia	10	Breast Cervix Lip, oral cavity Liver	14 12 11 7	7	Cervix Liver Lip, oral cavity Breast	10 10 10 10

Source: Cancer Research UK, Worldwide Cancer Incidence, 2014a
Cancer Research UK, Worldwide Cancer Mortality, 2014b

APPENDIX II

INSTITUTE OF AFRICAN STUDIES
UNIVERSITY OF GHANA

INTERVIEW GUIDE ON

CULTURE AND HEALTH CARE PLURALISM AMONG CANCER PATIENTS IN GHANA

CANCER PATIENTS

Introduction

This is one of four interview guides aimed at collecting information on culture and health care pluralism among cancer patients in Ghana. Below are some of the issues that will be considered when interviewing cancer patients.

1. Patients will be interviewed on what they perceive as the cause of their sickness (Paying attention to the mention of natural causes (infections, stress, organic deterioration) or personalistic causes (witchcraft, oracles, curse, envy, sorcery).
2. Patients will be asked about what their perceptions of illness are in general.
3. Patients will be asked if they knew about cancer before they acquired it.
4. They will also be asked for the local name and local perception of cancer if there is any.
5. Narratives will be taken on patients' disease discovery and diagnosis procedure (Paying attention to the order in which diagnosis was made).
6. Narratives on patients search for cure and treatment will be taken (paying attention to the order in which places are mentioned and whether they are orthodox or unorthodox or a combination)

7. Patients will be asked for the reasons for the choice of places they seek treatment.
8. Patients will be asked who their care takers are, as well as the people who know about their condition.
9. They will also be asked about what their coping strategies are.
10. They will be asked about how they make their choice of places of healthcare. Why one place and not the other?
11. They will be asked about who influences you their choice of healthcare.
12. They will be asked whether there are cost imperatives in their choice of healthcare.
13. They will be asked about the details of their regiment of treatment, how comfortable or uncomfortable they are.
14. They will also be asked about how they feel about their treatment. How their families feel about their treatment, and whether they will want to continue with their treatment or will change.
15. They will also be asked about how they think by using their current treatment they are getting better than before.

APPENDIX III

INSTITUTE OF AFRICAN STUDIES
UNIVERSITY OF GHANA

INTERVIEW GUIDE ON

CULTURE AND HEALTH CARE PLURALISM AMONG CANCER PATIENTS IN GHANA

HERBAL/SPIRITUAL CENTRES

This is one of four interview guides aimed at collecting information on culture and health care pluralism among cancer patients in Ghana. The following questions will be asked when conducting interviews with management of two herbal centers as well as a center where Chinese medicine is practiced.

1. What do you know about cancer?
2. What do you consider as the cause(s) of cancer?
3. Why do you hold such a belief?
4. What is the centre's position on the cause(s) of cancer?
5. Why does the centre hold such a belief about the cause(s) of cancer?
6. How often do people come here for cancer treatment?
7. What kinds of cancer are mostly recorded at your centre?
8. How do people hear about this centre?
9. What therapeutic options do you employ in treating cancer?
10. Can you give a detailed regiment of procedures cancer patients have to go through for treatment?
11. Does treatment differ across the various kinds of cancer?

12. Does treatment differ according to the different stages of cancer?
13. What are the costs associated with various treatment regiments?
14. How do you consider the efficacy of your treatments?
15. Have you been successful in healing some cancer patients? Are there any records to prove?
16. What is the socio-economic profile (young, old, rural, urban, poor, rich, etc.) of cancer patients who come here for treatment?
17. How do you compare the financial cost of healthcare at your center to that of the hospital or any other place?
18. Do you think there are any negative side effects to any medication that you prescribe?
19. If so, tell me about the negative effects.
20. Is there any counseling session for patients apart from providing medications?
21. How do you diagnose cancer?
22. How do you know if the treatment you prescribe is effective?
23. Do you advocate a combination of other healthcare treatments; for example combining your own with what other facilities provide?
24. What is your perception on seeking alternative sources of treatment of cancer?
25. What is your credential as the head of this center? (Training, education, experience)

APPENDIX IV

INSTITUTE OF AFRICAN STUDIES
UNIVERSITY OF GHANA

INTERVIEW GUIDE ON

CULTURE AND HEALTH CARE PLURALISM AMONG CANCER PATIENTS IN GHANA

HOSPITAL STAFF

Introduction

This is one of four interview guides aimed at collecting information on culture and health care pluralism among cancer patients in Ghana. The following questions will be asked during interviews with leadership of hospital staff at the cancer unit.

1. I should be grateful if you could make available statistics of patients receiving cancer treatment in this facility?
2. What types of cancer do you often treat here?
3. At what stages of the disease do patients usually report to the hospital?
4. When diagnosed to have a cancerous condition, what do the affected do?
5. Do they seek regular treatment in the hospital?
6. For how long are they willing to remain for treatment?
7. Do patients sometimes pause in the course their treatment, (radiotherapy and chemotherapy), to seek alternative treatment and if so, why?
8. Do such patient return after a while?
9. Are there statistics to show this?

10. Is there an effective counseling and support unit or service for cancer patients in this hospital and how relevant is it to the healing of the patient?
11. Do cancer patients have alternative sources of treatment?
12. What do you know about other places cancer patients seek treatment?
13. What is your perception about these places?
14. How do those other treatments interfere with biomedical treatment of cancer?
15. How do you think those alternative treatments affect the lives of cancer patients?
16. What other challenges do you face with treating cancer patients?