

**SCHOOL OF NURSING AND MIDWIFERY
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LEGON**

**WOMEN'S EXPERIENCES WITH TRADITIONAL AND ORTHODOX
MANAGEMENT OF CERVICAL CANCER IN THE ACCRA METROPOLIS**

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(10295001)

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DECLARATION

This is to certify that this thesis is the result of research undertaken by David Ayangba Asakitogum towards the award of the Masters of Philosophy Degree in Nursing from the School of Nursing and Midwifery, University of Ghana, Legon. The research has been undertaken under the guidance and supervision of Prof. Lydia Aziato and Dr. Lillian Akorfa Ohene, both of the School of Nursing and Midwifery, University of Ghana, Legon.

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ABSTRACT

Cervical cancer is a public health problem that affects women's well-being worldwide. The literature on cancers from high-income countries indicates that patients combine traditional and western medicines for the treatment of cancer. However, there is scant empirical evidence on cervical cancer patients' experiences in both traditional and western medicine usage. The study, therefore, explored the experiences of women on the traditional and orthodox management of cervical cancer in the Accra Metropolis using the traditional healers' practices and western management approaches for psychiatric diseases (Abbo, 2011) as an organizing framework for the study. The study employed a qualitative exploratory descriptive design. Twelve (12) women with cervical cancer in the Accra Metropolis were purposively recruited. Face-to-face interviews were conducted using a semi-structured interview guide. The interviews were audio recorded with each interview lasting between 30 – 45 minutes. The interviews were then transcribed verbatim and thematic content analysis procedures were applied to generate the findings. The participants believed that they acquired the disease through their parents' genes, inappropriate personal lifestyle, and behaviours. They also believed that vagina hygiene education could prevent cervical cancer. The women experienced pain and blood loss during cervical cancer screening; vulva itching and hair loss as side effects of chemotherapy and radiotherapy; four women were declared free of cervical cancer after combined use of traditional and orthodox treatment; some attributed their improved health status to orthodox treatment only; and others felt their health status was worse with the traditional treatment. However, all participants lived their lives in fear and they coped with the disease by using faith in God. The women suffered physically, psychologically, sexually, and socially whilst undergoing cervical cancer treatment in Ghana. Therefore, Ministry of Health should formulate appropriate national policy for cervical cancer care with priority on human papillomavirus vaccinations to all girls and women in order to prevent cervical cancer, and step-up efforts on cancer education programmes.

DEDICATION

I dedicate this work to my family especially my late Mum and Dad, Madam Ataribono Ayorigya and Mr. Asakitogum Nsoh both of blessed memory. Your selfless sacrifice for the Aziigra-tia's family is very fruitful. Enesty my wife, Loma and Bryan my children, Cynthia, Ancilla, and Prospera my sisters; I love you dearly for providing me emotional support and your prayers. I also dedicate the work to all women affected by cervical cancer in the world.

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LIST OF ABBREVIATIONS

ACS:	American Cancer Society
ART:	Abdominal Radical Trachelectomy
VRT:	Vaginal Radical Trachelectomy
CINAHL:	Cumulative Index to Nursing and Allied Health Literature
DSM V:	Diagnostic Statistical Manual V
EBSCOhost:	Elton Bryson Stephens Company
FIGO:	International Federation of Gynecology and Obstetrics
GARH:	Greater Accra Regional Hospital
GLOBOCAN:	Global Burden on Cancer
GHS:	Ghana Health Services
GHS-ERC:	Ghana Health Services Ethics Review Committee
HBM:	Health Belief Model
HIV:	Human Immunodeficiency Virus
HPV:	Human Papilloma Virus
IARC:	International Agency for Research on Cancer
ICD 10:	International Classification of Diseases 10
KBTH:	Korle-Bu Teaching Hospital
MOH:	Ministry of Health
NAC:	Neoadjuvant Chemotherapy
NIC:	National Institute of Cancer
NMIMR-IRB:	Noguchi Memorial Institute for Medical Research Institutional Review Board
OPD:	Out Patient Department
Pap:	Papanicolaou Smear Test

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PUBMED:	Public/Publisher MEDLINE
TB:	Tuberculosis
TCA:	Thematic Content Analysis
TV:	Television
UK:	United Kingdom
USA:	United State of America
WHO:	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Cancers are among the most chronic debilitating disease affecting the lives of people around the world. Cervical cancer is the second most common cause of cancer deaths in women worldwide after breast cancer (WHO, 2012). Globally, there are over 500,000 new cases of cervical cancer and 250,000 deaths per year due to the disease (Haghshenas et al., 2013). The disease results in about 274,000 deaths annually (GLOBOCAN, 2014). Thus, cervical cancer remains a major public health problem in low-income countries especially those in Africa where there is an estimated death rate of 53,000 women per year (Arbyn, Castellsagué, de Sanjosé, Bruni, Saraiya, Bray, & Ferlay, 2011). Ferlay, Shin, Bray, Forman, Mathers, and Parkin (2010a), also approximated 85% of all cervical cancer-related burden globally to have occurred in the low-income countries. Furthermore, the rates of death of cervical cancer patients have been on the increase in contrast to the decreasing trends in terms of its incidence and morbidity in the high-income countries (Murthy, Li, Azzam, Narasimhadevara, & Yezzo, 2010).

Many studies in Africa have also shown that cervical cancer is frequently diagnosed and is also the leading cause of cancer-related deaths among women in Sub-Saharan Africa (Ferlay, Shin, Bray, Forman, Mathers & Parkin, 2010b; GLOBOCAN, 2012; Jemal, Bray, Center, Ferlay, Ward & Forman, 2011). It has again, been noted that most of the cervical cancer cases in Sub-Saharan Africa are diagnosed at the advanced stage of the disease (Eze, Emeka-Irem, & Edegbe, 2013). The cause and risk factors associated with cervical cancer is varied but the exposure to the Human Papilloma Virus (HPV) types 16 and 18 through sexual intercourse at either early age or having multiple sexual partners have been highly implicated (ACS, 2015; Ago, Agan, &

Ekanem, 2013; Eze et al., 2013; Okolo, Franceschi, Adewole, Thomas, Follen, Snijders & Clifford, 2010; WHO, 2015). Other identified risk factors responsible for the development of cervical cancer include smoking; immunosuppression; prolonged use of oral contraceptives; intrauterine device; three or more full-term pregnancies (ACS, 2015); as well as poverty (Eze et al., 2013).

Cervical cancer incidence rate is reported as 15.2 incident cases per 100,000 women per year (Berraho, Obtel, Bendahhou, Zidouh, Errihani, Benider & Nejjari, 2012), constituting approximately 8% of the global burden of cancer among women (GLOBOCAN, 2014). In developing countries, the mortality rate of cervical cancer is estimated to be 9.6 per 100,000 women, which is twice the rate in developed countries. This disparity in prevalence between the developing and developed worlds can be attributed in part to lack of effective cytological screening programmes (Wright, Faseru, Kuyinu & Faduyile, 2011). The disease tends to occur in middle-aged women mostly below the ages of 50 and rarely in women below age 20 (ACS, 2015; Eze et al., 2013)

Cervical cancer is preventable and preventing infection with the causative virus (HPV) would reduce the incidence of cervical cancer since the disease process takes over 10 years to develop into full cancer (Bazarra-Fernandez, 2010). Vaccination against the HPV is therefore recommended and presently there are two prophylactic vaccines (GlaxoSmithKline "Cervarix" and Merck "Gardasil") available for vaccination. WHO (2015) recommends the HPV vaccination to young girls between the ages of 9 and 13 years before their first sexual encounter.

In Ghana, the incidence and mortality rates of cervical cancer has been reported to be among the highest cases in the World and it was predicted that by 2025 an estimated 5,000 new cases, as well as 3,361 related deaths, will occur in Ghana due to the disease (Lingwood, Boyle,

Milburn, Ngoma, Arbuthnott, McCaffery, Kerr, 2008; WHO/ICO, 2007). The lifetime risk for women in Ghana to develop cervical cancer is estimated at about 2.2% (2000 women) annually (WHO/ICO, 2007). Another study observed that at any hospital in Ghana, cervical cancer accounts for about 60% of the gynaecological cancers diagnosed and 70% of these cases are mostly diagnosed at the advanced stages (Duda, Chen, and Hill, 2005).

There are various management approaches available for the treatment of cervical cancer but the prognosis is always poor when the treatment starts at the advanced stage of the disease (Vistad, Cvancarova, Kristensen, & Fossa, 2011). Vistad et al. (2011) identified surgery, chemotherapy, radiation, and hormonal-therapy as effective orthodox treatment options for cervical cancer. The side effects and complications of these treatment options can be very serious. Traditionally, surgical management of early-stage cervical carcinoma is considered as a sterility procedure, since the uterus is removed (Thomakos, Trachana, Davidovic-grigoraki, & Rodolakis, 2016). Other complications of the orthodox treatment for the condition include psychosexual dysfunction, depression, grief, stress, fatigue, and decreased quality of life (Barnas, Skret-Magierlo, Skret, & Bidzinski, 2012; Gizzo, Ancona, Saccardi, Patrelli, Berretta, Anis et al., 2013; Plante, 2013). These demonstrate significant emotional and physical impact on the patients' life. In order to minimize some of these effects, radical vaginal trachelectomy combined with laparoscopic pelvic lymphadenectomy was considered as the appropriate fertility sparing approach for early-stage cervical cancer (Dargent, Brun, Roy & Remi, 1994; Thomakos et al., 2016).

Traditional medicines or alternative therapies for cancer management also exist (Cassileth, 1996). These are treatments other than the orthodox treatment. WHO (2012) defines traditional treatments as the sum of knowledge, skills, and practices that are based on theories,

beliefs, and experiences unique to different cultures which are used to maintain health, prevent diseases or treat physical and mental illnesses. The use of traditional medicines or alternative therapies has increased greatly in recent times especially among cancer patients (Elliott, Kealey, & Olver, 2008; Oh, Butow, Mullan, Beale, Pavlakis, Rosenthal & Clarke, 2010).

It is estimated that 60–80% of the population go to traditional healers for their health care needs (Eisenberg, 1998; Ekor, 2013), suggesting a massive consumer base. Many of these consultations are carried out at the same time as the patient may be receiving care from the modern health care system (Abbo, 2011; Gardiner, Graham, Legedza, Ahn, Eisenberg, & Phillips, 2007). In Australia, up to 61.5% of cancer patients used alternative and complementary medicines during their cancer treatment (Klafke, Elliott, Wittert & Olver, 2012). Herbal medicine is reported to be the most preferred choice of treatment for the majority of people around the world particularly in developing countries (Aziato & Antwi, 2016). The reasons or facilitators identified for the use of alternative medicines included active religious practice, the effectiveness of herbal medicine, personal preference for herbal medicine, and perceived ineffectiveness of western medicine (Aziato & Antwi, 2016; Klafke et al., 2012).

Many countries have integrated herbal/traditional medicine into their national health system for its practitioners to consult and prescribe herbal/traditional medicine for clients both in the government and private hospitals (Chang et al., 2016; Lao & Ning, 2015; Aziato & Odai, 2016). A study has shown that herbal medicines used alone are relatively safe, but the risk for adverse reactions may increase when herbal and hospital drugs are taken concurrently (Jeong et al., 2012). These combined systems of traditional –orthodox management of diseases especially when used for cervical cancer can have dire consequences and there are very little works done on the experiences of women with the traditional and orthodox management of cervical cancer.

Therefore a qualitative study will provide detail information on Ghanaian women experiences with traditional and orthodox management of cervical cancer in the Accra Metropolis.

1.2 Problem Statement

Globally, cervical cancer is mostly diagnosed at the advanced stage of the disease (Eze et al., 2013; Murthy et al., 2010). Both medical and surgical management of the disease at the advanced level is likely to show very little efficacy and may rather result in serious complications (Vistad et al., 2011). It has been observed that the high-income countries have well-developed screening programmes for early detection and treatment of cervical cancer. Although the disease is frequently diagnosed at an early stage in these countries, the percentage of women suffering from the disease still remains high (Greggi & Scaffa, 2012; Thomakos et al., 2016).

It has been established that the orthodox management of the disease at the advanced stage do not yield positive results and its attendant high cost of treatment puts a serious financial toll on the patient and the family (Kennedy, Haslam & Pryce, 2007; Maree, Masalo & Wright, 2013). Studies have also confirmed that a good number of patients have used and/or combined traditional forms of treatment while in the hospitals (Abbo, 2011; Eisenberg, 1998; Jeong et al., 2012) and cervical cancer patients may not be an exception.

In Ghana, 64.3% of the cervical cancers are diagnosed first time at IIA – IVB stages of the disease (Duda et al., 2005), and this had resulted in 2,006 deaths out of 3,038 cases –that is 66% death rate in 2008 (Adjei-Mensah, 2013). Personal experience with some women who were diagnosed with cervical cancer at Mabiha-Ghana, Bolgatanga indicated that they had initiated herbal insertions prior to the screening and diagnosis of the cases. Late reporting and diagnosis

of cervical cancer and the patients' experiences with cervical cancer management, therefore, need to be investigated.

Previous studies in Ghana and beyond were based on incidence, awareness, screening, and the lived experiences of cervical cancer patients (Abotchie & Shokar, 2009; Domfeh, Wiredu, Adjei, Ayeh-Kumi, Adiku, Tettey, & Armah, 2008; Edwin, 2010; Hobenu, 2015). Little is known about what treatment cervical cancer patients start at home before reporting late at the health facilities for orthodox treatment. This study, therefore, seeks to explore the experiences of women on traditional and orthodox medicines management approaches for cervical cancer in the Accra Metropolis using the theoretical framework for traditional healers' practices and western management approaches for psychiatric diseases as an organizing framework.

1.3 Purpose of the Study

The purpose of the study is to explore the experiences of women on the traditional and orthodox management of cervical cancer in the Accra Metropolis.

1.4 The Specific Objectives

The specific objectives are:

1. To explore the belief systems women with cervical cancer have on cervical cancer in the Accra Metropolis;
2. To investigate the experience women with cervical cancer have on traditional and orthodox diagnostic systems in the Accra Metropolis;
3. To describe the experiences of women with cervical cancer on traditional and orthodox interventions for cervical cancer in the Accra Metropolis; and
4. To document the experience women with cervical cancer have on the outcomes of traditional and orthodox interventions for cervical cancer.

1.5 Research Questions

The study seeks to answer the following research questions:

1. What belief systems do women with cervical cancer have on cervical cancer in Ghana?
2. What experiences do women with cervical have on the diagnosis of cervical cancer in Ghana?
3. What experiences do women with cervical cancer have on the traditional and orthodox management of cervical cancer in Ghana?
4. What experiences do women with cervical cancer have on the outcome of traditional and orthodox management of cervical cancer in Ghana?

1.6 Significance of the Study

Findings from the study are expected to inform policymakers to design appropriate interventions for cervical cancer management. Healthcare providers would be guided by the findings of this study on what women with cervical cancer expect from healthcare providers as well as the consequences of treatment they received from healthcare providers. The findings may inform the development of training modules for healthcare professionals to improve the care of women living with cervical cancer. It will also contribute to nursing knowledge building in the research area.

1.7 Operational Definitions

Cervical Cancer: abnormal growth of body cells in the cervix of the uterus.

Women with Cervical Cancer: refers to women who are 18 years and above and have been medically diagnosed to have a malignant growth of the cervix that forms part of the womb or uterus and has received both traditional and orthodox treatment for the cancer in the Accra metropolis at the time of data collection.

Experience: the situations that a woman living with cervical cancer goes through on a prescribed treatment.

Traditional Management: refers to any treatment women with cervical cancer have received at home for the purpose of curing the disease (cervical cancer) before reporting to the hospital for treatment or combination of home treatment with hospital treatment for the purpose of curing cervical cancer.

Orthodox Management: refers to hospital treatment given to women with cervical cancer following medical investigations and diagnosis in the hospital for the purposes of curing cervical cancer.

Belief System: refers to people pre-conceived ideas (perceptions) about cervical cancer including its causes, preventions, the disease process, and its management outcomes.

Intervention/Treatment: refers to a set of processes and procedures designed for the purpose of curing cervical cancer or alleviating the suffering of cervical cancer patients.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter describes the literature on experiences of women on the traditional and orthodox management of cervical cancer, which are deemed relevant to this study. The chapter also presents the conceptual framework of the traditional healers' practices and western medicine management approaches of psychiatric diseases and its constructs. A narrative literature review on women experiences of cervical cancer management is then carried out based on all the constructs of the model employed. This was presented as women beliefs about cervical cancer, women experiences with cervical cancer diagnosis, women experiences of cervical cancer interventions, and women experiences with cervical cancer treatment outcomes.

2.1 Literature Search

A search for literature on women's experiences with traditional and orthodox management of cervical cancer was done using databases such as Scopus, Science Direct, PubMed, Google search, Google Scholar, CINAHL, Sage, Taylor & Francis, EBSCOhost, and BioMed Central. Keywords used in the search include "experience" or "women experience" in combination with terms such as "indigenous medicine" or "traditional medicine", "orthodox medicine" or "western medicine", "cervical cancer management" or "cervical cancer treatment", "diagnosis", "beliefs", "interventions", and "treatment outcome" or "management outcome". Most of the articles retrieved were published between 2010 and 2018 in the English language on the above databases concerning women experiences with traditional and orthodox management of cervical cancer. In all, 152 articles were retrieved from the databases – 112 international articles, 26

articles from Africa, and 14 Ghanaian articles. Eleven (11) books on research methods, and other related subjects, as well as 9 gray kinds of literature, were utilised for this thesis.

2.2 Some Theories Considered Not Appropriate for the Study

In the search for a model to fit the research topic, the health belief model (HBM) and bio-psycho-social model were considered important but not relevant to be used to discuss the experiences of women on the traditional and orthodox management of cervical cancer. These two models are briefly discussed:

The Health Belief Model (HBM) is a model that seeks to explain and predict health behaviours of individuals. Social psychologists such as Hochbaum, Rosenstock, and Kegels developed this model in the 1950s. The model was developed in order to explain the failure of free tuberculosis (TB) health screening programme in the USA (Hochbaum, 1958). It has been used severally to explore a variety of long-term and short-term health promotion behaviours, including studies of cancers (National Institute of Cancer, 2003).

The HBM has four initial constructs, which are 1) perceived susceptibility, 2) perceived severity, 3) perceived benefits, and 4) perceived barriers, with additional two new concepts; clues to action, and self-efficacy (Rosenstock et al., 1988). These concepts form the bases of the model and on the assumption that a person will take a health-related action readiness to act depending on how that person feels the perceived threats and overall benefits of his condition in relation to the concepts. For instance, a cervical cancer victim's health-seeking behaviours as whether to consult the traditional healer or the medical doctor can be explained and predicted using the HBM. However, the concepts in the HBM cannot adequately explore the victim's experiences with the treatment received. This is because the diagnostic tools and interventional

approaches used in the treatment process of cervical cancer are outside the domain of the HBM. Thus, the HBM is an important model but not relevant for this study.

Engel developed the bio-psycho-social model in 1977. It is one of the general models developed to guide orthodox medical practice. The model consists of four concepts – biological factors, the social factors, the psychological factors, and health. The model states that the health of an individual is influenced by the biological, psychological, and social factors and these play a significant role in the functioning of the individual especially in the context of disease or illness (Engel, 1977). The model, therefore, requires all orthodox medical practitioners to subject sick persons to scientific scrutiny in the three-factor domain. This will enable the medical practitioners to detect which factor(s) indeed play a significant role or influence the cause of the sickness and to be able to treat the patient accordingly. Thus, the standard protocol expected from a health facility is that the patient should receive medical care from the medical doctors and nurses, receive psychological care from the clinical psychologists, and also receive social care from the social welfare officers.

Cervical cancer patients are familiar with the operations of the bio-psycho-social model and could share experiences with its treatment. But, the model cannot explore the experiences of the participants in this study regarding cervical cancer care received from traditional healers. Therefore, the bio-psycho-social model alone is not sufficient for this study.

2.3 The Theoretical Framework of the Study: Traditional Healers' Practices and Western Medicine Management Approaches to Psychiatric Diseases.

The traditional healers' practices and western medicine management approaches to diseases, a theoretical framework applied to psychiatric illness is a multi-theory model developed by Catherine Abbo in 2011. The framework was developed to assess and describe the outcomes

of traditional healers' practices and western medicine practices on severe mental illness in Uganda. The researcher did not identify any previous study that has used the framework apart from the proponent.

The framework has four main domains: concepts of patient's health belief systems, disease diagnostic tools, disease intervention approaches, and the expected outcomes of combined treatment of traditional and western medicine for psychiatric illness. These domains are described subsequently.

In the framework, the health belief systems comprise of patient-practitioner shared beliefs, the concept of mental illness, patient expectations from a practitioner, and treatment in a familiar environment. This part of the framework makes use of Kleinman's explanatory model of illness to describe patient's health-seeking behaviours and health service utilisation. Kleinman asserts that healing and treatment must be situated in a particular social and cultural context. Patients, therefore, have their individual beliefs about illness, choices of treatment alternatives, and the roles the sick and practitioners play in order to help the sick recover either in the health care-related institutions or in the traditional and cultural set up (Abbo, 2011). Thus, health belief systems are generally influenced by illness.

Diagnosis of diseases is described as the power or ability to tell accurately what is wrong with the sick person or being able to prophesy the cause of diseases. The framework identifies culturally accepted diagnosis such as spirits telling, possessions, and witchcraft seeing as well as scientific diagnoses such as diagnostic statistical manual V (DSM V), international classification of diseases 10 (ICD 10), and laboratory investigations as the diagnostic tools for psychiatric illness (Abbo, 2011).

Traditional & Orthodox Management Experiences of Cervical Cancer

Interventional approaches for diseases are ways and means by which health practitioners and traditional healers treat or manage sick persons of their illnesses. Disease intervention approaches in this theoretical framework encompasses culturally accepted interventions – use of herbs, appeasing spirits, and witchcraft removal as well as western medical interventions – use of drugs, electroconvulsive therapy, and psychotherapy for psychiatric patients (Abbo, 2011).

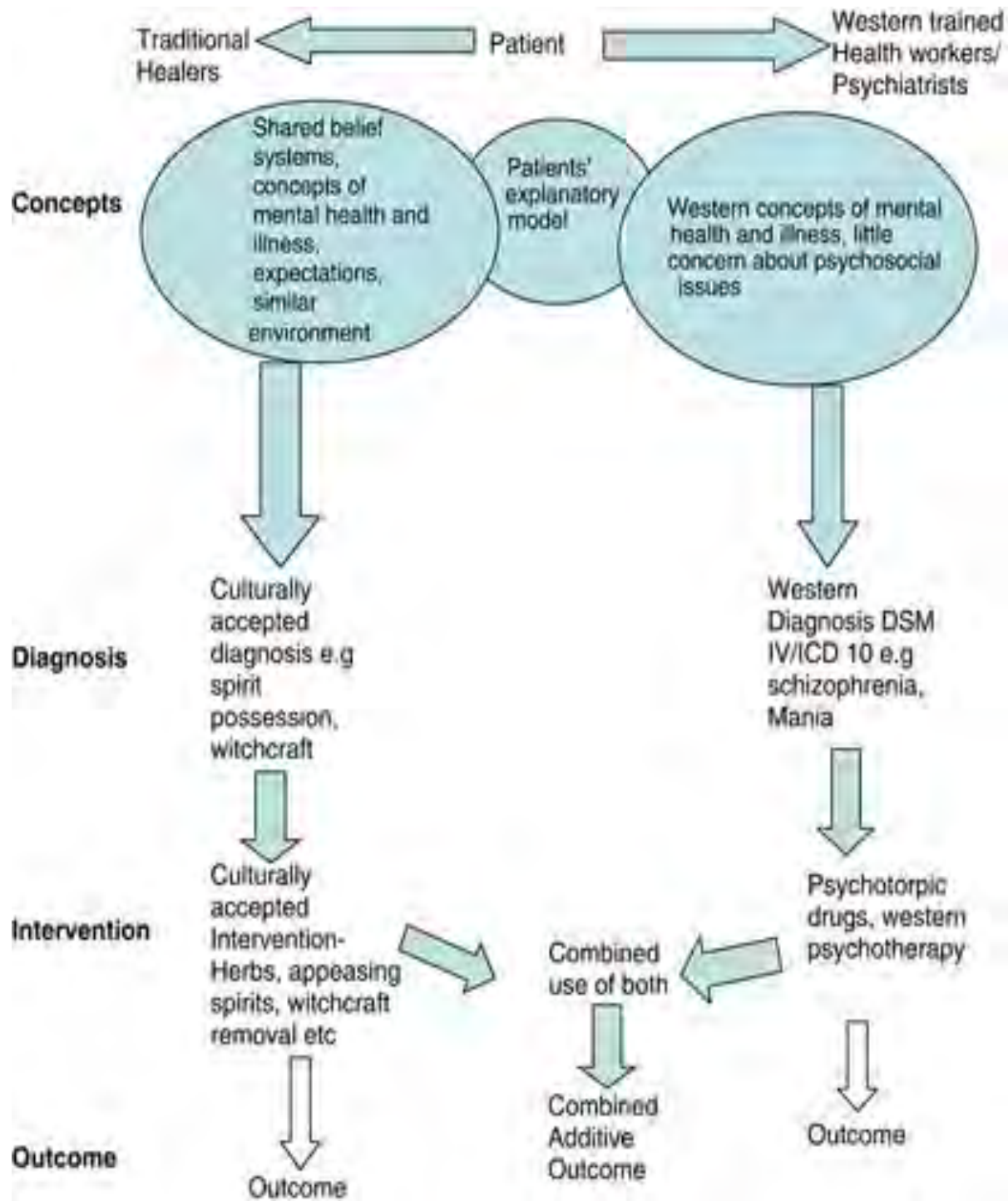


Fig. 2.1: Theoretical Framework for Traditional healers' practices and western medicine management approaches applied to psychiatric illness. Source: Abbo (2011).

2.4 Justification and Relevance of the Traditional Healers' Practices and Western Medicine Management Approaches to Psychiatric Diseases for the Study

This theoretical framework is made up of health concepts derived from three models. These models are the Explanatory model of illness, Bio-psycho-social model, and the Holistic healthcare model. The other concepts include diagnostic tools used in traditional healers' practices and western medicine practices, the interventions used in traditional healers' practices and western medicine practices, and the outcomes of treatment given. These constructs can adequately assist in exploring women experiences with traditional and orthodox management of cervical cancer.

The Explanatory model of illness states that illness influence health-seeking behaviour and health service utilisation, and that healing is anchored in a particular social and cultural context (Kleinman, Eisenberg, & Good, 1978). The Bio-psychosocial model is a general care approach that posits that biological, psychological (thoughts, emotions, and behaviours), and social factors all play a significant role in human functioning in the context of disease or illness (Engel, 1977). This model was critiqued on the basis that western medicine practitioners focused more on biological etiology (Richter, 1999) which sometimes might result in clients' dissatisfaction leading to clients opting for traditional healers.

The Holistic model is a health care model that seeks to treat the ill person as opposed to the illness with the goal of achieving optimal physical, mental, emotional, social, and spiritual health. The model is much used by traditional healers who lack the etiological capacity to diagnose with evidence (Klinghardt, 2005). In the light of these, a single model of health care is not sufficient in meeting the entire health needs of human beings at the time of illness and disease (Sewell, 2008). Therefore, there is the need for this study to be based on this theoretical

framework which has a broader view of patients' health seeking perspectives and contacts with different categories of health care providers to help achieve a comprehensive view of women experiences with traditional and orthodox management approaches of cervical cancer in the Accra Metropolis, Ghana.

2.5. Women Belief Systems of Cervical Cancer

The belief systems of individuals have a lot of influences on their health-seeking behaviours especially when they are ill (Ase et al., 2017). This is important because the belief about the cause of ones' illness including cervical cancer determines which route the sick person should take to treat it or get the sickness to resolve effectively. For example, a focus group discussion among women and community opinion leaders in a rural setting in Ethiopia reported that the cause of cervical cancer was due to punishment from ancestors and personal gods for abnormal sexual behaviours of married women and also attributed the cause to the works of the devil (Birhanu et al., 2012). In the same vein, Marlow, Waller, and Wardle, (2015), in their qualitative interview with women from ethnically diverse community in London also reported the belief about women having sexual intercourse outside of marriage as the cause of cervical cancer.

On the contrary, a study on cervical cancer knowledge among pregnant women in a rural district hospital in Ghana revealed that the beliefs of women breaking community taboos, and the insertion of herbal concoctions into the vagina are the causes of cervical cancer (Asakitogum & Dede, 2012 unpublished). Similarly, the use of substances such as chemicals on men's penis (Williams & Amoateng, 2012) and vagina herbs (White et al., 2012) by both men and women to enhance sexual enjoyment was believed to be contributors for cervical cancer in Africa.

Intravaginal practices such as vagina cleansing and insertion of products were reported in a study conducted in Los Angeles to be high among both young ladies and older women. It showed that pre-sexual intravaginal washing was 54% and post-sexual intravaginal washing 70%. Most of the intravaginal products identified included lubricants, petroleum jelly, body lotions, oil and wet wipes. Some of the reasons for intravaginal products use were to increase lubrication, preparing for sex, smelling good and preventing sexual infections (Brown et al., 2016). A study in Odisha, India also observed that participants who used reusable absorbent pads were more likely to contract urogenital infections than those who used disposable pads. It further stressed that lower education among participants was a major factor associated with menstrual hygiene management and urinary tract infections (Das, Baker, Dutta, Swain, & Sahoo, 2015).

Studies in Africa on knowledge and causal factors for cervical cancer have documented that women believed that menopause or retention of blood (Ngugi et al., 2012; White et al., 2012), and dirty vagina (White et al., 2012) were responsible for the development of cervical cancer. Moreover, eating bad food and heredity were also reported to be the cause of cervical cancer (Chirwa et al., 2010; Ngugi et al., 2012). Other studies have also queried multiple sexual partners as acts that make women vulnerable to cervical cancer (White et al., 2012; Williams & Amoateng, 2012).

Furthermore, a systematic review of qualitative studies on cervical cancer found that poor nutrition, oral contraceptives use, parity, smoking, and immune-suppression were the contributors for the high incidence of cervical cancer (Driscoll, 2016). It was found in a study among cervical cancer patients in Brazil that the women attributed the cause of the disease to unbearable emotional situations in their life and therefore blamed themselves for the illness. They also believed that cervical cancer is a bad luck disease (Peuker et al., 2015). León-

maldonado, Wentzell, Brown, and Allen-leigh, (2016) in their study in Mexico, reported that women attributed human papillomavirus transmission to men's sexual behaviours specifically infidelity and poor hygiene. Some of their participants also believed that untidy public toilets and genetic traces could also cause human papillomavirus transmission.

The notion that cancers, in general, have no cure has an impact on the beliefs of women about orthodox management of cervical cancer. For instance, a study in Ethiopia reported that women in their qualitative study believed that western medicine could not cure cervical cancer. They, however, indicated that the cause of cervical cancer has no links with western medicine (Birhanu et al., 2012). The most common beliefs studies have identified on cervical cancer were women fear of being diagnosed with cancer, the belief of not being at risk for cervical cancer, the perceived low benefits of cervical cancer screening, and some cultural and religious factors (Mcfarland, Gueldner, & Mogobe, 2016; Nwobodo & Ba-Break, 2016). All these beliefs and misconceptions of women about cervical cancer may lead them to seek traditional healing for the disease.

Traditional medicine is highly viewed to be associated with holistic health care services (Abbo, 2011). Those who patronised traditional medicine believed that the medicine reconnects them to their land, ancestors and spiritual whelms that enhance personal overall wellbeing (Shahid, Finn, Bessarad & Thompson, 2009). Ethiopian women, therefore, believed that cervical cancer could be cured with the use of traditional medicine and the use of holy water (Birhanu et al., 2012). Similarly, a study in Australia revealed that people believed that traditional healers perform a variety of roles that promote healing and wellbeing. These roles include providing strong psychological and spiritual support, being able to address the supernatural dimensions of the cause, and as well provide social support and counseling (Adams et al., 2015).

Mwaka, Okello, and Orach, (2015) reported that women have superior socio-cultural beliefs about traditional medicine for the treatment of cervical cancer. They also have perceived greater privacy in accessing traditional medicine but reported to have experienced difficulties paying medical bills in the hospital. These barriers to orthodox care of cervical cancer and the community believe in the effectiveness of traditional medicine encourage women early seeking of traditional medicine for cervical cancer treatment. This eventually leads to late reporting for orthodox treatment at the advanced stage of the disease (White et al., 2012). The combined effect of faith healing, herbal and orthodox medicines were believed by cervical cancer patients in Ghana to have given them a complete cure of the disease (Binka, Nyarko, Awusabo-Asare, & Doku, 2018).

Mistrust of orthodox health care providers and lack of understanding of the causes of cervical cancer were reported to be some of the reasons for women dislike of orthodox treatment for cervical cancer (Driscoll, 2016). Hinnen et al. (2014) also observed low trust between patient-physician relationships in their study in the Netherlands and reported that lower trust levels were associated with more patient emotional distress. The reasons cited in their study for patients distrust for western medicines were; western medicine unfamiliarity, the culture, and traditions of the women. These reasons on trust issues explain patients' continuous engagement with traditional healers. On the contrary, however, a study in Manchester, U.K on the evaluation of gynaecological oncology services reported a high level of patients' trust and confidence in nurses who provide the services of psychosexual counseling to cancer patients including cervical cancer patients (Iavazzo, Johnson, Savage, Gallagher, & Datta, 2015). Another study in Denmark showed that cancer patients who lack trust in physicians and have no relation with health

professionals, a nurse navigator offered a new trusting relationship to them and such patients felt reassured (Thygesen, Pedersen, Kragstrup, Wagner, & Mogensen, 2012).

Currently, WHO has approved two vaccines – Cervarix and Gardasil to be used by member countries for vaccination against the human papillomavirus as a drastic measure for the prevention of cervical cancer and other neck and head cancers (Aggarwal, 2014). A systematic review of human papillomavirus vaccination cost-effectiveness found that the vaccine is cost effective and should be considered as the panacea for cervical cancer burden reduction in low-income countries (Silas et al., 2018). Another systematic review of the efficacy of the human papillomavirus vaccine had estimated between 86 – 100% potency of the vaccine in preventing cervical cancer (Mousavi, Moosazadeh, Afshari, & Davoodi, 2017). These systematic reviews findings, therefore, give hope for the fight against cervical cancer.

Another study on the underutilization of cervical cancer prevention services in low-income countries identified unfamiliarity with cervical cancer preventive services, the service inaccessibility, African communities regarded the talk of reproductive issues as taboo especially on cervical cancer, and women subordinate position in the family as barriers against women ability to access cervical cancer screening and prevention services (Chidyaonga-Maseko, Chirwa & Muula, 2015). Similarly, a study in Papua New Guinea found that women reproductive issues especially gynaecological cancers were least spoken about and the lay meanings of diseases in the Papua New Guinean society were varied with biomedical diagnosis (Ase et al., 2017). These socio-cultural beliefs continue to affect the knowledge of women on reproductive health problems.

Incarcerated women in Kansas jail in the USA believed that HPV infection is as serious as human immunodeficiency virus (HIV) infection, and some attributed the HPV infections they

contracted to their ex-husbands but did not know the potential of HPV as the cause of cervical cancer. They also expressed frustrations about the age requirement for the HPV vaccine and therefore desire more for HPV infection information and vaccinations before they get out of prison (Pankey & Ramaswamy, 2015).

However, a qualitative study in Zambia on the evaluation of national human papillomavirus vaccination programme has identified medical misconceptions about the vaccination. It was revealed that Zambians believed that the vaccine was used as a birth control measure. The health professionals also had fears about the side effects of the vaccine and thought that there was inadequate empirical research on the vaccine, thus, many Zambians did not patronise the vaccine (Venturas & Umeh, 2017). The transmission of human papillomavirus infection was reported in a study among Chinese American female immigrants in the USA to be related to poor personal hygiene, the use of public washrooms or heredity. The women believed that people who eat fresh food, fish, and living a less-stress life are less prone to cervical cancer. They, however, felt ashamed of talking about their gynaecological problems to people especially male physicians because of cultural beliefs about self-exposure and loss of self-control (Seo, Li, & Li, 2018).

The literature review on this section identified cervical cancer beliefs as punishments from ancestors and gods, breaking taboos, and the use of chemicals and vagina verbs for sexual enhancement as the causes of cervical cancer. Women also believed that cervical cancer could be cured with the use of traditional medicine, thus women are more likely to combine traditional and orthodox treatment for cervical cancer based on these beliefs.

2.6 Women Experiences with Cervical Cancer Diagnosis

It is observed that close to 12,360 women are newly diagnosed with invasive cervical cancer yearly and one-third of this number die from the disease (Pareja et al., 2015). Studies have shown that many women felt emotional discomfort going through the diagnostic procedures for cervical cancer. For instance, women experienced fear, embarrassment, shame (Marlow et al., 2015), uncomfortable with male gynaecologist or physicians and felt ashamed to go back and complete the required regular screening for the disease (Williams & Amoateng, 2012). Some women also expressed the loss of their privacy and human dignity through the process (Ding, Hu, & Hallberg, 2015). These negative experiences were well remembered by all women and could be a barrier to repeat attendance for cervical cancer screening (Marlow et al., 2015).

Studies have shown a range of adverse psychological outcomes of cervical cancer screening such as anxiety, distress, and worries (Bosgraaf et al., 2013; Sharp et al., 2013). Connor et al. (2015) reported that women experienced both short-term and long-term psychological distress whilst going through cervical cancer screening. In their qualitative study, the short-term distress women experienced immediately after the colposcopy included feeling unprepared for the procedure, having a negative feeling about the procedure and attending the clinic in the absence of their partners. The reported long-term distresses were related to concerns about fertility in the future, fear of being diagnosed with cervical cancer, and concerns about sexual intercourse. Other long-term distresses expressed were the impact of after-effects of post procedural in the life of the woman, and continues clinical evaluation.

In other context, women express satisfaction with a self-collected sample for HPV testing and their readiness to continue to screen in a similar manner (Iqidbashian, Boveri, Spolti, Radice, Sandri, & Sideri, 2011). For example, women in a community interventional study in Canada

were perceived to be comfortable with a self-collected sample for HPV testing. This evidence showed that the screening rate among the interventional group was increased by 15.2% against an increase of 2.9% in the control group who went through the routine cervical cancer screening. The self-collected sample for HPV testing relieves some of the discomfort and embarrassment that some women feel with a Pap smear, which may be a barrier to screening (Duke et al., 2015).

Furthermore, studies have reported poor attitudes of cervical cancer screening officers towards women undergoing the screening process. For example, about 95% of human immunodeficiency virus (HIV) infected women who have had Pap test done within the last three years in the USA experienced no encouragement from the health care providers to continue their regular screening for cervical cancer. They alleged that their partners supported and encouraged them to receive the regular screening for it (Ogunwale et al., 2016).

According to Ase et al. (2017), most women in their qualitative study in Papua New Guinea have expressed extreme doubts about the credibility of the diagnosis of cervical cancer. Their uncertainties arise from the women lack of knowledge about the location of the cervix, while the thought of the unreliability of the test has to do with the approach and attitudes of the screening officers.

The commonly diagnostic experiences of cervical cancer patients discovered under this section of the literature review revealed that women were uncomfortable with male gynaecologists or physicians during Pap smear test. There were poor attitudes of cervical cancer screening officers towards the women, and the women expressed doubts about the credibility and reliability of cervical cancer diagnosis in the hospital. These can be described as barriers to cervical cancer early diagnosis and treatment.

2.7 Women Experiences with Cervical Cancer Interventions

Interventions designed for the management of cancers ranges from the use of chemotherapy, surgery, radiotherapy and hormonal replacement. Clients receiving one or more combinations of these interventions undoubtedly have huge experiences with the treatment processes. A qualitative study conducted in India has described the experiences women expressed in relation to cervical cancer treatment as best experiences and worst experiences (Pati, Chauhan, Mahapatra, Nayak, & Weller, 2017). The best experiences women perceived included supportive behaviour of medical staff such as administering treatment promptly, providing information regarding treatment regimen, and offering moral and mental support continuously to the patients to help fight the disease. The worst experiences on the other hand related to pain, traveling long distances for the treatment, frustration with delays in arriving at the diagnosis and poor attitudes of some staff.

Many women undergoing cervical cancer treatment have expressed high levels of financial stress and challenges (Maree et al., 2013). The medical cost for cervical cancer management especially radiotherapy is being described by patients as too high such that the ordinary women cannot afford it (Hobenu, 2015). Those women who were employed also lost their wages to the disease (Pati et al., 2017) and all of these depletes the family income thereby decreasing the socio-economic status of the family. This also adds on to the global economic burden of cancers especially on the low-income countries (Jemal et al., 2011).

Literature has shown that women have experienced emotional and psychological distress when dealing with the treatment of cervical cancer (Zeng et al., 2011). Women feel that they are a burden on their families, and unable to perform their usual roles. It is reported that upon being diagnosed with cancer, apprehension about cure and treatment procedures were often the causes

of distresses (Pati et al., 2017). Other sources of worries identified in other studies were long hospital waiting times, poor communication and information delivery, and problems with referral systems were described as the healthcare experiences that caused cancer patients' distress (Tishelman et al, 2010).

Studies have also identified stigma and discrimination as major barriers patients of cervical cancer faced in seeking treatment for the disease. Women feel stigmatised by health care providers and this has a negative impact on the care they received (Birhanu et al., 2012). Stigma by community had diminished their social support. This, therefore, makes cervical cancer patients reluctant in disclosing their condition to their partners and family members because of the social consequences associated with it. This suggests that there should be a strong support for culturally tailored interventions to improve care delivery and enhance the patients' social wellbeing (Birhanu et al., 2012; Carrasquillo, Fatil, Jones, Jean, & Kobetz, 2015). Women also feel stigmatized because of impending disability and death, isolation or verbal stigma from husbands, family, and community (Nyblade, Stockton, Travasso, & Krishnan, 2017).

Again, a qualitative study conducted in Uganda on cervical cancer treatment pathways reported that patients have experienced delay diagnosis and delay treatment for the condition. Delay diagnosis was associated with the women making consultations with husbands, relatives, and friends which had influenced decision and timing for seeking health care. The women also had repeated consultations at private clinics and lower level health facilities. The inability to make the right diagnosis or make a quick referral at these smaller health facilities also contributed to the delay treatment experiences (Mwaka et al., 2015).

Studies support the assertion that women experienced physical and sexual difficulties in the treatment of cervical cancer (Maree et al., 2014; Tornatta, Carpenter, Schilder, & Cardeness,

2009). Cervical cancer survivors in a study considered sleep disturbances, urinary difficulties and sexual dysfunctions as the highest impact of cervical cancer treatment in their lives (Westin et al., 2015). Similarly, a comparative study indicated that survivors of cervical cancer have worse physical and mental health-related quality of life as compared with survivors of other cancers (Wenzel et al., 2015).

Qualitative studies have documented side effects that women experienced with cervical cancer treatment. Women who have used radiotherapy have experienced signs of vaginal stenosis (Miles & Johnson, 2014), signs of long-term urinary and gastrointestinal toxicity (Georg et al., 2013) and sexual dysfunction (Jensen & Froeding, 2015). Similar findings were found with women who underwent a radical hysterectomy, and hysterectomy with bilateral pelvic lymphadenectomy such as bladder and bowel dysfunction, dyspareunia, and decreased sexual arousal. Long-term side effects such as sexual or bladder dysfunction, pelvic cyst formation and lymphoedema of the legs were also reported (Kokka, Bryant, Brockbank, Powell, & Oram, 2015) respectively.

However, side effects such as late miscarriage and premature labour were identified in pregnancies where the women have had a trachelectomy (Kokka et al., 2015). Recurrence of the disease was also reported in a quantitative study among women with a tumour larger than 2 cm to be 20.8% after Vaginal Radical Trachelectomy (VRT) and 20% after Abdominal Radical Trachelectomy (ART) (Rob, Pluta, Skapa, Robova, 2010). The combined use of brachytherapy and chemotherapy also results in serious acute complications experienced by patients during and immediately after the radiotherapy (Wolf et al., 2017). Chronic or late complications were also reported to have developed six months after completion of the treatment (International Atomic Energy Agency, 2012; Ntinga & Maree, 2015). Women with cervical and breast cancers in a

study in the USA revealed that they encountered disrespect and rudeness from hospital staff during cancer treatment. These inhumane manhandling had resulted in anger and sadness of the patients. Thus the patients had a change of behaviour relating to their willingness to seek care and choice of health care provider (Thorburn, Kue, & Levy, 2012).

Studies have identified varied treatment support systems for cervical cancer. The literature showed that women support themselves through group contributions (Garrett & Barrington, 2013; Francis et al., 2011). Some husbands were said to have been supportive in finding a cure for their wives (Garrett & Barrington, 2013). Friends, relatives and health care providers sometimes also provide financial support to cervical cancer patients (Calvo et al. 2010). A study in a rural Ghana also identified treatment support systems for cervical cancer to be social, financial and non-material support from family members and the church (Binka et al., 2018). The study further reported that the coping strategies for the patients included sexual abstinence, conscious about personal hygiene maintenance, and the use of defense mechanism of disease denial. Rogala et al. (2016) also reported prayer, deep hope, and conscious attention diversion from the disease as the coping strategies used by their participants.

This literature showed that interventions such as chemotherapy, surgery, and radiotherapy are available in the hospital for cervical cancer patients but no specific traditional intervention for cervical cancer treatment has been reported. Qualitative studies reported some common experiences of patients with orthodox interventions as stigma and discrimination, physical and sexual difficulties, and varied side effects of chemotherapy, surgery, and radiotherapy.

2.8 Women Experiences with Cervical Cancer Treatment Outcomes

Quantitative studies have shown good overall survival rates of surgeries for cervical cancer patients. For instance, Xia et al. (2016) study in China reported an overall survival rate of

43 patients who received surgery for cervical cancer with lymph node metastasis to be 66.6% and disease-free rate as 34.1%. Similarly, another study estimated a three-year disease-free and overall survival for nodal positive patients to be 54.4% and 57.9% (n=368) respectively without adjuvant radiation (Wolf et al., 2017). Again, other studies reported 5-year recurrence-free survival in patients with parametrial involvement and upfront surgery to be 58.5% (Ho et al., 2004) while Wolf et al. (2017) 5-year overall survival rate among 368 patients with FIGO stage II B cervical cancer in their study was 70%.

Neoadjuvant Chemotherapy (NAC) with surgery is promising equally good outcomes for cervical cancer patients. A study with 28 cervical cancer patients shown 21.4% complete response (no residual disease after NAC), microscopic residual disease (tumours smaller than 3 mm in the largest diameter) was 39.3%, macroscopic residual disease after NAC was also 39.3%, 71.4% retained their fertility with mortality rate of 10% (2/20) (Robova et al., 2014). However, women with tumours greater than 2 cm in size have experienced a high rate of treatment relapses (12.5%) after radical trachelectomy (Beiner & Covens, 2007). Meanwhile, women have experienced better pregnancy outcome after simple trachelectomy than after radical trachelectomy or abdominal trachelectomy (Rob et al., 2011).

Furthermore, a study among survivors of gynaecological cancer on the impact of treatment on health and well-being revealed that gynaecological cancer survivors experienced a high frequency of health conditions which have a direct association between treatment modality and specific health concerns (Westin et al., 2015). However, Wenzel et al., (2015) reported that there was an improvement of cervical cancer patients' quality of life following their interventional study in which psychosocial telephone counselling was provided to the patients. This confirms the views that psychological interventions have positive effects on the

psychological functioning and quality of life of patients with cancers (Faller et al., 2013). It is again been shown that patient education improved cervical cancer knowledge of women. A one – time interactive, multimedia educational intervention improved cervical cancer knowledge and attitudes among low-income women but had no effects on cervical cancer screening behaviour in USA Latina (Valdez, 2016).

A focus group discussion among women and men on cervical cancer treatment outcomes in Kenya revealed that the treatment was beneficial in preventing sudden deaths and brings improvement in the wellbeing of the patients (Ragan et al., 2018). They, however, expressed concerns about the treatment side effects, treatment-related fear and stigma, marital discord and financial access to orthodox treatment as the major challenges confronting the patients. Similarly, a qualitative study in rural Ghana on cervical cancer patients' coping strategies found that the women attributed a complete cure of cervical cancer to the combined effect of faith healing, herbal medicine usage and orthodox therapies they got from the hospital (Binka et al., 2018).

Furthermore, a 20 years update on the outcomes of radical surgery and radiotherapy with 343 participants in Italy indicated 10% (31) death rate due to cervical cancer complications, the overall survival rate of 72% and 77% respectively, and 28% recurrence of cervical cancer as a whole. It further identified risk factors for cervical cancer patients' survival to include histotype of cancer, tumour diameter and lymph node status of the victim (Landoni et al., 2017). Ben-Arye et al. (2017) observed in their study that herbal medicine used with chemotherapy by patients with ovarian cancer may influence the anti-cancer activity of the chemotherapy. Studies have also described the marital status of persons living with cervical cancer as poor due to widowhood and divorces (Ma et al., 2012; Bates & Mijoya, 2015).

Literature under cervical cancer treatment outcomes was limited to quantitative reviews of overall survival rates of surgeries, chemotherapy, radiotherapy or their combination for cervical cancer patients.

2.9 Summary of Literature

There seems to be no study on women beliefs or experiences on traditional management practices on cervical cancer. Similarly, there are little empirical studies on the experiences of cervical cancer patients on the orthodox diagnosis and intervention processes from the patients' perspective. Although, much work has been done on cervical cancer, most of the literature on cervical cancer boards on the causative agents of the disease, effectiveness of screening, and treatment quality as well as patients quality of life experiences. Again, the studies that I have reviewed have no theoretical framework that guided the studies. In view of these inadequacies, there is an existing knowledge gap in the area of the experiences of patients with cervical cancer on the traditional and orthodox management of cervical cancer and therefore, this study sought to fill this knowledge gap.

CHAPTER THREE

METHODS

3.0 Introduction

This chapter describes the conduct of the study. It covers areas such as research design, research setting, study population, sampling technique and sample size. The inclusion and exclusion criteria, data collection tool, pretesting, the procedure for data collection and data management are also discussed. In addition, analysis, methodological rigour and ethical considerations are described.

3.1 Methodology

This study employed a qualitative approach. Qualitative research is used when the investigator wants to get in depth understanding of the phenomenon (Mayan, 2009). The philosophical underpinning of qualitative studies is that knowledge is the product of people experiences of things around them and in their life (Polit & Beck 2010) and one's experience is more subjective than it is conjured as objective. This approach is chosen because the researcher is interested in understanding the experiences cervical cancer patients go through when accessing health services from both traditional healers and orthodox medical practitioners.

Again, the researcher did not seek to make generalisations but to try and explore what is it that patients with cervical cancer endure with various treatment modalities (real experience). Unlike quantitative studies, qualitative studies major focus is to collect quality data for the purposes of describing and understanding the real meanings (Creswell, 2014). With this methodology, the researcher was able to conduct face – to – face interview with the participants in order to discuss in detail their subjective experiences with cervical cancer management in the Accra Metropolis.

3.2 Research Design

The design of this study is an exploratory descriptive design. This is a type of qualitative research design which describes the experiences of the study participants (Creswell, 2014) about the phenomenon (cervical cancer management approaches). This design was chosen because the researcher is interested in exploring experiences of women with cervical cancer who attempted treating the cancer with traditional medicine and have also received hospital treatment for the cancer in the Accra Metropolis.

The exploratory descriptive study allows the researcher to follow-up on emerging themes. Therefore, during the conduct of the study, the exploratory nature of the study permitted a flexible approach to the data collection whereby the researcher was able to follow-up with participants for clarifications of issues discussed. The descriptive nature also allowed direct quotations from the participants to support the presentation of findings. This design has yielded a rich data on the phenomenon particularly as participants were encouraged to share their experiences which reflected the traditional and orthodox management approaches used to treat cervical cancer. The design also allowed participants to freely express themselves with minimal interference from the researcher who probed occasionally. This method was seen as empowering since participants were allowed to express themselves in an open way as compared to closed-ended questions used in quantitative methods (Mayan, 2009).

3.3 Research Setting

The Accra Metropolis is the research setting for this study using the reproductive health unit in Greater Accra Regional Hospital as an outlet for recruiting the participants. Accra is a cosmopolitan metropolis in the Greater Accra Region. It is the capital city of Ghana and has a land size of about 200 square kilometers with a total population size of about 1,695,136 people.

Its annual growth rate is about 3.36% (Ghana Statistical Service, 2012). Accra as a city has eleven (11) sub-metropolitan areas – Ablekuma Central; Ablekuma North; Ablekuma South; Ashiedu Keteke; Ayawaso Central; Ayawaso East; Ayawaso West-Wuogon; La, Okaikoi North; Okaikoi South; and Osu Klottey. The indigenes of Greater Accra are Gas and they speak the Ga language. Their primary occupation is fishing and trading. The immigrants formed about 44 % of the total population of Accra. The varied ethnic characteristics of these immigrants including those of the Gas make Accra a mixed culture society. Other languages such as Asante Twi, Fante, Ewe, Hausa, Adangbe, and English are spoken in the Accra Metropolis.

The Accra Metropolis houses the government of Ghana administrative businesses as well as international business transactions and other private organisations. The Metropolis also has a lot of public and private schools including University of Ghana, Legon. In terms of health facilities, there are a total of 28 government hospitals including Greater Accra Regional Hospital, 60 private hospitals, 130 health centres, and Korle-Bu Teaching Hospital (KBTH) – the national and major referral Medical Centre in Ghana.

Greater Accra Regional Hospital (GARH) is the second largest hospital in the Accra Metropolis. The Hospital has a comprehensive cervical cancer screening programme and clients are referred from other hospitals including Korle-Bu Teaching Hospital to GARH to have cervical cancer screening and testing done to inform further management. Thus, GARH is noted as cervical cancer screening and diagnosis Centre in the Accra Metropolis. Therefore, Greater Accra Regional Hospital was used as the outlet for the recruitment of participants for this study. The reason is that the Hospital has a Unit well equipped for diagnosing cervical cancer and the facility also treats cervical cancer using surgical operation (hysterectomy). They also, in turn, refer advanced diagnosed cervical cancer cases to KBTH for chemotherapy and radiotherapy

management. Accra Metropolis is used as the setting because of its cultural diversity of indigenes and immigrants living together.

3.4 Target Population

The target population in research refers to the total number of people in which a researcher is interested to recruit participants for a study (Korb, 2012). However, qualitative research participants are selected based on their unique knowledge, experiences or views related to the study (Munhall, 2012). Therefore, the target population for this study was all women diagnosed with cervical cancer who have received hospital treatment and have used traditional medicine in the treatment of cervical cancer in the Accra Metropolis.

3.5 Inclusion Criteria

The study included women diagnosed with cervical cancer who have commenced treatment for at least 6 months and are 18 years old and above. The women either had started traditional treatment for the cancer or combined both traditional and orthodox treatment for the cancer in the Accra Metropolis. They all willingly accepted to participate in the study. Again, they were women who could speak Ga, Fante, Grune, Asante Twi (local dialects) and English language. This helped the researcher to easily transcribe the recorded data verbatim since he understands the above-mentioned languages.

3.6 Exclusion Criteria

The study excluded women diagnosed with early stage (1A-1B1) cervical cancer. Those women who met the inclusion criteria but were found to be too ill to participate as well as those who refused to participate were also excluded in the study.

3.7 Sample Size and Sampling Techniques

Sample size is the total number of participants in a study (Khan, 2012). Data saturation was used to determine the actual sample size for this study. Data Saturation is reached when the researcher no longer gets new insights from the data (Creswell, 2014). However, the sample size for this study was 12 women with cervical cancer and by this, there were no new insights from the interviews.

Sampling technique is one of the key distinguishing features between quantitative research and qualitative research. In quantitative studies, where the aim is to generalize findings to the larger population, random sampling techniques and statistical probability theory are applied (Mayan, 2009) whilst in qualitative research where the concern is to get the meaning of the phenomenon or obtain quality information and not to generalize, a convenience and purposive techniques are commonly used (Crouch & McKenzie, 2006). Notwithstanding the distinctions, sampling is the selection of participants from a target population who share similar features of the target population (Khan, 2012). A purposive sampling method was used to select the study setting and outlet for data collection for this study because of the presence of the services the outlet institution provide and the fact that the National Radiotherapy Centre is in the Accra Metropolis which serves as the main cancer referral center in the country. Similarly, purposive sampling method was used to select women with cervical cancer who have accessed both traditional and orthodox medicines and have the requisite knowledge and qualities to participate in the study.

3.8 Data Collection Tool

The data for this study was collected using a semi-structured interview guide. The interview guide was developed by the researcher and his supervisors based on the objectives of the study.

The guiding questions were classified into two sections. Section A was used to obtain the socio-demographic data of the participants while section B had questions on health beliefs about cervical cancer, diagnosis of cervical cancer, interventions of cervical cancer, and cervical cancer management outcomes pertaining to both traditional and orthodox management approaches (see Appendix A) for details. A tape recorder was employed with the permission of participants for recording the conduct of the interviews. The researcher also used field diary to take notes of important non-verbal clues to confirm and support verbal responses. The data was enriched with probing questions.

3.9 Pre-testing the Interview Guide

The interview guide was pre-tested using two participants in Greater Accra Regional Hospital. The pretesting was aimed at clarifying the ability of the interview guide to elicit information that would answer the research questions. It enabled the researcher to determine the time required for each interview and also helped the researcher to improve on his interviewing skills.

3.10 Data Collection Procedure

The researcher visited the GARH, cervical cancer screening unit where he identified the participants by accessing the register for women screened for cervical cancer. The addresses and mobile phone numbers of cervical cancer patients were used to contact them. The participants were contacted through phone calls. The purpose of the study was explained to seek the consent of the participants. After participants' consent, to participate in the study the researcher scheduled interview dates and venues based on agreements with the participants. Seven (7) agreed and were interviewed at GARH. The other five (5) were interviewed at the participant's workplace inside an office. The researcher conducted a face-to-face interview with each of the participants. The interviews were conducted in the English language, and Asante Twi (local

dialet) based on the preference of the participants. The use of participants' preferred language gave an opportunity to the participants to express themselves freely such that detail data was generated (Singleton & Straits, 2010).

The data collection lasted for eight (8) weeks and each interview took between 30 to 45 minutes. Before the start of the interview, each participant was guided to complete the background information sheet (see Appendix A). The completion of background information helped the researcher to understand each participant's background, and also facilitated the participants easily transit into the sharing of personal experiences in the interview. The interview was audiotaped with permission from the participants. The participants were constantly reminded that they could refuse to answer any question without reasons or withdraw from the study at any time. They were assured that their refusal to provide some answers or withdrawal from the study would not in any way affect the care they were receiving at the hospital.

The participants were asked questions on beliefs about cervical cancer, experience with cervical cancer diagnosis, traditional and orthodox management approaches to cervical cancer, and treatment outcomes (see Appendix A) and only participants who met the inclusion criteria were interviewed. During each interview session, responses of participants were probed and redirected to focus their responses on the objectives of the study. The non-verbal cues such as change of voice tone, eyes tearing, and facial expression was noted as field notes. Each interview was transcribed before the next interview. In all, only two interviews were translated (local dialect) into English before transcription. At each interview, however, a reflective journal was kept noting thoughts, feelings, ideas, moments of confusion, biases, interpretations, and observations. This reflective journal enhanced data analysis and data credibility.

3.11 Data Management Strategies

The transcription of data was done by the researcher himself. During the transcription, the researcher isolated himself from friends and family members and at the same time used an earpiece to listen to the audio recording in order to prevent people from hearing the audio recorded information. The transcripts were saved as a word document on the researcher's personal computer in identifiable folders with security code/password to make them inaccessible to any other person except the researcher and supervisors. The printed transcripts, the field notes and audio records were labeled with codes numbers and pseudonyms and then stored in the researcher's cabinet under lock and key but was made accessible to supervisors for audit trail purposes. The data is to be kept for 5 years and then be discarded according to the data protection Act. The information elicited during the interviews is not to be discussed with any other person apart from the supervisors.

3.12 Data Processing and Analysis

In research data analysis, regardless of whether quantitative or qualitative data, the purpose is to organize, provide structure to, and elicit meaning from the data. This is quite challenging in qualitative data analysis because of its large amount of data and the fact that there are no universal rules for analyzing such data (Polit & Beck, 2010). However, data in this study was analysed using Thematic Content Analysis (TCA). Thematic Content Analysis is been described as the most foundational for qualitative data analysis. It allows the researcher to read the text repeatedly and identifies common themes that represent the true content of the entire data set and the same time ensures that the themes are guided by the constructs of the model used in organising the study (Anderson, 2007).

The data analysis in this study was done concurrently with the data collection. After each interview, the data was transcribed verbatim. The researcher read the transcripts severally to be able to elicit the ideas and generate codes for it. This was done through the use of words or phrases that have a bearing on the objectives of the study. The codes were joined together to form subthemes. The subthemes provided a better picture of those codes and where necessary, these subthemes were rephrased to match with the research objectives. Major themes were formed from the subthemes. A major theme had a number of subthemes that provided a better explanation of the meaning of the experiences shared. The researcher then used direct quotes from the participants' responses to consolidate the themes and subthemes for discussion.

3.13 Ethical Considerations

In every research study, the welfare of the participants is critical (Polkinghorne, 2005). The welfare of the women participating in this study was paramount to the researcher. This study of women experiences with traditional and orthodox management of cervical cancer is a non-interventional study. It was envisaged that as a non-interventional study no harm would be done to the participants. However, Johnson and Long (2006) indicated that all research studies must follow the right ethical principles (as in Belmont Report) in order to prevent or reduce the unforeseen harm to human participants. These rights of ethical principles included autonomy, beneficence, non-maleficence, and justice (Belmont Report). These ethical principles were upheld in this study.

The principle of autonomy says that the research participant has the right to agree or refuse to be part of a research study. This study allowed the individual participants to willingly agree to take part without any undue coercion from the researcher. It was only those who were satisfied with the information on the information sheet (see Appendix B) and were willing to

share their experiences with cervical cancer treatment modalities were interviewed. The participants were informed that decision to withdraw could be made at any point during the study period without giving reasons for the withdrawal.

Beneficence is the second ethical principle that encourages researchers to do good at all times when dealing with research participants and this was ensured in the study. The participants were informed from the onset that they would not benefit directly from the study and that there was no compensation package for participation (see Appendix B IV). But indirectly, the information they shared, would help nurses and medical doctors to be able to give more care that is satisfying to other women with cervical cancer in the future.

Non-maleficence is the third ethical principle, which states that do no harm to the research participant, no matter the situation (Belmont Report). As mentioned earlier, this study is not an interventional study and participants were physically free from harm. It was expected that the length of time for the interview would not last more than 60 minutes. This was planned to prevent participants from cognitive exhaustion and talking for a longer time. Other measures put in place to ensure non-maleficence were; to stop the interview in case of participant exhaustion, to provide such a participant with a canned of Malta drink, and to provide psychological counseling by a clinical psychologist in case of emotional breakdown.

The fourth ethical principle that was ensured in this study was **Justice and Fairness**. This principle relates to the researcher being fair and true to every member of the target population (all cervical cancer patients in Accra metropolis) and the selected study participants. Thus, the participants for this study were selected strictly according to the inclusion and exclusion criteria (see page 33). The researcher did not coerce participants in any way during the selection.

All the interviews were audio recorded with the permission of the participants and participants' information was treated with utmost **confidentiality and anonymity**. Participants' privacy was maintained during data collection by conducting the interviews in an office at Ridge hospital or an isolated place in participant's home or workplace. The participants were advised to stop the researcher anytime in the process of the interview they felt their privacy has been interfered with. The participant's data and information contained documents were protected as stated under data management strategies (see page 36) in an attempt to guarantee the confidentiality and anonymity of participants in this study (Aguinis and Henle, 2004).

Lastly, all these ethical considerations described above were examined by the Department of Adult Health, School of Nursing and Midwifery, University of Ghana; Ghana Health Service Ethics Review Committee (GHS-ERC); and Noguchi Memorial Institute for Medical Research (NMIMR) for approval (see Appendix E & F). The GHS-ERC and NMIMR have approved that the approach proposed to carry out the study, which seeks to investigate the experiences of women on the traditional and orthodox management of cervical cancer, is ethical and that the rights and safety of the participants would not be violated. It was only after the substantive certificates of approval – GHS-ERC 011-2017, and NMIMR-IRB 022/17-18 were obtained that paved way for the start of this study.

3.14 Study Trustworthiness

The trustworthiness of a study examines the quality and the true sense of the study results (Lincoln & Guba (1985) cited in Grove, Gray & Burns, 2015). This study ensured trustworthiness by applying Lincoln and Guba (1985) criteria for establishing trustworthiness in qualitative research. According to Lincoln and Guba cited in Grove et al. (2015), the degree of

trustworthiness of a study is determined by the extent to which the findings are credible, transferable, dependable and confirmable.

Credibility refers to a study producing results that reflects the participant's view (Murphy & Yelder, 2010). To ensure this, only participants who met the inclusion criteria were purposively recruited. The researcher transcribed interviews personally and coded the transcripts. There were members checking through debriefing sessions with the participants to confirm responses prior to producing the final research report.

Transferability is the ability to move the findings of a qualitative study to other contexts with similar groups (Petty, Thomson & Stew, 2012). This was achieved by the detail description provided for participants' selection, the data gathering procedure, research setting, and data analysis process. These processes were kept as an audit trail so that the conduct processes of this study would not be in doubt.

Dependability refers to a study being able to yield similar results with other groups in a similar context (Polit & Hungler, 1999). Dependability of this study was ensured by the documentation of the participants' background information; the chosen research method; and the participants were interviewed with the same interview guide throughout. These helped ensured that the research process was logical and traceable. The findings of the study were also peer reviewed and the recorded tapes, printed transcripts, and emerging themes were made available to supervisors for audit trail purposes.

Confirmability is the appraisal of the audit trail of a study by other researchers who agreed that the authors' conclusions are logical (Murphy & Yelder, 2010). The researcher kept a reflective journal containing field notes, analysis notes, audio recordings, and coding details. The researcher reflexivity was maintained by 'bracketing' personal biases (vagina insertions, etc.).

All these made a complete audit trail for independent auditors to go through the appraisal process for this study.

CHAPTER FOUR

FINDINGS OF THE STUDY

4.0 Introduction

This chapter presents the findings of the study. The findings are organised according to the objectives of the study. The structuring of the findings is also guided by the study framework, traditional healers' practices and western medicine management approaches to psychiatric diseases.

The presentation of the findings also covers the demographic characteristics of the participants, the themes, and subthemes of the study. Again, the themes and subthemes of the study were analysed and supported with verbatim quotes from the data gathered. Pre-summary statements for major themes of the study were also provided. The chapter ends with the summary of the findings of the study.

4.1 Demographic Characteristics of Participants

Twelve (12) women participated in this study. The ages of participants ranged between 35 years and 68 years old, with eight (8) of the participants being 54 years or more. Participants' level of education was; tertiary (4), secondary/O' level (3), and basic (5). All the participants were once married but three (3) of them got divorced before the diagnosis of cervical cancer and other three (3) of the women became widows after the diagnosis of the condition. Eleven (11) of the women practice Christianity, and one (1) participant believes in Hinduism.

Seven (7) of the women had their first sexual intercourse between the ages of 11 and 18 years and the rest of the women had their first sexual encounter between the ages of 20 and 28 years. With the exception of three participants who had one (1) sexual partner each, the rest had three (3) or more sexual partners at the time of data collection. Ten (10) out of the twelve (12)

participants believed that their sexual partners had multiple sexual partners. All the participants had children with the least number of children being two (2) and the most being eight (8).

The length of being diagnosed and living with cervical cancer was between 16 months and 6 years at the time of data collection, with few of the women still on follow up visits to the hospital. Regarding the management of the disease, three (3) women had a combination of chemotherapy and radiotherapy, two (2) women had surgery and chemotherapy, one (1) woman had chemotherapy only, and five (5) women had only surgery. All the women have used traditional forms of treatment for the disease. Most of the women have practiced family planning for over 1 year and up to 10 years at the time of interview. Participants most preferred family planning method was the injectable.

The occupation of participants includes; trader (6), ship crew manageress (1), nurse (1), fashion designer (1), evangelist (1), store manageress (1), and teacher (1). The participants spoke the English language except two of them who spoke local dialect – Ashanti Twi during the interview. However, some of the participants could speak Ga, Ewe, Nzema, Fanti, and Krobo. All the participants were living in the Accra Metropolis at the time of data collection. Table 4.2 details the demographic characteristics of the participants (see Appendix G).

4.2 Organisations of Themes

Five themes emerged from the data. The themes include; beliefs about cervical cancer, diagnosis of cervical cancer, cervical cancer interventions, cervical cancer management outcomes, and living with cervical cancer. Four (4) of these themes (beliefs about cervical cancer, diagnosis of cervical cancer, cervical cancer interventions, and cervical cancer management outcomes) were consistent with the constructs of the traditional healers' practices

and western medicine management approaches to psychiatric diseases framework. The fifth theme (living with cervical cancer) emerged from the data.

Subthemes were developed from the data code. In all, thirty-three (33) subthemes emerged from the data. Out of the 33 subthemes, only nine (9) subthemes were consistent with the guiding framework. The main reason for the subthemes inconsistency is the fact that, the framework was designed for psychiatric illness, which has entirely different sets of diagnostic and interventions systems as against those for cancer management. The subthemes were analysed and supported with direct verbatim quotes from the participants. The participants' confidentiality and anonymity were maintained by the use of pseudonyms. Table 4.1 on page 47 shows the themes and subthemes that emerged from the data.

Table 4.1: Women's experiences with traditional and orthodox management of cervical cancer: organisation of themes and subthemes

MAIN THEME	SUBTHEMES
Beliefs about Cervical Cancer	Beliefs about the Causes of Cervical Cancer: • Biological • Behavioural • Do not know the cause of Cervical Cancer Beliefs about Cervical Cancer Prevention: • Vagina Hygiene Education • Human Papilloma Virus Vaccination Beliefs on Cervical Cancer Treatment/Care : • Trust Issues with Care Providers • Familiarity with Cervical Cancer Treatment • Perceived Severity of Cervical Cancer
Diagnosis of Cervical Cancer	Testing for Cervical Cancer Pap Smear Screening Experiences: • Pain • Invasion of Privacy • Lose of Blood • Fear of Cervical Cancer Diagnosis
Cervical Cancer Interventions	Traditional Ways of Treating Cervical Cancer: • Treatment without Diagnosis • Use of Herbal Medicine • Insertion of substance into the Vagina • Prayer for Healing Cervical cancer Orthodox Ways of Treating Cervical Cancer: • Surgery • Chemotherapy • Radiotherapy Cost of Cervical Cancer Treatment Treatment Support System Health Care Provider Actions
Cervical Cancer Management Outcomes	Improved Health Outcomes Poor Health Outcomes
Living with Cervical Cancer	Fearful Life Coping Strategies

To answer the research question: “What beliefs do women with cervical cancer have on cervical cancer in Ghana?” beliefs about cervical cancer emerged from the data as a major theme in this study.

4.3 Beliefs about Cervical Cancer

The participants in this study expressed their beliefs about cervical cancer and its management. They believed that cervical cancer has various causes and thus, had employed different services such as orthodox, and traditional health care services for the management of the disease. The participants’ beliefs about cervical cancer were organised under three subthemes. These include; perceived causes of cervical cancer, beliefs on cervical cancer prevention, and beliefs on cervical cancer treatment.

4.3.1 Beliefs about the Causes of Cervical Cancer

In this study, participants identified perceived causes of cervical cancer. These perceived causes can be described as biological causes and behavioural and lifestyle causes.

4.3.1.1 Biological Causes of Cervical Cancer

Some participants identified the cervix as a hidden organ inside the woman’s body. They also stated that the cervix bears the weight of the baby during pregnancy and these contribute to cervical cancer development.

“...Where the disease is, is the cause of it. See where it is hidden inside the vagina. If something is wrong how will you know ... and it is the same neck that holds your baby when you are pregnant. That is why I think that it is cancer....” (C11).

“Hmm, I don’t know but the way I have seen the thing that is the closing point of your baby when you are pregnant...and I’m imagining the weight of my eight pregnancies resting on that thing. I think that also contributed” (C7).

Again, some of the women indicated that human papillomavirus was responsible for the disease. They, however, believed that they contracted the virus through sexual infections from their

husbands or their male sexual partners. Husbands or male sexual partners were therefore perceived as the reservoir or source of human papillomavirus.

“...Eeerrrr! I really don’t know what causes it but with the little information I had, aaahh it says eee human papillomavirus” (C2).

“It is through infections. Infections! I have two major infections of the vagina. Yes, vagina infections I notice I was itching and I have pains during sexual intercourse. ... The last doctor who treated my infection also called for my husband but he refused to go. Because he knew what he was doing with other women out there. From the gynaecologist, the disease can be caused by a virus gotten through sexual infections. I’m not the outgoing type so how am I supposed to get it? He (husband) gave it to me, period!!” (C10).

A participant who is a retired health professional added that low immunity could also cause cervical cancer.

—Human papillomavirus is responsible for this disease. It is only when you have sexually transmitted infections from your partner which goes on to decrease your immune system that can lead to the disease easily. ...so when you have low immunity it is a cause too” (C3).

Some participants considered cervical cancer as a hereditary disease and believed that they acquired the disease through their parents’ genes especially genes from biological mothers.

—I became very concerned one day when I found out from my uncle that my mother had passed away because of cervical cancer. That was 7 -8 years later before he told me that cervical cancer was the cause of death of my mother. ...so I was looking to do the test and see what God has for me and look, it was passed on to me, I have it.” (C2).

“My mother had breast cancer. My sister who influenced me to do the Pap test was diagnosed and treated for cervical cancer. ...my own results were positive, this you can see that cancer is the disease of my family if your mother has it there is no way you can dodge it ...” (C10).

“I also think that if your parents suffer from this disease before, you can get it too. I’m not sure if that has caused my cancer but the first time I heard about cancer was when one of my aunts died and the doctors said that she died of cancer of the womb...” (C12).

The participants, therefore, believed that the anatomy of the cervix, the action of human papillomavirus, reduced body immunity, and passing of cancer genes contribute to the cause of cervical cancer.

4.3.1.2 Behavioural Causes of Cervical Cancer

Some participants attributed the causes of cervical cancer to multiple sexual partners and lifestyle. The women made references to behaviours such as; wearing of inappropriate and unkempt underwear, eating imported food products (perceived chemically induced foods), and indulging in unprotected sexual intercourse.

4.3.1.2.1 Wearing of Inappropriate and unkempt Underwear

According to the participants, one cause of cervical cancer is the use of non-cotton women's underwear. They also reported that wearing tight dresses could cause excessive heat within the human body and eventually cause cervical cancer.

"I heard that when you don't take good care of what you wear especially your panties you can get cervical cancer. That to me is true because all the dirt from these things (dirty underwear) will travel along the vagina and stop at that place (cervix). But you see, no woman will have many pants and refuse to change what you wear or have soap and will not wash your panties well. I, for instance, growing up I didn't have the luxury to change panties" (C1)

"I don't know the cause. I learned dirty panties can cause some of these diseases. ...Especially when the dresses are not cotton type. But those cotton types are expensive, you can't buy many" (C7).

"I will advise young ladies not to use these fitting dresses. It's not good because it will give you heat and no air for you at that place (cervix). I don't know, but I think some of these things cause the problem (cervical cancer). Now, I wear dresses it is better than trousers" (C9).

A participant attributed the cause of cervical cancer to the prolonged use of the sanitary pad.

"Our mothers were using these racks for their period but we now use a pad and someone will use the pad from morning to evening tonight and will not change it. The underwear too is not cotton, it may be the tighten one. All these can generate cervical cancer". (5)

4.3.1.2.2 Inappropriate Sexual Behaviours

Most of the participants related the cause of their disease to their personal inappropriate sexual behaviours and that of their partners. They identified these inappropriate sexual behaviours as;

first sexual intercourse at an early age, having multiple sexual partners, partner(s) having multiple sex partners, and one indulging in indiscriminate unprotected sex.

Some participants reported that they had their first sexual encounter before age 13. They said that their early exposure to sexual intercourse with men contributed to the disease development.

“...to be honest with you I had my first sexual intercourse before my teen years. And this was not with small boys but real men who knew what they wanted. I have really played the fool of myself for money at the time and the reward is cervical cancer for me ...” (C11).

“...I think starting sex early in life has a role to play in bringing this thing (cervical cancer). I cannot remember exactly but either at the age of 11 or 12, I started this sex thing and I now see that it was not good at all. At some point, I wanted to stop but the urge is always there...” (C2)

Some of the women have attributed the cause of cervical cancer to the acts of having multiple sexual partners or male sexual partner having multiple sex partners.

–Secondly, I was thinking is it because I was changing those men before marriage that has given me this disease? And even after my divorce ..., I still have three (3) relationships with men who have wives. I know I have sinned against God with this. But all these happened before I became a woman of God” (C5).

Furthermore, indiscriminate unprotected sex was labeled as a contributory factor for the cause of cervical cancer. Some participants have expressed their inability to stop unprotected sexual intercourse with their suspected cheating husbands or sexual partners. The participants who reported that they resisted unprotected sexual intercourse with their partners got divorced.

–And also they say having unprotected sex with several men (sounding uneasiness – appears self-guilty with her head lowed and her eyes looking down)...hmm I have some past experience about it...” (C1)

“I don’t want to talk about that man again. I have had enough from him – the lies, the cover-ups and his unwillingness to use a condom with me, all these were the reasons why we parted before I even got to know that I have cervical cancer. I suspect I got the virus from him” (C3)

Criminal abortion was also reported in this study as a cause of cervical cancer. A participant linked the cause of her disease to the uncountable criminal abortions she did in the past.

“...at first in my young age, I did some abortions, Yes! Many abortions on my own, so when it (cervical cancer) started I was thinking it is because of the abortions that made that place (cervix) cancer” (C5).

Interestingly, a participant mentioned eating imported food products or chemicals induced food products as one cause of cervical cancer. She alleged that the cumulative effect of these chemicals in her body was the cause of her sickness.

—My idea was that I used to buy this imported chicken and keep it in my fridge and consumed it with my children. We were consuming it with pig feet which were also imported. So in fact, that is the idea I have...That those things have caused it (cervical cancer). Because I read that, these imported chicken, they inject them with some injections and these injections help them to grow fast and if you chew and chew the bones, some of the drugs they used to inject the animals are kept in the bones...and if you continue eating this for a long time, it can also affect you in that way...” (C3).

4.3.1.3 Do not know the cause of Cervical Cancer

Some of the participants stated that they do not know the exact cause of cervical cancer.

“I don’t know the cause” C7.

“...Eeerrrr! I really don’t know what causes it but ...” C2

“I cannot really tell what has caused my cancer but...” C8

The perceived causes of cervical cancer identified in this study include; the hidden and weight-bearing nature of the cervix, human papillomavirus, inherited cancer genes, wearing non-cotton women’s underwear, early exposure to sexual intercourse, unprotected sexual intercourse, criminal abortion, and effects of chemicals in imported food products or chemically induced food products.

4.3.2 Beliefs on Cervical Cancer Prevention

The participants have expressed beliefs about their own commitment towards cervical cancer prevention. Almost all the participants stated that they kept to their follow up visits with the

doctors simply because of fear of recurrence of the disease. Some participants believed that all women need reproductive health education especially on vagina hygiene and the practice of sex safe. Others believed that getting access to the human papillomavirus vaccine is the surest way of preventing the disease. Eating organic food or foodstuff produced naturally devoid of chemical sprays, and avoiding imported food products were also mentioned as preventive measures against the development of cervical cancer.

4.3.2.1 Vagina Hygiene Education

Participants stated that there is lack of proper reproductive health education in Ghana. They expressed that vagina hygiene education, in particular, is forbidden in the Ghanaian society. They believed that giving vagina hygiene education to women will prevent cervical cancer. Some of the women expressed worry about the use of sanitary pads without any authoritative information on their safeness and effects to consumers. A participant shares her doubts and frustrations:

“...I was advised that the way we put the pads ... Keeping them for long and ...Even how we hanged our underwear can germinate this virus (HPV). Our mothers were using pieces of rags for their period but we now use pads and ...nobody knows what exactly the (pads) are made up of and the effects the (pads) pose on us ...we need proper education on some of these things” (C5).

A 60 years old participant observed that women needed more knowledge on vagina care but parents, teachers, doctors, and nurses have failed in imparting this knowledge to young girls. She attributed the failure to lack of courage or expert knowledge on the subject. She laments:

—All my years of life on this earth both in school and at home and going to the hospital, nobody was brave enough to look into my face and say this is the right way to take care of the vagina. You see so many things have entered here—pointing to the position of the vagina, I even thank God I’m still alive... The health workers should learn and teach women how to take care of the vagina” (C12).

Another participant mourned her late mother and attributed her death to lack of information about cervical cancer. She proposed that there should be health education on cervical cancer in schools, churches, and mosques to help prevent the disease and its associated deaths in Ghana.

“...If my mother had known this she will still be alive today. Had it not been the timely information from my uncle about my mother’s cause of death, my own would have also blown to full cervical cancer and who knows where I would have been by now? We have to talk about all we know about it (cervical cancer) to young girls and all women on regular bases in schools, churches, and mosques...” (C2)

4.3.2.2 Human Papilloma Virus Vaccination

The women mentioned human papillomavirus vaccine as a preventive measure against cervical cancer development. They believed that getting all women and young girls vaccinated with the vaccine would prevent cervical cancer. Some of the participants expressed their desire to be vaccinated against the human papillomavirus to prevent possible recurrence of the disease.

“...Unfortunately, I haven’t had the opportunity to go back to the doctor for the second review. I was supposed to come back so that he will clear me off so that I can take the vaccine...” (C2)

“I was told there is a vaccine for cervical cancer but it is not available. That is sad because all women and girls need it to protect them against the disease. If there is a way that government can help women with it, it will be good...” (C8)

However, one participant believed that eating organic food or food produced naturally could be a remedy for cervical cancer. She alleged that eating green vegetables, nuts, drinking coconut water, and eating *‘aluguntugui’* (local apple) had helped her recover fully from cervical cancer.

“... I change my nutritional style. Formally, I was eating anything at all like imported chicken, meat, and sugary foods in abundance. But when I was diagnosed... I contacted a dietician who told me that if I stopped eating those things, it might help to clear the virus from my system. So I change my lifestyle my eating style to organic foods. I think that has helped me recover fully” (C3).

The participants in this study believed that; mass education on cervical cancer, instituting or promoting vagina hygiene education, providing human papillomavirus vaccination to young girls

and women, and eating natural food products whilst avoiding chemically induced food products can prevent cervical cancer.

4.3.3 Beliefs about Cervical Cancer Treatment

In this study, the women have expressed; trust for their close friends, mistrust for hospital workers, familiarity with traditional forms of treatment, and also expressed that orthodox treatment for cervical cancer is as deadly as cancer itself. These beliefs were discussed under three subthemes – trust issues with care providers, familiarity with cervical cancer treatment, and perceived severity of cervical cancer.

4.3.3.1 Trust Issues with Care Providers

In this study, participants considered close friends, herbalists, natural remedies dealers, nutritional and dietary researchers, and health workers as health care providers.

Some of the women in this study expressed fear for the loss of personal integrity through the inadequate provision of privacy in the hospital.

“You know it is not easy to go to the hospital to talk to people (doctors and nurses) about these things (reproductive health problems)...In the OPD the nurses will always try to know why you have come before they will write to you. There are also many people in the consulting room, sometimes you can’t even talk” (C1)

Most of the participants, however, expressed total trust for their close friends.

“ I have full trust for my friend and that is why when she directed me to that woman who sells those things in the market I had to look for the woman (herbalist) and bought the balm and the herbs” (C11).

“So I talked to my pathologist friend about it because he (friend) has a lot of experiences” (C2).

Some participants believed in nutritional and dietary researchers and natural remedies dealers who speak on radio and TV programmes on cancer management. Even after Pap smear-positive

results, some of the participants consulted these natural remedies providers first and later reported to gynaecologists.

“...I decided to start drinking leaf tea and stuffs like that...An advice I got from one natural remedies dealer that concerns care of cancers...It has helped me, I think!” (C2).

“When I was diagnosed, I talked to a person who has done a lot of research on that disease in relation to the dietary management... I used to listen to him on FM station in the evenings before my diagnosis...And so I believed and trust that he can manage my cancer” (C3).

4.3.3.2 Familiarity with Cervical Cancer Treatment

This study revealed that participants were familiar with the traditional forms of treatment prescribed for cervical cancer.

“They (friends) cut some different (3x) tree leaves and brought to me to boil and use. I boiled those things and I was drinking it and bathing with some too in the house” (C1).

The participants further reported that they took part in the preparation of some of the traditional treatment for their disease.

“I just boiled it and take it like that. I drink it 3 times a day but as much as I can take. Those leaves are just like the chemotherapy treatment according to my research” (C2).

Some of the participants expressed personal closeness with the herbalists. They described the relationships as a family relation, a friend or a sister friend.

“He is my nephew; I think am older than him. Ooh, I think he went to Tech and his first son also went to Tech and did that herbal medicine” (C4).

However, orthodox treatment for cervical cancer was considered by some of the participants as the last resort before death.

“My thinking was that the pastors could help me out because if you take the hospital treatment for cancer you will still die. So when they were sending me to the hospital, I knew I was going there to die” (C12).

4.3.3.3 Perceived Severity of Cervical Cancer

The beliefs about the severity or how serious the patient or family members consider a particular disease such as cervical cancer, may be very instructive in the determination of treatment options. Some of the participants were unaware of cervical cancer seriousness. They indicated that they started traditional treatment initially because they considered the disease as vagina discharges.

“When it started I did not know it will be a serious problem like that. I complained to my friends and I was advised by them to use those things (herbs)” (C1)

“This is a hidden disease. You don’t know that it is killing you and you will be using traditional medicine for it. That one (traditional medicine) too cannot cure you. It is when I came here (hospital) that I got to know how dangerous the disease is” (C4).

On the contrary, some of the participants stated that cervical cancer is a serious disease and believed that orthodox treatment for cancer is as deadly as cancer itself. Thus, they tried to avoid hospital treatment for it.

“Yes, cancer is serious; those days when you hear that somebody has cancer, you are afraid...Because for cancer, there is no cure. The treatment (orthodox) for it will even kill you...That is why I first went to my spiritual pastor before he contacted a professor and we went to the hospital for the treatment” (C6).

“In fact, I was very disturbed because I heard so much about this thing (cervical cancer) and that to go through chemotherapy I will die with this disease all. I panic I was afraid...I came back home for two months. I did not go because I was praying and I was taking this local medicine” (C5).

The beliefs about cervical cancer treatment identified in this study were; that the participants believed that traditional treatment for cervical cancer is familiar, there is trust for traditional care providers, the orthodox treatment for cervical cancer is deadly, and that there is mistrust for orthodox care providers.

In the search for answers to the research question –“What experiences do women with cervical cancer have on the diagnosis of cervical cancer in Ghana?” experience with cervical cancer diagnosis emerged as one of the main themes from the data gathered.

4.4 Experiences with Cervical Cancer Diagnosis

The findings of this study showed that the women were taking through a set of diagnostic procedures in the hospital. These procedures include; Pap smear testing, blood sample analysis, abdominal scans and physical examination. Two sub-themes emerged under this theme; diagnosing cervical cancer, and Pap smear screening experiences.

4.4.1 Diagnosing Cervical Cancer in the Hospital

All the participants have reported that they have undergone series of screening and laboratory testing through which they were diagnosed with cervical cancer in the hospital. They demonstrated that they did and repeated severally these test procedures at different places for the confirmation of the disease.

Pap smear test was reported as the main testing procedure for diagnosing cervical cancer in this study. Participants said that they repeated the Pap smear test several times for cervical cancer confirmation in the hospital.

“The doctor asked me to go there (another hospital) and do some test and I went and did the test (Pap smear)... and he (doctor) told me it was cervical cancer” (C7).

“...they did the test (Pap smear) and said they have found something bad about my womb...they (nurses) pick something from my womb and asked me to send it to the standard board for further testing...” (C6).

“...Yes, so I quickly went to the hospital to have the Pap smear test done. They told me the result was negative but that they have found other vagina infections of which they gave me treatment. It was then on my second Pap smear test that I was told the result was positive” (C2).

In addition to the Pap smear test, participants did abdominal scans for differential diagnosis.

“...So I was given a note to go for a scan. When the results came, the doctor told me that there was no fibroid seen. And I have other test done and everything was perfect but the doctor advised me that it's better I come here (hospital) for the Pap smear and I did. They did another Pap smear there (another hospital) by one other doctor. According to the doctor, they took ecto and endo specimen and sent to the pathology department again. I think it took 21 days I went for the results and they said it was cervical cancer” (C4).

“They did several tests and scans and told me it was necessary to remove the womb. They took something from my genital organs and put it in a bottle and asked me to send it there...” (C8).

Participants also reported that doctors physically examined them and had their blood samples taken for laboratory analysis. They believed that these procedures were necessary for appropriate diagnosis.

“Here, the doctor feels me and they took my blood to the laboratory for testing. They also sent me to another hospital and there too, they did some test and told me that I have cancer with my womb (cervical cancer). I felt that they were doing the right things to help me but the tests were plenty, plenty of tests” (C6).

“Is at the hospital that the doctor did an examination on my body...he also asked me to do some test using blood sample at the laboratory and they took some part of my womb too...he told me its cervical cancer after he has looked at all the results...” (C1).

4.4.2 Pap Smear Screening Experiences

The women reported that they experienced pain, invasion of privacy, anger, frustration, and bleeding in the process of screening for cervical cancer. They attributed these predicaments to the disease and the fact that they needed treatment for the disease.

4.4.2.1 Pain

All the participants indicated that they experienced pain when undergoing the Pap smear procedure. They attributed the pain experienced to the disease state of the cervix and the instruments used for the procedure.

“Oooh, because I have those things; they said bruises, I feel pain when they put that thing inside. It was not comfortable at all” (C2).

“I feel ok but what they were doing was painful...Especially using that thing (instrument) inside the vagina” (C6).

Some women described the pain as sharp and severe.

“They wore gloves and used something like ear cleaner stick and took something out. There was this sharp pain and that was it” (C10).

“It was painful and severe and after, I saw small drops of blood” (C8).

Some of the women indicated that their pains were not satisfactorily managed.

“They told me it (pain) will happen, I don’t know because of that they didn’t give anything for the pain...They said I will be fine” (C8).

“They talk to me about the pain and so I was ok with it” (C1).

However, one participant stated that painkillers were used to managing her pain.

“At the hospital, the pain was severe because I was already having pains in the left leg, so the doctor gave me a prescription to buy painkiller” (C5).

4.4.2.2 Invasion of Privacy

Most of the participants stated that they lost their personal dignity and integrity through privacy invasion during the Pap smear testing. They expressed shame and worry about the removal of their clothes in the presence of male doctors and students.

“Hmmm, it’s not easy for a woman to open yourself like that especially with those male doctors, young doctors. Some people were there and they called them students or national service personnel and they say they are learning. They are always there looking at you and you have to open yourself but that is what the situation has called for, what will I do” (C1)

“...the cervical cancer test I have to lose myself but that was very difficult. It is similar to you are going to give birth. They lay you on the bed as if you are giving birth and your private part is just exposed” (C5).

“Because of sickness you don’t think about people seeing your private organs but it is not good. Even if you are feeling shy you have to put it aside... Yes, I felt and have shyness” (C7).

4.4.2.3 Loss of Blood

Some participants experienced bleeding of the cervix during and after the Pap smear test. They described the bleeding as drops and clots of blood.

“I was given injections so I didn’t feel pain much but there were clots of blood after the test” (C4)

“Though I stop bleeding, when he (doctor) started I feel pains and started bleeding and the doctor said it because there is a sore there” (C5)

“After that, I saw small drops of blood. First, they inserted a metal in my genital part...And used that thing to take something from my genital part. I think the bleeding is due to that” (C8).

The women stated that they have used the sanitary pad to manage the bleeding.

“Ooh, that one I used the pad for it” (C4).

“He (doctor) said I can use the pad to stop the bleeding” (C5).

4.4.2.4 Fear of Cervical Cancer Diagnosis

All the participants expressed some level of fear of cervical cancer diagnosis. They expressed the fear in the form of sadness, psychological and emotional pain, panicking, and fear of death. The reasons for expression of fear were cancer has no cure, cancer treatment is deadly and cancer is dangerous.

Some participants indicated that they were sad and confused with the news of Pap smear-positive results.

“I was really down because I went there on my own and this is it...So when I was on my way home, I was so down (low tone) such that I was asking myself who sent you there? if I hadn’t, I would have my peace of mind. I was really confused” (C10).

“When I got home that day, I didn’t want to talk to anybody and I don’t know who I was. In fact, I was lost” (C6).

The participants expressed serious fear of death before and after receiving the news of cervical cancer diagnosis.

“I was seriously praying that it is not cervical cancer because I heard much about cancer on radio and TV that cancer is deadly. ...Receiving the diagnosis was not easy that I have cancer. I don’t even know whether cervical cancer or whatever cancer, I knew that whatever cancer, it is deadly” (C1).

“When I first came to the family planning and they told me about the disease I really became frightened. I thought it was going to kill me” (C8).

Some of the women described their fear for the diagnosis as panicking.

“They gave me another week and when I came they gave me the results and the woman said I have that sickness (cervical cancer). That time my heart was beating and I was sweating” (C9).

“I panicked I was afraid when he gave me that report. I was told it has no cure; the possibility of the cure is very low. I told one of my sons and he said ooh, this thing is life and death thing ooh ...As for cancer no (3x)...” (C5).

Many participants experienced emotional pain after they were informed about the diagnosis of cervical cancer.

“Hmm, the time I hear that I have cervical cancer, I was always crying” (C6).

“Ooh, it was not easy initially taking that news that I have cervical cancer. I was always thinking about it and asking myself can I be safe and still be able to do my work. It was a difficult time in my life” (C11).

The participants believed that the counseling they received following the diagnoses of the disease helped in the relief of the psychological burden of the cervical cancer diagnosis.

“The nursing sister I talked about had to explain to me what the report was about. She counseled me too and told me that I will have to see a doctor at the hospital for the treatment. That helped me a lot” (C10).

“So the woman said I have to go through cervical cancer operation but added that oh don’t worry the doctor will do it nicely for you don’t worry” (C9).

The diagnosis experiences shared in this study include; pain, loss of personal dignity and integrity, loss of blood, fear of cervical cancer diagnoses, and having to go through testing procedures repeatedly in the hospital.

To answer the research question, —*What experiences do women with cervical cancer have on the traditional and orthodox management of cervical cancer in Ghana?*” cervical cancer interventions/treatment emerged as a theme in this study.

4.5 Cervical Cancer Interventions/Treatment

In this study, the participants interpreted treatment or interventions to mean taking herbs, eating certain foods or fruits, insertion of a substance into the vagina, prayers, surgery, chemotherapy, and radiotherapy. Under this theme, there is five major subthemes – traditional ways of treating cervical cancer, orthodox ways of treating cervical cancer, cost of cervical cancer treatment, treatment support systems, and health care provider actions.

4.5.1 Traditional Ways of Treating Cervical Cancer

Participants in this study indicated that they have used herbal medicine, prayers, and insertion of substances into the vagina for the treatment of cervical cancer. They added that with the traditional care providers no specific diagnosis was made before the commencement of treatment.

4.5.1.1 Treatment without Diagnosis

The study showed that when herbalists and/or friends were confronted with cervical cancer complains, the signs and symptoms presented becomes the basis for prescription of treatment.

“...I discussed with them (friends) what I was going through like the discharges. They didn’t know it was cervical cancer. They knew it is itching, discharges and abnormal bleeding from my private part. And they said when people have those things (signs and symptoms) that are the treatment for it” (C1).

“When I told my friends about how I was feeling, they were advising that it is just a sore if I take that medicine (herbal) it will go. So I started all that for one year and as I was taking it I saw that it is rather becoming severe” (C5)

The data gathered also revealed that close friends and herbalists used previous experience to prescribe treatment for cervical cancer.

“Some of them (friends) said they knew of ladies who have similar problems and have used them (herbs) and they (ladies who used herbs for similar problems) are fine, so I used it too...” (C1)

“You know, she (herbalist) has also gone through that herself, she had that pain when she was in school and was flown to Liberia and there it didn’t work. So she came back to

Ghana and she got that herbs. And since that time she has been treating all these diseases. She has more experience in handling women problems” (C11)

4.5.1.2 Herbal Medicines for Cervical Cancer

Nine (9) out of twelve (12) participants used herbal preparations in the form of a fluid (sap) to treat their cervical cancer. Drinking, bathing, and douching were the means by which the sap was delivered into the body for healing to effect.

“...Tree leaves, branches, different (3x) flowers that they brought. I boiled them before I use. I used some to bath, some to wash my private part, and I drink too” (C1).

“...He gave those things (herbs) to me and instructed me to boil them for 3-5 minutes, sieve it and drink it like water. So I did it and drink twice a day, morning and evening, that is all” (C4).

The women stated that they consulted close friends and herbalists who then prescribed herbs and other substances to be used as a treatment for cervical cancer.

“One of my friends took me to a man who cooks this herbal medicine. He gave me the roots, not the leaves to come home and cook it and use” (C5).

“It was my sister’s friend who brought the herbs from a certain herbalist. We were convinced that it will work since it has worked for others. I never knew my situation was different” (C12).

The women identified the herbal preparation processes as; boiling the herbs and sieving the sap before use.

“...I was drinking leaf tea and some other leaves...I boiled it and sieve the water into a water container and drink it” (C2).

“No, it was not only the balm that I used. She also showed me some roots to buy and boil it, sieve it and drink as well. She said combining these will help to kill the disease fast” (C11).

4.5.1.3 Prayer for Healing Cervical Cancer

All the participants believed that God had healed them through their prayers. They stated that the prayers were said purposely for healing cancer.

Some of the participants believed that they were living by the grace of God and its only God that has healing power.

“...I came back home for two months after the diagnosis. I did not go because I was praying... I have been living by God grace, I pray a lot I know God is my healer so I pray a lot...” (C5).

Some of the participants consulted Pastors at prayer camps for prayers and healing services for their cervical cancer.

“The first time they told me that I have the disease; I didn’t have money to do the treatment. So I went to a prayer camp trusting that with the prayers the cancer will go. The pastor prayed for me several times for a year but the cancer was rather increasing” (C12).

“I went to my pastor for prayers... it is just like my normal prayers but it’s said with the purpose of healing my cancer. I told my pastor that pastor I get cancer pray for me. So it is my pastor who brought a professor at some time and they sent me to the first doctor” (C6)

Many of the participants stated that they fasted and prayed for the healing of their cervical cancer.

“I have not sent it to church but I always pray when I’m in the house. Sometimes I also fast and pray. I prayed that God should not let them operate on me. He should operate on me in the spirit and heal me so that I will give Him the thanks” (C7).

“Hmm, I became tired of fasting and prayer for this thing to go away. But now I’m grateful to God that He has healed me through the hands of the doctors” (C11).

However, one participant prayed to God to avert surgical and treatment mistakes likely to arise from the cancer treatment.

“We are human beings and mistakes can happen, so I asked God to help the doctors to remember everything they learned about the treatment of this disease and treat me without mistakes. I was having hope but I pray to God that nothing bad should happen during the operation” (C8).

4.5.1.4 Insertion of Substances into the Vagina as Treatment for Cervical Cancer

The study revealed that some of the women had inserted ‘balm’, penicillin ointment and other substances into the vagina to treat cervical cancer.

“So I will sit in hot water and also insert something like penicillin ointment to cure it” (C5).

“I met this woman who was selling medicinal oil something like a balm. She told me it’s good for treating vagina infections and sores. I bought them and usually, after a bath, I will insert it into the vagina” (C11).

“I consulted an herbalist in Nima who gave me some things to always insert it into my private part in the evenings” (C12).

However, one participant mentioned that the insertion of penicillin ointment was meant to treat the sores on the cervix.

“...I inserted something like penicillin ointment to cure it. I was thinking like it is sore if I insert the ointment, the sore will go” (C5).

Apart from the use of herbs, prayers and substance insertions, one participant indicated that she used fruits, vegetables, and some iron supplement drinks to treat the cancer.

“...What you have to stop eating and what you have to be eating. Those I have to eat: green vegetables, nuts, coconuts, groundnuts, pomegranate, I tried to drink cocoanut water 2x a day, „attatwe”(tiger nuts) I chew it even when I’m in a car...A certain fruit in Akan called „aluguitugui”(local apple) I eat it and sometimes blend it and be drinking... I squeezed lemon in warm water and drink every day...I believed that these things helped me” (C3)

This study has identified traditional treatments for cervical cancer as; herbal medicines, prayers, vagina insertions of balm and other substances, and eating of certain fruits and vegetables.

4.5.2 Orthodox ways of Treating Cervical Cancer

In this study, participants shared experience in the surgical operations (hysterectomy), chemotherapy (use of cancer drugs), radiotherapy and their side effects. They also expressed concerns about health care providers’ actions, the cost, and support for treating cervical cancer.

4.5.2.1 Surgery for Cervical Cancer (Hysterectomy)

Seven (7) out of twelve (12) participants stated that they had a hysterectomy done. The experience shared under this sub-theme was categorized as before operation, during operation, and after operation experiences.

All the participants who underwent a surgical operation for cervical cancer experienced psychological worries before the operation procedure. They expressed fear of death and fear of unable to procreate following the operation.

“I had the feeling that once your womb is being removed it means you are not a normal person... So I thought that it was something every ,ameem” wil end up your life” (C4).

“It was not easy hearing that as a woman your womb was going to be taken away and at this stage of my life too? For my womanhood to be taken away! And I can even die from the operation” (C1).

Again, the women revealed that accepting surgical operation for cervical cancer was a difficult decision. They expressed dilemmas between the love of life and love for children.

“On a second thought, I decided that it is better to lose my womanhood and stay alive than to be thinking of having children in the near future and not even living to have those children... It is better to stay as a man than to die while hoping to be a woman” (C1).

Some of the participants have indicated that they were pre-operatively prepared for the hysterectomy. They stated laboratory investigations, booking, admission and explanation of procedure as the pre-operative preparations.

“They told me what they were going to do for me. That they will give me an injection and it is very painful. They told me processes I will go through” (C8).

“They said cervical cancer operation. They will remove my womb...so a day was fixed for me to come to the hospital. When I went, they admitted me but the following day the doctor had emergency operations for pregnant women and so my own was canceled. It was the following week that they operated on me” (C9).

On the contrary, one participant felt that she was not adequately prepared for the hysterectomy.

“He (doctor) quickly has to take me through surgery. And that was that. So, I visited the hospital on Friday, Saturday-Sunday I went for the admission and on Monday I have the surgery is done” (C2).

During the operation procedure, participants reported chatting with the anesthetist and the theatre team.

“They were chatting with me when doing the surgery” (C8).

“The room was a bit scary because of the things inside. The people were talking and laughing inside there. One man injected me and was conversing with me while the operation was on” (C11).

However, one participant said that she slept off at some point in the conversation she had with the surgical team.

“I was made to lie down on a bed and one man injected me and whilst he was doing that we were conversing. After the injection, he asked me whether I can move my legs and I said no. That is all I can remember” (C9).

After the operation, participants described their surgical wounds as sizeable horizontal or vertical wound on the lower abdomen. They further stated that their wounds healed satisfactorily with thin scars.

“I started my recovery process and a couple of weeks later when I went back for review; he noticed that my wound was healing. And he was happy with the progress I made...the scar wasn’t a worry because it’s thin” (C2).

“The sore after the operation was not small but not also big. It’s straight under my navel. They started dressing the wound on the third day but it didn’t delay before going” (C11).

4.5.2.2 Chemotherapy for Cervical Cancer

Participants described the chemotherapy regimen as prolonged and difficult drugs.

“That drug, I don’t want to hear the name chemotherapy it is so difficult to take. You taking the drug have to take every week for up to 3 months” (C1).

“For chemotherapy, they told me the three types but the one I used is the infusion and I have to take it six (6) times in 6 weeks, once every week. The chemotherapy is long...” (C5).

All the six (6) participants who used chemotherapy lamented that chemotherapy side effects were terrible. The immediate chemotherapy side effects identified included itching vagina and gastrointestinal tract problems (nausea, vomiting, diarrhea, & anorexia). The post-procedure side effects experienced were sleeping disturbances, hair loss and bodily weakness.

“With the side effects of the drug, when you are taking the drug you are not able to eat, you want to vomit, and you become weak after taking the drug” (C1).

“When they put the chemo on you, your vagina (excused me) will be itching for some time. You will also start „running”(diarrhea). You will feel like vomiting, and the vomiting will be there and this diarrhea too. At times too, you cannot sleep when you take the chemo” (C5).

Some of the participants noted that anti-emetics and sedatives were prescribed for the management of nausea and vomiting, and sleep disturbances respectively.

“They will give you some tablets to take for you not to vomit, and some to help you sleep at night but for the sleeping tablets, I didn’t use it” (C5).

“When I take the chemo, I cannot sleep that night. I have to use the sleeping tablets to help me sleep” (C6).

4.5.2.3 Radiotherapy for Cervical Cancer

Similar to chemotherapy, the radiotherapy regimen was described as a prolonged treatment.

“The doctor told me that I will go for radiotherapy for 6 weeks. In a week I will go from Monday – Friday” (C5).

“They put me in the machine for some weeks and the second machine I stayed there for 3 days. After that, every week I go for treatment” (C6).

Participants narrated that the first stage of radiation is the mapping of the cancer fields on the skin with marks from a machine.

“The first one was to go into the machine... They did that for the machine to show where the thing has (cervical cancer) spread to. The machine itself will give you a sign, some marks on your skin. And they will also put some ink or medicine on your skin” (C5).

“They are two machines. The first one will let them know where the cancer reached and the second one will give you the therapy” (C6).

The participants explained that after being positioned well on the therapy bed, a big machine moves along the marks on the skin and radiates the cancer cells for some few minutes.

“You also lie down on the bed ,half-naked” and the machine will come and wherever the mark is, the machine will try to go there to radiate or do something like that” (C5).

“In the therapy room, it”s the machine that gives you the therapy. The boys will leave you there alone” (C7).

Participants mentioned the immediate radiotherapy side effects such as skin itching and heat whilst the post-procedure effects included marks on the skin, sores on the skin, darkened skin and burnt skin.

“The therapy is heat and when you finished and you coming home, it is very itching. If you scratch, it turns sores” (C5).

“Because it is fire - the heat, the skin becomes like they have burnt it. When you are fair, you will turn black” (C7).

The women expressed initial fear of the unknown as they were left alone with the machine and also expressed ashamed as they were positioned half-naked on the therapy bed.

“The boys will leave you there alone. So on the first day, I was afraid” (C7).

“You go ,half-naked” into the machine first...and you also lie down on the bed ,half-naked” and the machine will come...lying naked was uncomfortable and shame” (C5).

One of the participants expressed worry about treatment disruption due to the breakdown of the machines at the time of her therapy.

“At times we have problems with the machine. They will say the machine is spoiled, it is not working, you should go and when they finished repairing it they will call you. You will come home for 2-3 days before they will call you” (C5).

However, one participant has used infrared radiation to treat her cervical cancer.

“...He told me that he was going to do something which is called infrared for me... I was in the lithotomy position and he put that thing into the vagina. It looks like he was doing an examination of the vagina. There was no pain, nothing. I didn”t feel anything. It did not take up to 2 minutes, and then it”s completed. He did that for about 3 times-once every month for 3 months” (C3).

The most frequent orthodox treatment method used for cervical cancer in this study is a surgical operation (hysterectomy). Hysterectomy related experiences shared include; fear of death with operation and fear of unable to give birth after the operation and eventual development of surgical wounds and scars. Chemotherapy experiences identified are prolonged treatment regimen, terrible side effects such as vagina itching, gastrointestinal tract problems, loss of hair, body weakness and sleepless night. Radiotherapy side effects experienced include; itching skin, burnt skin, marks on the skin, and sores on the skin.

4.5.3 Cost of Cervical Cancer Treatment

Almost all of the participants reported that the orthodox treatment for cervical cancer was very expensive.

“They told me the amounts involve and it was so huge...The chemo was Ghc1800, and radio was GHc5500 for the 6 weeks” (C5).

“I was asked to pay an amount of Ghc3000 for the surgery and there was no money. I have to call on my daughter and she gave me the money...and I have to buy the medicine too, I bought it for Ghc2200...So it wasn’t easy but I went through” (C4).

However, one participant enjoyed free medical care for infrared radiation because of friendship.

“Hmm, I can’t really account for how much I have used. In fact, the doctor didn’t charge me because I was working with him. Maybe that was why, I’m sure if it was an outsider, he might charge the person but for me, he didn’t charge anything. I even used to scrub for his cases, so the doctor didn’t charge me” (C3).

Some of the women have indicated that cervical cancer has caused loss of resources to their families.

“Cervical cancer treatment is very, very expensive. It’s really expensive, all my savings is gone just because of this cancer” (C1).

“My husband was a pensioner and I was a trader so we use all the savings we have and my three children who are working also helped. We have spent a lot” (C8).

Although National Health Insurance is used in Ghana, participants lamented that the health insurance does not cover for cervical cancer treatment.

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“The surgery, I have national health insurance it doesn’t cover, so I have to pay Ghc3000 and I have to buy the medicine too, I bought it Ghc2200” (C4)

“ As I speak with you I’m on national health insurance but cancer is not part of the health insurance I don’t know whether those suffering from cancer we are not Ghanaians or what” (C1).

On traditional treatment, most of the participants considered the cost of herbs, prayer and balms to be inexpensive.

“They showed me some different (2x) tree leaves to cut and boil. It was at no cost to me” (C1)

“I have to go to the hospital and pay some huge amounts but the herbal medicine is not like that” (C5).

“Ooh no, the pastor didn’t charge me for anything. But I do my normal church offerings” (C6).

One participant who used food and dietary products considered the cost of traditional treatment to be expensive.

“It was in a big bottle and that day it cost me about Ghc700. In all, I spent about GHc1500 on those supplements and the drinks. This excludes the vegetables and the fruits which have now become my diet and the diet for the family...its bit expensive” (C3)

4.5.4 Treatment Support System

According to the participants, they had emotional and financial support from their respective families and the church during the treatment of cervical cancer.

“I have to call on my daughter and she gave me the money. My church too supported me with Ghc1000” (C4).

“I have many brothers but one of them looked after me fine. My grandchildren also supported me well. Anything that I need I ask them, to do this for me, do that thing for me and they did all that” (C6).

“My husband understands what I’m going through. He is supportive. It’s quite ok” (C1).

4.5.5 Health Care Provider Actions

The study has revealed two sets of health care provider actions exhibited in cervical cancer patients – caring actions and killing actions.

Some of the women described the action of encouragement as caring.

“For the nurses whenever you call them, they will come. They were giving me words of encouragements and counseled me too. I was so happy; I didn’t think much about the disease” (C4).

Others also described the action of reassurance as caring.

“I had reassurance from him (food and dietary researcher) and by the time I leave his Centre I was much relief” (C3)

Again, some of the women also described the action of counseling as caring.

“...the doctor told me that you are killing yourself if because of fear you won’t come, don’t mind them, you will live. You just do what we say and I say that if I do that, my hair and my body will change and the doctor said oh if your hair is not there and your body changes at the age of 53 and you are alive, don’t you like it?” (C5).

Furthermore, some participants stated that being friendly and respectful was caring.

“They were smiling at me, they will ask me how are you feeling, what is happening to you? I got hope from them, they were really fine” (C8).

“Like you speak to somebody like your mother, some of them were like that” (C6).

However, some of the participants described some health care providers’ actions as killing. They considered actions such as; rudeness, impatience, being disrespectful, and being strict on money as killing actions.

“Some time they (therapists) take out your folder and say go and pay some amount what you have paid is not enough and that day you will miss the therapy meanwhile they told us that it’s bad to miss the therapy” (C5).

“Some (nurses) don’t respect. But if you are sick by cancer and you (nurse) don’t have the patience for us (cervical cancer patient) then you (nurse) will kill the person (cervical cancer patient)” (C6).

“Another time the doctor wanted me to do the test that you don’t have to eat in the morning but they (doctor, nurse, laboratory technician) did not tell me and because I’m taking BP (hypertensive) drugs I ate in the morning. They will now say no (3x) you shouldn’t have eaten. I will go home and come back again. It was worrying, Ooh that thing it was killing me „shaking head””(C9).

This study has identified the cost of orthodox treatment for cervical cancer as very expensive; many of the women have lost family resources to the disease, and family members and the

church have provided emotional and financial support to the women. The participants have described care providers' encouragement, reassurance, and friendliness as caring actions. Other actions such as rudeness, impatience and strict on money were those identified as killing actions towards cervical cancer patients.

To help provide answers to the research question –“What experiences do women with cervical cancer have on the outcome of traditional and orthodox management of cervical cancer in Ghana” cervical cancer management outcomes emerged from the data as a major theme.

4.6 Cervical Cancer Treatment Outcomes

In this study, participants expressed cure, better health status, poor health status, and not able to give birth after taking the treatment of cervical cancer. These expressions are discussed under two subthemes – improved health outcomes, and poor health outcomes.

4.6.1 Improved Health Outcomes

In this study, four (4) of the participants reported that they have been declared cured of cervical cancer. They, however, indicated that both traditional and orthodox treatment cured them.

“In addition, I went to the hospital and reported to my doctor. The doctor too did cervical cancer treatment for me. So I think after changing my eating lifestyle and taking the hospital treatment both of them helped me to be cured”(C3).

“Ooh, I am ok „appears excited”. Yes, since that time till now I am ok. So I can eat properly now, first I couldn't, even to take water was a problem but going through that (herbal treatment) I'mok. I don't feel any pain, at first aaii, I can't even sit up and talk to you. The pain is so severe and vomiting but now is gone” (C4)

Six (6) out of the 12 participants stated that their health status has improved due to the orthodox treatment they have received.

“Now, I feel better than when the disease started. Ooooh, first time, hmm, I can't eat and can't do anything but now I do the washing, bath myself because first my grandchildren bath for me. I do everything myself now” (C6).

“I am much better now. I am much better now than when I was taking those treatments the leaves at home” (C1).

However, 2 participants had abandoned orthodox treatment because of financial constraints and were willing to re-start traditional treatment for the disease.

“I don’t work and I don’t know where to get that GHc1500, so I’m praying to God that I will get help from someone. If not that I’m deciding to go back for herbs medicine again...because you know for therapy I’m not drinking it, I’m deciding that if I drink the herbs, it will kill the internal” (C5).

4. 6.2 Poor Health Outcomes

Some of the participants reported that their health status worsened as a result of the use of traditional treatment for the cancer.

“It is because the herbs did not help me. It was becoming worst. I said to myself that no, I have used this herb for some months now and there are no changes; I have to go to the hospital” (C1).

Two (2) participants reported that they developed complications – pelvic pains, and adhesions as a result of the surgery (hysterectomy).

“Another one and half months I came again, and according to the doctors I had adhesions. So I couldn’t take water, I couldn’t take food, so I was on admission for 12 days and after that everything was ok” (C4).

However, 2 participants who were expecting additional children were unable to conceive 3 years after the surgery (hysterectomy).

“I have two girls and we were hoping to get a boy but 3 years after the operation there is no sign of pregnancy” (C11).

4.7 Living with Cervical Cancer

Living with any disease can be challenging. However, the women in this study reported that they were living their life (s) with fear and that their means of sustenance is their trust in God (highly

spiritual), and hope in life. The subthemes under this theme include; living fearful life and coping strategies for cervical cancer.

4.7.1 Fearful Life

The participants reported that they lived with cervical cancer secretly because of fear of stigma and discrimination.

“You know in our system, there are certain conditions if you tell somebody that you have it they are going to shun your company. And so I didn’t inform anybody apart from my children” (C3)

Some of the women also lived their life with the fear of divorce.

“My husband said he will get marry to another woman because we were not able to have sex... Giving him such a chance he can go and not come back again so I’m scared” (C7)

Again, some of the participants after cervical cancer treatment expressed fear of death.

“At first I was not happy about it at all because I heard if someone has cancer, by all means, the person will die but two of my friends at therapy Centre did not complete the treatment and they died, so you are not sure of your survival” (C5).

“My close friend but hers is breast, any time she sees me, she will say Janet yours is better woooo. And I will ask her why? She will say many people have died of cancer” (C6).

Few of the participants expressed the fear of the impact of chemotherapy challenges on their life.

“I think the side effects of the drugs (chemotherapy) alone will make me not have a better lifestyle...my hair is all down; I cannot live without putting on a wig”(C1).

“...how they were speaking about the chemotherapy because of the hair loss and all those things, I was not happy with myself ,kotakota” not at al I always feel sad” (C5).

Many of the participants revealed that they had decreased sexual drive compared to life before cervical cancer and cervical cancer treatment.

“I don’t sleep with a man, so all I wanted was a good life. And so am not bothered „laughs“...it because I sometimes feel pains...” (C8).

“Eeeeh I don’t feel like anything again. Like to have sex, I don’t feel anything again... Eeeeh yes, I was having feelings a bit but now I don’t have any feelings for sex. And I may say that since that time we don’t have sex again (laughs)” (C9).

4.7.2 Coping Strategies

The participants indicated that their strength to live with cervical cancer comes from their belief in God Almighty, and hope in life. Thus, all the women demonstrated high spirituality in their faith and trust in the Almighty God.

“I feel so proud. I felt God has helped me. Anytime I go to the church, I thank my God because being diagnosed of cancer with three (3) Plus (+++) and after these few years the thing has become negative not all people can get this favour” (C3).

“We hear that the cancer is not good but from 5 to 6 years now, I’m alive it only God. Yes, that is why I’m calling God. Not my power, not my anything but it’s God grace” (C6).

Some of the women also showed a high level of hope in life.

“I was afraid but they have some posters that say that cervical cancer can be prevented, so if you are infected and come early they can help you. Because of that, I got hope when I saw those posters and told myself there is life to me” (C8)

“So I just thank God for everything. Based on that report that said I’m free of cervical cancer, that even helped boost my mental strength, it took away my fears. I just saw it as a condition and it’s being treated” (C2).

Some of the participants believed that family (husband and children) encouragement and support gave them the strength to live on.

“Because my husband does the cooking and my children will do the sweeping and fetching of water” (C7).

“My husband understands what I’m going through. He is supportive” (C1).

4.8 Summary of Findings

In this study, twelve (12) women were interviewed. Eight (8) out of twelve (12) women were aged 54 years and above. The overall analysis of the data showed that all the participants had expressed similar thoughts and feelings about the questions asked. However, participants C1, C2, C3, C5, and C11 had contributed most in terms of verbatim quotes in the study. These participants except C5 had a better understanding of cervical cancer information because of the

college level of education they had attained. Above all, C5 provided rich data probably because of her evangelism background.

The study has revealed beliefs about cervical cancer among a section of Ghanaian women diagnosed with the disease. The women believed that cervical cancer is caused by the weight of the pregnant uterus and hidden nature of the cervix; human papillomavirus; low immunity of the individual; and hereditary. They further identified that the wearing of non-cotton panties and tight dresses; prolonged use of sanitary pads; first sexual intercourse at an early age; multiple sexual partners; and indiscriminate unprotected sex was perceived to be associated with the cause of their cancer. The women, however, believed that cervical cancer could be prevented through vagina hygiene education; human papillomavirus vaccination; and eating local food products while avoiding chemically induced food products or imported food products.

Again, the participants had expressed absolute trust for traditional treatment providers as against their mistrust for hospital staff providing orthodox treatment and believed they are familiar with the traditional forms of treatment. Thus, this study revealed that the participants consulted traditional treatment providers first before seeking orthodox treatment for cervical cancer.

On cervical cancer diagnosis, the study has identified:- Pap smear test; blood sample analysis; and use of abdominal scans for diagnoses. However, the women experienced pain; loss of personal dignity and integrity; loss of blood; and fear of cervical cancer diagnosis whilst going through the cervical cancer screening in the hospital.

The study has also established that the traditional interventions/treatments for cervical cancer include: the use of herbal medicine; the use of prayer; and insertion of substances into the vagina. The orthodox treatments were: surgery; chemotherapy; and radiotherapy. The study also

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showed that the cost of cervical cancer was expensive for orthodox treatment and inexpensive for traditional treatment. The results further indicated that the participants had emotional and financial support from family members and the church during the treatment of cervical cancer.

The management/treatment outcomes of cervical cancer in this study include cure of cervical cancer (traditional and orthodox); better health status (orthodox); worst health status (traditional); and infertility (orthodox). The study further established that participants live a fearful life with cervical cancer. This was expressed as fear of stigma and discrimination; fear of divorce; and fear of death. The women, however, had strong faith in God, and hope in life, these were identified as their coping strengths.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Introduction

This chapter details the discussion of the findings of the study as presented in chapter four. The discussion is done in relation to the literature reviewed, and also according to the objectives of the study. This study had four major objectives: to explore the belief systems of women diagnosed with cervical cancer in Ghana; to investigate the experience of women with cervical cancer regarding traditional and orthodox diagnostic systems in Ghana; to describe the experience of women on traditional and orthodox interventions for cervical cancer; and to document the experiences of women on the outcomes of traditional and orthodox treatments for cervical cancer. The discussion is meant to demonstrate the extent to which these objectives have been achieved.

The discussion is organised according to the themes and subthemes of the study. The participants' demographic data is discussed first. This is followed by discussions on the themes in the order of beliefs about cervical cancer; experiences with a cervical cancer diagnosis; cervical cancer interventions; cervical cancer management outcomes; and living with cervical cancer.

5.1 Participants' Demographic Characteristics

In this study, the participants were married women from the Accra Metropolis who were diagnosed with cervical cancer in the hospital. The participants had used both traditional and orthodox medicine for the treatment of cervical cancer. This finding is consistent with several studies, which reported combined use of traditional and orthodox treatment by general patients in the hospital and at home (Abbo, 2011; Jeong et al., 2012). Most of the women in this study were

aged 54 years. This finding agrees with Binka et al. (2018) who described 53 years as the average age among cervical cancer patients in a rural hospital in Ghana. It, however, differs from the findings of Eze et al. (2013), who observed in their study that cervical cancer mostly occurs among women below age 50 in Nigeria. The reason for this disparity could be the late reporting of cervical cancer cases in Ghana (Adjei-Mensah, 2013; Duda et al., 2005).

Most of the participants in this study had a basic education with an average number of four children. This confirms the findings of Binka et al. (2018) who reported an average number of four children and high rate of illiteracy among their participants. The low educational background of participants coupled with the high dependence of children in the present study could have accounted for the high unemployment rate and the participants' inability to meet hospital bills for cervical cancer management (Hobenu, 2015).

Most of the participants in this study were Christians. This reflects the general perception that Ghana is a Christian Nation. However, the majority (seven out of twelve) of the participants had their first sexual intercourse during the teen years which suggests that they do not live according to the doctrine of the Bible which prescribes marriage before sexual intercourse (Burchardt, 2011; Edger, 2012).

5.2 Beliefs about Cervical Cancer

This study revealed the health beliefs about cervical cancer such as perceived causes, perceived preventions, and beliefs about treatment of cervical cancer. The women described the cervix as a hidden weight bearing organ in the female reproductive system and believed that by its hidden nature and functioning, cervical cancer could result. The function of the cervix among others is to close the pregnant uterus in order to keep the foetus safe till labour, and also dilate during labour to allow the baby pass out through the birth canal (O'Brien et al., 2018; Vink, Qin,

Brock et al., 2016). This process of closing and opening of the cervix each time a woman is pregnant particularly in the cases of multiple pregnancies or multiparous women is believed to be the cause of cervical cancer (Word, Li, Hnat, & Carrick, 2007; Harper, Caughey, Odibo, Roehl, Zhao, & Cahill, 2012). This supports many studies, which reported multiple pregnancies and parity as risk factors for cervical cancer (Driscoll, 2016; White et al., 2012; Williams & Amoateng, 2012). This implies that exertion of pressure on the cervix each time a woman is pregnant could be a sufficient stimulus to trigger the uncontrollable growth of the squamous-columnar cells of the cervix resulting in cervical cancer development.

Human papillomavirus was also identified as a cause of cervical cancer in this study. The human papillomavirus is one of the biological agents that cause sexually transmitted infections such as cervical cancer (Ago et al., 2013; Eze et al., 2013). The virus is believed to be contracted through sexual intercourse with the opposite sex partners (León-maldonado et al., 2016). Similarly, the women in this study believed that men are the reservoir of the virus and transmit the virus. The virus, however, may be considered as a normal flora since it is common among adolescent boys and girls, and is responsible for several cancers such as neck and head cancers (Aggarwal, 2014).

It was reported that low immunity of an individual could easily facilitate the development of cervical cancer. Low immunity means that the individual has less number of antibodies which protect and fight against disease-causing germs, bacteria, and viruses from attacking the human body cells (Schreiber, Old, & Smyth, 2011). In high immune individuals, antibodies make the body cells resistant to infections and cancer-causing virus (Ngoi et al., 2018). Many studies, however, have proven that immunosuppressive state of individuals is a major factor that hastens

viral infections including human papillomavirus and this could cause cervical cancer development (Ngoi et al., 2018; Driscoll, 2016).

Participants in this study further perceived genetics as a cause for the development of their cervical cancer. Some of the women reported a family history of cancer and also indicated that they had lost family members especially biological mothers to cervical cancer. Cervical cancer is therefore believed to be a family disease where parents transmit cancer-related genes to their children (Seo et al., 2018). Children, who had acquired cancer hereditary tendency from parents or grandparents, develop cancer later in life (León-maldonado et al., 2016).

Furthermore, the study found that most of the participants (ten out of twelve) had multiple sexual partners, seven out of the twelve women had a first sexual encounter at an early age – 11 to 18 years, and some encounter unprotected sexual intercourse. These findings – multiple sexual partners, first sexual intercourse at an early age, and unprotected sexual intercourse are consistent with literature as risk factors for cervical cancer (Ago et al., 2013; Eze et al., 2013). In line with these findings, Fiaveh (2011) suggested that sexual behaviours of individuals should, therefore, be targeted when developing cervical cancer prevention campaigns. It is not surprising that several authors have suggested measures that could change the authoritarian attitude or actions of men who have total control over sexual affairs in sub-Saharan Africa (Chai, Sano, Kansanga, Baada, & Antabe, 2017; Fiaveh, 2011; Jewke, Dunkle, Nduna, & Shai, 2010).

Some of the women believed that health education on vagina hygiene and safe sex practices could prevent cervical cancer. This is believed not only to prevent cervical cancer but to also help resolve female reproductive system infections and sexually transmitted infections

(Fiaveh, 2011). Although there are reproductive health units in hospitals in Ghana, the educational programmes do not address vagina hygiene issues and safer sexual practices (Tenkorang, 2012). The traditions in some parts of Africa including Ghana also forbid the mentioning of vagina openly in the family (Ase et al., 2017; Chidyaonga-Maseko et al., 2015) which further prohibits vagina hygiene education. This finding is in congruence with Williams, Kenu, Dzubey, Dennis-Antwi, and Fontaine, (2018), who identified that women lack knowledge on the preventive care of reproductive health issues, and this forms a challenge to cervical cancer prevention.

The participants believed that vaccination of women with the human papillomavirus vaccine could prevent cervical cancer in Ghana. This belief agrees with similar findings from Aggarwal (2014) and Mousavi (2017) studies, which reported on the vaccine efficacy and effectiveness as 86 – 100% potent. The vaccine is also reported to be cost-effective (Silas et al., 2018). However, this finding is at variance with a qualitative study in Zambia, which testified low patronage of the vaccine because the women of Zambia believed that the vaccine was meant to serve as a birth control measure, and the health workers were also afraid of possible side effects of the vaccine (Venturas & Umeh, 2017). In this study, the women were eager to be vaccinated in order to prevent cervical cancer recurrence. Their challenge was the general inaccessibility of the vaccine in Sub-Saharan Africa (Chidyaonga-Maseko et al., 2015).

Only one woman believed that eating locally produced food products (free chemically induced) is a preventive measure against cervical cancer. Eating bad food (Chirwa et al., 2010; Ngugi et al., 2012) or poor nutrition (Driscoll, 2016) is a major contributor in producing a high incidence of cervical cancer in the low-income countries. The finding further agreed with Seo et al. (2018) whose study among Chinese American women revealed that women who eat fresh

food, fish and also live a less-stressful life were less prone to cervical cancer. The belief is that continuous consumptions of chemically induced food products may lead to a cumulative effect of chemicals in the body system. This effect could result in cervical cancer development in later life (Grosse, et al., 2011).

Women believed and had trust for herbalists or traditional healers. In this study, all the participants indicated that they visited either a herbalist or an individual natural remedies provider first before seeking hospital treatment for cervical cancer. This finding concurs with the studies of Driscoll (2016) and Hinnen et al. (2014). The finding, however, disagrees with Iavazzo et al. (2015) who observed a high level of trust and confidence in nurses providing psychosexual counselling to gynaecological cancer patients in the UK. Iavazzo et al. (2015) finding is not surprising as the focus of their study was on psychosexual counselling after cancer treatment and not the treatment itself.

Furthermore, the women were familiar with the traditional treatment substances. The participants collected leaves and flowers from the environment, bought herbs and food supplements from the local market and departmental stores, and also collected herbal preparations from herbalists for the treatment of cervical cancer. These findings are similar to that of Hinnen et al. (2014) where their study identified unfamiliarity of western medicine as a reason for patients' distrust of orthodox medicine. This shows that the indigenous/traditional treatment substances are common and available for use (Abbo, 2011). The sick only needs to contact a trusted person such as; an elderly person, herbalist or a person who has knowledge on a natural substance, to recommend the treatment substance for an individual to use (Abbo, 2011). This highlights the need for the development of local treatment technology for the treatment of diseases including cervical cancer in the hospital (Hinnen et al., 2014).

Some of the participants believed that the hospital is a dying place for cancer patients. In context, cervical cancer is diagnosed in Ghana at the advanced stage and sometimes in a much-deteriorated form (Adjei-Mensah, 2013). When the patient is admitted in the hospital at the advanced stage of the cancer, the prognosis is always poor (Vistad et al., 2011), and when such patients finally die in the hospital death certificates are issued with cancer as the cause of death. Many cancer patients, therefore, died while receiving hospital treatment (Murthy et al., 2010; Kennedy et al., 2007; Maree et al., 2013). The stigma of cancer attached to such deaths (Myrick, 2016; Mukherjee, 2010) makes the women believe that cancer has no links with orthodox medicines (Birhanu et al., 2012). Thus, the perception is that the hospital treatment for cancer would rather facilitate the early death of the patients. This finding is a wakeup call for general cervical cancer screening in Ghana to help dispel this dangerous cancer myth.

Some of the women used traditional treatments for the disease because they were unaware that the disease was serious. Others also tried avoiding hospital treatment because they were aware that cancer is serious, and that the orthodox treatment for cancer is equally dangerous. These findings are similar to the findings from studies that reported low trust in doctors, the low perceived severity of symptoms and prior negative experience as reasons for medical avoidance (Byrne, 2008; Taber, Ph, Leyva, Persoskie, & Ph, 2008; Vanderpool, & Huang, 2010). This implies that lack of screening and seeking traditional treatment for minor vaginal symptoms may result in late detection of cervical cancer and increased poor treatment outcomes (Taber et al., 2008).

5.3 Experiences with Cervical Cancer Diagnosis

Pap smear test was the main test procedure for diagnosing cervical cancer in Ghana. This finding is consistent with a study conducted in the USA by Ogunwale et al. (2016). All the

participants in this study confirmed that they took the Pap smear test. They also reported that they have experienced pain when undergoing the Pap smear testing. Similar findings such as body discomfort and distress were reported in the studies of Duke et al. (2015) and Marlow et al. (2015) respectively. In this study, the women described the pain as being sharp and severe. They associated the pain with the disease state of the cervix and the instrument used for the procedure. It will, therefore, be prudent that medical professionals consider pain-relieving measures during Pap smear testing just as it was indicated that intracervical injection of lignocaine and adrenaline or prilocaine and felypressin appeared to be the optimum analgesia for colposcopy treatment (Gajjar, Martin-Hirsch, Bryant, & Owens, 2016).

Another finding was that some of the women experienced loss of personal dignity and integrity. They said male doctors and students invaded their privacy, which made them ashamed and worried. This finding supports other studies which indicated that women were uncomfortable with a male gynaecologist or physicians (Williams & Amoateng, 2012), and some also expressed a loss of privacy and human dignity (Ding et al., 2015). This, therefore, demands a design of a new technique that would allow women themselves to take a swab of the cervix for Pap smear testing, just as the technique for HPV self-sampling testing (Duke et al., 2015). This will help relieve some of the discomfort and embarrassment that some women feel with a Pap smear (Duke et al., 2015; Iqidbashian et al., 2011).

Most of the women experienced bleeding of the cervix during the Pap smear testing. There seems to be no information from the literature on women's experience of bleeding of the cervix following Pap smear test. This finding, therefore, needs further investigation among a large number of cervical cancer patients. However, most of the women (eleven out of twelve) in this study were already having the signs and symptoms of the disease prior to the Pap smear test.

The excessive bleeding of the cervix among participants in this study following the Pap smear test could be attributed to the disease state of the cervix. This also means that cervical cancer screening officers should devise ways for the control of bleeding of the cervix among clients.

Furthermore, it was evident that there was a general fear of cervical cancer diagnosis among the participants. This agrees with many studies that have reported that cervical cancer diagnosis is associated with fear (Bosgraaf et al., 2013; Marlow et al., 2015; Sharp et al., 2013). The women expressed their fear of cervical cancer diagnosis in various forms such as sadness, psychological worries, and fear of death. With regards to sadness, some of the women indicated that they were confused with the news of Pap smear-positive results and therefore were unable to talk to anybody about it. The overriding reason was that cancer is a dangerous disease and nobody wants to hear of it or be associated with it, thus there are conscious efforts by individuals not have any discussions on cancers (Nyblade et al., 2017).

Another manifestation of fear of cervical cancer diagnosis is the expression of psychological worries. The reason for the expression of worries is the belief that cancer treatment is deadly. This reason differs from Connor et al. (2015) who indicated that the reasons for long-term psychological distress among women who underwent cervical cancer screening were concerns about; infertility in future, sexual intercourse after the procedure and having to continue clinical evaluations for cervical cancer. These expressed reasons for women psychological worries is a wakeup call for healthcare professionals to develop cervical cancer screening counselling tool that could adequately address or help minimize psychological concerns of clients undergoing cervical cancer screening (Arbyn et al., 2010).

On the other hand, there were no traditional means by which herbalists or traditional healers use to diagnose cervical cancer. This finding agreed with Klinghardt (2005) when he criticized traditional healers on their lack of etiological capacity to diagnose diseases with evidence. However, it is noted from the data that when the traditional medicine dealers were confronted with complains of ill health, the signs and symptoms presented becomes the basis for prescriptions of treatment for the disease (Krosch, 2010; Hubbell, Luce, & McMullin, 2005). The use of previous experience was also strong compelling evidence in drawing cervical cancer patients to embrace and accept the prescribed traditional treatment (Krosch, 2010). Although the theoretical framework for this study has established some traditional diagnostic systems, none of those in the framework was identified. The reasons may be that this study did not include the herbalists or traditional healers and could not conclude on their lack of capacity to diagnose, and the women interviewed might not also have insight about how they were diagnosed by the herbalists or traditional healers if there was any.

5.4 Cervical Cancer Interventions

Most of the women have used herbal medicine for the treatment of cervical cancer. This finding confirms the assertion that 60 – 80 % of general patients at OPD used traditional medicine for their health needs (Ekor, 2013) and also for cancer treatment (Klafke et al., 2012). In this study, the herbal medicine was described as herbal preparations in which the women themselves had participated in the preparation processes – boiling the herbs and sieving the sap (fluid) for use. The mode of administration of herbal preparations in this study was basically drinking the fluid, using the fluid to bath and/or for vagina douching with the conviction that this would cure the cancer.

The herbal medicine prescription for cervical cancer in this study is comparable to findings from several studies that showed that many countries have integrated herbal/traditional medicines into national health care systems where registered herbal practitioners prescribe herbal medicine for treatment (Chang et al., 2016; Lao & Ning, 2015; Aziato & Odai, 2016). However, Adams et al. (2015) suggested that traditional healers are able to provide strong psychological, social and spiritual support, address the supernatural dimensions of the disease, and also provide counselling that promotes healing and wellbeing of cervical cancer patients in Queensland, Australia. These can be considered as the values and strength of traditional practitioners.

Another traditional form of cervical cancer treatment was prayer. All the participants believed that they were healed by the grace of God through insistent prayers. Whiles some of the women consulted pastors in the church and at prayers camps for healing and deliverance prayers, others fasted and prayed inside their rooms for God to effect healing upon them. They also extended the prayers to cover health professionals by asking God to avert treatment mistakes that could arise from the cancer treatment. These findings are similar to the findings of McFarland et al. (2016) and Nwobodo et al. (2016). In their studies, cultural and religious factors were said to have influenced the negative changed of attitudes of the women against orthodox treatment for cervical cancer. The finding, however, agreed with Binka et al. (2018) who found that Ghanaian women employed faith healing for cervical cancer.

Furthermore, insertion of balm and penicillin ointment, and other substances into the vagina for cervical cancer treatment was also identified. The women explained that the insertion of these substances into the vagina was meant to cure the sores of the cancer and relieved them of the signs and symptoms of the disease. These substances are inserted into the vagina in the mornings and in the evenings, and also immediately after bath to treat the disease. This finding

of vagina insertions is comparable but with different purposes to the findings of several studies in Africa. The use of substances such as chemicals on men penis (Williams & Amoateng, 2012), vagina herbs (White et al., 2012) and insertion of herbal concoctions (Asakitogum & Dede, 2012 unpublished) into the vagina to either enhance sexual enjoyment or treat vagina infections were believed to be contributors of cervical cancer in Sub-Saharan Africa (Driscoll, 2016). Elsewhere in America, a quantitative study on intravaginal practices also confirmed high usage of insertions of products (lubricants, petroleum jelly, body lotions, oil and wet wipes) into the vagina for sexual enjoyment purposes and to also prevent infections (Brown et al., 2016).

What is clear is the fact that insertions of substances into the vagina are practiced in Ghana. Ghana is noted as one of the countries with the highest incidence of cervical cancer globally (Lingwood et al., 2008; WHO/ICO, 2007). Whether the insertion of substances into the vagina causes or treats cervical cancer, the incidence levels of cervical cancer are predicted to double in Ghana by 2025 (Lingwood et al., 2008; WHO/ICO, 2007). Therefore, there is an urgent need for cause-effect investigations of all substances purported to be used as intravaginal practices in Ghana to establish their effects on the cervix.

The findings that the women had experienced emotional pain prior to hysterectomy agreed with the findings of two studies by Zeng et al. (2011) and Pati et al. (2017). Zeng et al. (2011) observed psychological distress among cervical cancer patients undergoing treatment. In a different study, Pati et al. (2017) reported cervical cancer patients' apprehension about the cure and treatment procedures as the source of their patients' psychological distresses. In this study, the fear of death during surgery or due to surgery complications, and the fear of infertility following hysterectomy were the sources of participants' emotional pain. Their emotional pain was expressed in the dilemma between the love of life (to be cure with hysterectomy), and love

for more children after treatment. This really made decision making difficult for the women in this study regarding the acceptance of surgical operation for the condition (Aparecida et al., 2012). This suggests that efforts must be made by medical doctors to master themselves in the arts of fertility-sparing hysterectomy types (radical vaginal trachelectomy, and/or laparoscopic pelvic lymphadenectomy (Thomakos et al., 2016), and be able to explain same to cervical cancer patients in order to minimize the negative experience of hysterectomy.

Participants were prepared pre-operatively for the hysterectomy. According to the participants, the doctors requested several laboratory tests including full blood count, blood groupings and cross-matching and blood pressure monitoring before fixing a date for the operation. This was to ensure that the patients were fit physically and physiologically for the surgical operation and also to prevent surgical complication during and after the operation (Mitchell, 2006). Some of the women reported that they were scared upon entering the surgical operating theatre because of the huge equipment and gadgets in the theatre. This suggests that the pre-operative preparations recounted was not adequate enough to have taken the psychological fears, worries, and the scary nature of a surgical operating theatre for the cervical cancer patients (Huang, Li, Chia, Hsu, Shen, & Tsai, 2011). To ensure a successful surgical operation, adequate pre-operative psychological preparations of surgical patients is of paramount to the surgical team. It is therefore, imperative for doctors and nurses to uphold this principle (Huang et al., 2011; Mitchell, 2010).

During the operation, participants said they were given spinal anaesthesia which made them not to have experienced pain. They were also engaged in conversation with the anaesthetist and other surgical team members. Although this study did not examine relationships, this finding suggests that having a conversation with surgical patients help in managing fears during surgical

procedures (del Blanco, Torrente, Fernández-Manjón, Ruiz, & Giner, 2017) and this contributed to surgery success in this study. Another finding of the study is that the side effects of the chemotherapy and radiotherapy were described as terrible. The terrible nature of the therapies could also account for the participants' feelings that the treatment regimen was too long. Vistad et al. (2011) reported on terrible side effects of chemotherapy and radiotherapy just as experienced in the present study.

The immediate chemotherapy side effects identified were vulva itching and gastrointestinal tract problems (nausea, vomiting, diarrhea, & anorexia). These immediate chemotherapy side effects are comparable to the findings of several studies (Georg et al., 2013; Maree et al., 2014; Tornatta et al., 2009; Wenzel et al., 2015). Georg et al. (2013) described the gastrointestinal tract problems as gastrointestinal toxicity and Wenzel et al. (2015) identified vagina related problems as physical and sexual difficulties. The women also experienced post-procedure chemotherapy side effects such as sleep disturbances, hair loss, and bodily weakness. These findings are supported by the findings of Westin et al. (2015) sleep disturbance, Ezi et al. (2013) and Maree et al. (2014) hair loss, and Barnas et al. (2012) reported fatigue respectively.

Most of the gastrointestinal problems and sleepless night experienced by the women were resolved by the use of anti-emetics (tablets Phenergan 10mg prn), and sedatives (tablets valium 20mg noct.) respectively. In this study, hair loss was a major concern to some of the participants. These women have to put on wigs each time they have to go out because the hair loss was extensive and attracts shamefulness. A systematic review study on effects of cancer-related alopecia also found hair lost as a distressing side effect of cancer treatment and the women coped with the disease by concealment and social avoidance (Dua, Heiland, Kracen, & Deshields, 2017).

It was revealed that orthodox treatment for cervical cancer is very expensive in Ghana – surgery cost ranges between Ghc1500 (\$335) to Ghc3000 (\$670); a minimum amount of Ghc1800 (\$400) for chemotherapy; and minimum cost of radiotherapy is Ghc5500 (\$1225). This indeed is an expensive amount for an ordinary woman in Ghana to afford the treatment (Hobenu, 2015). Several studies have also reported high levels of financial challenges confronting cervical cancer patients in Africa (Jemal et al., 2011; Maree et al., 2013; Pati et al., 2017). However, the women in this study expressed that traditional treatment for cervical cancer is inexpensive, available and affordable. The challenge with the traditional treatment deduced from the data is its effectiveness. Investigations of the effectiveness of the natural medicinal substances used for cervical cancer treatment in Ghana are therefore, recommended.

The immediate family members (husband and children), and the church were the sources of emotional and financial support for cervical cancer patients in Ghana. This confirms the findings of Binka et al. (2018) who stated support systems such as social, financial and non-material from family members and the church for cervical cancer patients in Ghana. Garrett and Barrington (2013) also noted that some husbands supported their wives to find a cervical cancer cure. The finding, however, disagreed with those findings from Garrett and Barrington (2013), Francis et al. (2011), and Calvo et al. (2010) studies, which revealed women groups' contributions; relatives and friends support, and health workers support for cervical cancer treatment respectively.

The national health insurance in Ghana does not cover the cost of cancer treatment partly because of the huge amounts of money involved (Hobenu, 2015). This expensive nature of cancer treatment and other negative beliefs about cancer in Ghana may be responsible for distant relatives, friends, and financial institutions in Ghana not interested in the support of cervical

cancer treatment. Considering this huge cost of orthodox treatment for cervical cancer in Ghana, the management of the condition and care of the patients should not be left to the nuclear family of persons living with the disease (Hobenu, 2015; Mwaka et al., 2015). Therefore, the national health insurance scheme should include cervical cancer in the treatment and drugs list for the national health insurance scheme.

Participants identified two sets of health care providers' actions shown towards cervical cancer patients while they were receiving treatment – caring actions and killing actions. This finding is comparable to the findings of Pati et al. (2017) who described cervical cancer patients' experience with medical staff as best, and worst experiences. The women in this study described actions such as encouragement, counselling, reassurance, and friendliness from health care providers as caring actions that impacted positively on their recovery and early discharge from the hospital. Actions such as rudeness, disrespect, impatience, and strict on money were identified as killing actions of some health care providers which had the potential for causing patients' self-image destruction, and subsequent withdrawal from treatment. These expressions are partly supported by a study conducted in the USA (Thorburn, 2012) which revealed that cervical and breast cancer patients were faced with disrespect and rudeness from hospital staff, which resulted in anger and sadness among the patients.

5.5 Cervical Cancer Management Outcomes

The finding that women in this study had improved health outcomes with orthodox treatment is supported by results of quantitative studies which showed a good overall survival rate of cervical cancer patients. This study revealed that some of the women (four out of twelve) have been cured of cervical cancer with negative Pap smear results after treatment (chemotherapy and prayer-1, radiotherapy and dietary management-1, surgery and herbal

medicine-1, and chemotherapy, radiotherapy, & prayer-1). This finding is similar to Xia et al. (2016) study findings in China. They reported 34.1% and 46.2% (n=43) cured and overall survival rate for cervical cancer patients who received surgery and radiotherapy, whilst Wolf et al. (2017) in their study in Leipzig, Germany, indicated that surgery alone revealed 54.4% and 57.9% (n=368) as cervical cancer-free and overall survival rate of the patients respectively. The finding is also similar to the results of Robova et al. (2014) study in the Czech Republic. Their study showed that cervical cancer patients who received Neoadjuvant Chemotherapy (NAC) with surgery had good treatment outcomes (21.4%, 39.3%, and 10% (n=28) for a cervical cancer cure, survival rate, and fertility retained respectively).

The finding also supports Binka et al. (2018) findings that showed that their participants recovered from cervical cancer due to the combined effect of faith healing, herbal medicine usage, and orthodox therapies. The women in this study believed that they were cured by the combined effect of the traditional and orthodox treatment. However, they were unable to determine the role each of these treatments played in their recovery. The finding agrees partially with results from several qualitative studies which cited perceived effectiveness of herbal medicine and ineffectiveness of western medicines as the predictors for traditional medicines use (Aziato & Antwi, 2016; Klafke et al., 2012). The finding further concurred with Ben-Arye et al. (2017) in their study on the safety of herbal medicine use during chemotherapy in patients with ovarian cancer found that herbal medicine may influence the anti-cancer activity of chemotherapy.

Again, some of the women attributed their improved health status to the impact of orthodox treatment only. These participants regret the use of traditional treatment initially and partially blamed friends for misguided treatment advice. They felt the traditional treatment

impacted negatively on their health. In Ragan et al. (2018) focus group discussion in Kenya, a similar reason such as orthodox treatment for cervical cancer prevents sudden deaths of women was noted.

Although all the women started traditional treatment first for their cancer, six (6) out of twelve (12) women maintained and trusted the efficacy of traditional treatment for cervical cancer. This is expressed in their efforts to continue to use natural food products and remedies in the maintenance of their health, and the willingness of two (2) participants to re-start herbal medicine after they have abandoned the orthodox treatment because of financial constraints. This finding supports the findings of Mwaka et al. (2015) who revealed that cervical cancer patients experienced difficulties paying hospital bills. They further indicated that community believes in the effectiveness of traditional medicine encourage women early seeking of traditional medicine for cervical cancer treatment in Northern Uganda. Similarly, White et al. (2012) also stated that cervical cancer patients sought counsel and advice from traditional healers first.

Furthermore, four (4) participants (4 out of 12) women developed cervical cancer treatment complications. The complications (pelvic pains-1, surgical adhesions-1, and infertility-2) were all attributed to hysterectomy. According to these women, they have incurred additional cost in the treatment of some complications such as the pelvic pains and the surgical adhesions, which caused them hospital re-admissions. They, therefore, expressed worry about their frequent health interruptions, which have a negative impact on their quality of life. These concerns were expressed similarly among gynaecological cancer survivors in the USA where survivors experienced specific health problems associated with the cancer treatment modalities (Westin et al., 2015). Wenzel et al. (2015) observed that persistent disruption of cervical cancer

patients' quality of life was intervened successfully with psychosocial telephone counseling of the patients, which improved their health status in the USA.

Again, studies have observed that women have experienced better pregnancy outcomes after simple trachelectomy than after radical trachelectomy or abdominal trachelectomy (Rob et al., 2011; Robova et al., 2014), and this confirms the inability of few women to conceive after hysterectomy in the present study. This finding also resonates with Gizzo et al. (2013) and Thomakos et al. (2016) who reported infertility and psychosexual dysfunctions of women who had cervical cancer treatment. Therefore, cervical cancer patients need periodic counsel to accept the consequences of hysterectomy.

5.6 Living with Cervical Cancer

The study revealed that cervical cancer patients lived a secret life with the disease because of constant fear of stigma and discrimination. They expressed that when the community members get to know that they have cancer, they would shunt their company and even begun to predict the time of the death of the patients and this makes living with cervical cancer openly and freely in the community very difficult. This finding echoes the findings of several studies (Birhanu et al., 2012; Carrasquillo et al., 2015; Nyblade et al., 2017) which showed that cervical cancer patients experienced stigma and discrimination from families, community, and hospital staff. This has resulted in decreased social support for the women. It also underlines the poor care received from the hospital. Some of the participants in the present study stated that because of fear of stigma and isolation they did not disclose their cancer status to third parties except to their husbands and children. Impact of stigma on cervical cancer treatment and care needs to be investigated in Ghana to inform appropriate cancer de-stigmatization tool development.

Some of the women expressed fear of divorce because their husbands have threatened to get second wives. The main reason for their husbands to get second wives was the fact that they could no longer have regular sexual intercourse with their wives or enjoyed full-time sex (Aparecida et al., 2012; Shirinkam, Jannat-alipoor, Chavari, & Ghaffari, 2018). The women explained that apart from the pains they endured during sexual intercourse, they also have decreased sexual drive probably due to the severe symptoms of the disease and its treatment. This finding – fear of divorce is similar to two studies Ma et al. (2012) and Bates and Mijoya (2015) who have described the marital status of women with cervical cancer as poor because of widowhood and divorces. However, the finding that women had decreased sexual drive is supported by findings from many studies (Maree et al., 2014; Tornatta et al., 2009; Westin et al., 2015; Jensen & Froeding, 2015; Kokka et al. 2015). It is perceived generally that when an African woman loses her marriage, it means that she has failed in life (Kyalo, 2012). For this reason, some women had to endure painful sex just to satisfy their husbands in order to safeguard their marriages to the detriment of their own life (Babazadeh, Mirzaeei & Akhlaghi, 2012). All these contribute to the insecure life of the women in this study.

Although the women were treated successfully and discharged from the hospital, there was an intense fear of death expressed by the participants. The belief that cancer has no cure has made it difficult for the women to trust that they were treated and might not die of cervical cancer (Birhanu et al., 2012). This finding concurs with the findings of (Nyblade et al., 2017) study in which the participants believed that cancer is incurable and its patients die quickly despite treatment. It appeared that for the patients to have a dignified death they would report to the hospital as a last resort so that death certificates could be obtained. The cause of death on such certificates further compounds the mystery ‘that cancer has no cure’, because to them any

cancer patient, who goes to the hospital, goes there to die. Some of the women recounted stories of cancer death certificates and/or the death of family member or friend to cancer as evidence that those patients were treated but still died.

The coping strengths of the women were rooted in their faith in God and hope in life. The women showed high resilience in their faith and believed that God Almighty is the giver of life, the healer of diseases, and taker of life (Krause, 2014). Their high spirituality sustained them to live on with the disease to the point that some of the women were sent to the hospital by their pastors. Fasting and prayers purposively for healing the cancer was noted to be one of their top priorities in their lives. They did all these because of the hope they have in life. The hope is that their husbands and children are the supporting pillars of their lives. To the women, whether there is support from the family or not once their children and husbands are around them, they felt that their life is full and free from worries. These findings are similar to the findings of Rogala et al. (2016). Their study reported that cervical cancer patients adapted to the disease and cancer pain by the use of prayer, deep hope, and conscious attention diversion from the disease. However, the findings disagreed with Binka et al. (2018) when their participants were said to have used sexual abstinence, personal hygiene maintenance, and the use of disease denial as coping strategies for cervical cancer.

5.7 Evaluation of the Traditional Healers' Practices and Western Management approaches to Psychiatric Diseases Model

This model was developed as an assessment tool to describe the outcomes of traditional healers and western medicine management practices on severe mental illnesses. The model has four main domains: Patients' health belief systems; disease diagnostic tools; disease intervention approaches; and the outcomes of traditional medicine or western medicine and/or combined

treatment of traditional and western medicine. The objectives of the present study were therefore, formulated based on these domains of the model. Five major themes emerged from the present study of which four themes (beliefs about cervical cancer, diagnosis of cervical cancer, cervical cancer interventions, and cervical cancer management outcomes) were consistent with the model. Living with the disease (cervical cancer) emerged from the data as the fifth theme and therefore does not relate to the model.

The patients' health beliefs domain of the model has; shared belief systems, concepts of mental health and illness, expectations, and similar environment as its subthemes. In this study, patients' health beliefs about cervical cancer had three (3) subthemes (beliefs about the causes of cervical cancer, beliefs about cervical cancer prevention, and beliefs on cervical cancer treatment). These subthemes further had seven (7) sub-subthemes (biological causes, behavioural causes, vagina hygiene education, human papillomavirus vaccination, trust issues with care providers, familiarity with cervical cancer treatment, and perceived severity of cervical cancer). With the exception of cervical cancer familiarity and severity, the rest of the subthemes and sub-subthemes under this domain in the present study were inconsistent with the model.

Although there is lack of consistency among most of the subthemes of the patients' health beliefs in the model and the present study, it is clear that the concept of health belief on a disease and the care provider for that disease could determine the choice of ones' treatment options for the disease. Therefore, the beliefs about the cause of a disease, beliefs about disease prevention, and beliefs on the treatment of the disease could form the bases of a sick person's choice of treatment consultations with either a healer/herbalist or medical professional or both. Thus, these subthemes should be accommodated in the model to help bring clarity to what is described in the model as shared beliefs systems and concept of mental illness.

The disease diagnosis domain of the model has two sets of diagnostic tools – the traditional diagnostic tools such as spirits telling, possessions, and witchcraft seeing, and the modern scientific diagnostic systems such as diagnostic statistical manual V, international classification of diseases 10, and laboratory investigations. The present study did not identify any traditional diagnostic tool for cervical cancer diagnosis. The reason might be the non-involvement of the traditional healers in this study since the participants might lack such information. However, laboratory investigations such as Pap smear test, blood sample analysis, and abdominal scans and physical examinations were reported in this study. These reflect the modern scientific diagnostic systems in the model.

The intervention of diseases' domain in the model also has traditional treatment modalities, and western medical treatment approaches. The subthemes under the interventional domain of the model included: culturally accepted interventions – use of herbs, appeasing spirits, and witchcraft removal, and the western medical interventions – use of psychotropic drugs, and psychotherapy. This study presented similar subthemes for cervical cancer management – 1) Traditional ways of treating cervical cancer: use of herbal medicine, insertion of substance into the vagina, prayer for healing cervical cancer; 2) orthodox ways of treating cervical cancer: surgery, chemotherapy, radiotherapy; 3) cost of cervical cancer treatment; 4) treatment support system; and 5) health care provider actions. The cost of treatment of the disease, treatment support systems, and health care provider actions in this study are inconsistent with the subthemes in the model.

The cost of disease treatment is considered very important to cervical cancer patients in this study and to the greatest extent every sick person. This is so because effective medicines are very expensive and ordinary persons cannot afford it. This could be a compelling force for many

ordinary men and women to use available natural medicinal substances to treat diseases. Therefore, cost of disease treatment should be considered as part of the model to help assess the ability to pay for disease treatments and disease treatments preferences.

The treatment support for the sick also has a healing and curing effect on the patient. In low-income countries, such sub-Saharan Africa, financial support systems dedicated to helping the sick are generally lacking. However, the practice of extended family system widely in Africa, enable the sick enjoys social and emotional support from friends and family members. These support systems when are available help the sick to recover quickly with treatment. Disease treatment support systems are therefore suggested for inclusion into the model to aid in determining the influence of support on disease treatment options.

There is no doubt about the importance of care provider (s) to the sick in the family, the community or in the hospital. Sick persons need holistic care (physical, physiological, psychosocial, emotional and spiritual) from care providers. Therefore, the actions of care providers during care delivery to patients must be apt. Because care providers are trained differently, their actions also varied. Therefore, how the people perceive the actions of a caregiver can have an influence on the sick choice of treatment for the sickness. Thus, actions of care providers for patients should be included in the model.

The domain for treatment outcome of the model consists of three subthemes – traditional treatment outcome, western treatment outcome, and the combined effect of traditional and western treatment. This study, however, reported three similar subthemes such as cured, improved health outcomes, and poor health outcomes. These subthemes reflected the experiences of the participants on both traditional and orthodox management of cervical cancer. It is worth

noting that the current study is a qualitative inquiry and thus could not measure the specific effects of various treatments used.

Furthermore, this study has identified living with the disease (cervical cancer) as a major theme. This new theme explores life with the disease (normal life or fearful life or both), and the patient's coping strategies with the disease. This is important because it is only the sufferer of the disease that can tell how it is to live with the disease. Living with the disease can also be considered as the overall outcome of the disease and its treatment in the person's life. It is again suggested that living with the disease should form part of the model for total disease and its treatment outcome assessment.

In general, all the main themes of the model were consistent with the present study with some variations. There is lack of consistency among the subthemes of the model and this study. The reason for the subthemes inconsistencies could be attributed to the fact that the model was designed for psychiatric illnesses which are totally different from cancers in terms of diagnosis and treatment. Therefore some modifications are needed to enhance the model capacity to adequately assess traditional and western management approaches for all diseases.

5.8 Suggestions for Model Modification

Based on the themes and subthemes of the present study, some suggestions are proposed for modifications of the traditional healers' practices and western management approaches to psychiatric diseases model for all diseases.

Subthemes such as beliefs about the cause of a disease, beliefs about disease prevention, and beliefs on the treatment of the disease could be made part of the model to help highlight and clearly define shared beliefs systems and concept of mental illness in the model. The cost of

disease treatment is also suggested for inclusion in the model to help assess the ability of patients to pay for disease treatments and their disease treatments preferences.

Treatment support systems were identified as having healing and curing effects on patients, and should, therefore, be included in the model to aid in determining the influence of support on disease treatment options. Again, care providers actions towards patients can influence the sick person's choice of treatment for the sickness, and therefore care providers actions should be considered part of the model in order to assist analyse the patients' treatment preferences.

The new theme of the present study, which sought to explore life with the disease, is important to the model since the theme is capable of measuring the overall outcome of living with the disease. Therefore, the theme – living with the disease could be made part of the model.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the summary of the study, implications of findings, and the limitations of the study, conclusion, and recommendations. The summary discussed the overview of the study with the key findings. Specific findings of the study are presented under the conclusion with accompanying recommendations directed to relevant authorities for redress. The implications of key findings of the study have also been highlighted.

6.1 Summary of the Study

Cervical cancer is a public health problem that affects women's well-being in Ghana. Patients with cervical cancer explore various treatment options to seek interventions and cure. The study, therefore, explored the experiences of women on the traditional and orthodox management of cervical cancer in the Accra Metropolis. The theoretical framework for traditional healers' practices and western management approaches for psychiatric diseases was used as an organizing model for the study. The specific objectives of the study were structured according to the constructs of the model. Reviews of empirical studies were done on traditional and orthodox management experiences on cervical cancer for the purpose of discussion of findings.

The study adopted a qualitative approach which employed exploratory descriptive design. Twelve (12) women with cervical cancer in the Accra Metropolis who met the selection criteria were purposely recruited. The face-to-face interview was adopted using a semi-structured interview guide for the data collection. The interviews were audio recorded with each interview

lasting between 30 – 45 minutes. The interviews were then transcribed verbatim and thematic content analysis procedures were applied to generate the findings.

Key findings showed that the women believed that cervical cancer is caused by the weight of the pregnant uterus and hidden nature of the cervix; wearing of non-cotton panties and tight dresses; prolonged use of sanitary pads; and abortions. They also believed that cervical cancer can be prevented by vagina hygiene education and eating of local food products (free chemically induced food) while avoiding imported food products. The study revealed that the participants consulted traditional treatment providers first before seeking orthodox treatment for cervical cancer. In addition, they trusted traditional care providers and showed mistrust for orthodox care providers.

The study identified: pain; loss of personal dignity and integrity; loss of blood; and fear of cervical cancer diagnosis as the experiences women encounter with cervical cancer screening in the hospital. The study also identified traditional treatments for cervical cancer such as herbal medicine; using prayer; and insertion of substances into the vagina. The orthodox treatments identified in this study were: surgery; chemotherapy; and radiotherapy. The reported side effects identified with orthodox treatment included; pain, vulva itching, hair loss and darken skin. The study further established that combined use of traditional and orthodox treatment has yielded:- cure; better health status; worse health status, and infertility as cervical cancer treatment outcomes. The women in this study lived a fearful life with cervical cancer and coped with the disease using their faith in God and hope in life.

6.2 Implications of the Findings

The findings of this study have implications for nursing practice, nursing research, and policy.

6.2.1 Implications for Nursing Practice

This study has established that cervical cancer patients experienced physical pain, emotional pain, and body disfigurement during treatment of the disease. This requires prompt and effective pain management, adequate pre-counseling and post-counseling, and thorough patient education. Therefore, there is the need for nurses to adhere to pain management guidelines in order to manage physical pain effectively. They should also endeavor to provide health education regarding side effects of cancer treatment to patients. Nursing care for cervical cancer patients should be based on the holistic individualized care approach where the physical, physiological, psychosexual, social and spiritual well-being of the individual is emphasized.

6.2.2 Implications for Research

Nursing as a profession has grown from apprenticeship to evidence-based-practice in the 21st century, and therefore, the importance of nursing research cannot be underrated. This study helped to illuminate understudied areas on cervical cancer and its management modalities, especially in sub-Saharan Africa. For instance, the impact of stigma on cervical cancer treatment and care, the effectiveness of the natural medicinal substances used for cervical cancer treatment, and cause-effect of all substances purported to be used as intravaginal practices on the cervix, all require investigating in Ghana. If these studies are conducted, evidence-based information will be available on causes of cervical cancer, effective and efficient local treatment, and impact of stigma on cancer treatment to inform the role of nurses, doctors, and policymakers regarding cervical cancer treatment and care in Ghana.

6.2.3 Implications for Policy Formulation

Policy guides training and practice of professionals and also regulates prices of goods and services in a country. This study showed that women have mistrust for hospital staff concerning confidentiality and privacy issues. This finding is rooted in the operating system of hospitals where a patient has to go through several units sharing his/her health problems. The cost of cervical cancer treatment in the hospital is also found to be very expensive and national health insurance does not cover cancer treatment in Ghana. These findings require policy formulations to ensure that cervical cancer treatment is funded by the state and other necessary measures instituted with the patient charter to ensure total maintenance of patient confidentiality and privacy in the hospital.

6.3 Limitations of the Study

The non-involvement of traditional healers or herbalists in the study was a major limitation of this study. Full information on the natural medicinal substances and traditional diagnostic systems could have been reported. The study may be subjected to the general limitations of qualitative inquiries but the sample size was adequate to ensure an in-depth appreciation of the experiences of the women in the study.

6.4 Conclusion

Participants in this study believed that they acquired the disease through their parents' genes, inappropriate personal lifestyle, and behaviours or that of their sexual partners. It was also realized that cervical cancer could be prevented with the use of vagina hygiene education to young girls and all women. The women experienced pain and blood loss when undergoing cervical cancer screening. They further described their experience of vulva itching and hair loss as terrible side effects of chemotherapy and radiotherapy. Few participants had complete cure

from cervical cancer with the use of traditional and orthodox treatment, some experienced improved health status with the orthodox treatment, and others felt their health status was worse with the traditional treatment. However, all participants lived a fearful life with cervical cancer diagnosis. According to the participants, their lives have been strengthened by their faith in God and hope in life.

In conclusion, women diagnosed with cervical cancer in the Accra Metropolis used traditional forms of treatment for the cancer first before orthodox treatment as a last resort. The women experienced physical, psychological, sexual, and social difficulties treating cervical cancer in Ghana. The model employed was useful and contributed immensely to the attainment of all the objectives of the study. The government of Ghana should formulate immediate national policy for cancer care with priority on human papillomavirus vaccinations to all girls and women in order to prevent cervical cancer and other HPV related cancers. Cancer education programmes to help reduce the non-communicable diseases burden on the economy must be policy driven and enforced.

6.5 Recommendations

The findings of this study have relevant recommendations for Ministry of Health (MoH), Ghana Health Services (GHS), Non-Governmental Organisations and the General Public, Nursing Researchers, Nurses and Medical Doctors.

6.5.1 Ministry of Health (MoH)

The MoH should:

- Put in place a national policy for cancer treatment and care.
- Institute cancer registry to be able to monitor the incidence of all cancers, especially cervical cancer.

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- Fund cancer treatment especially, cervical cancer to help save lives of mothers.
- Fund local cancer research to improve and develop local technology for cancer treatment and care in Ghana.

6.5.2 Ghana Health Services (GHS)

The GHS should:

- Organise refresher training on cancer treatment and care for all staff caring for cancer patients to enable them to acquire up-to-date clinical practice skills.
- Develop cervical cancer assessment checklist and referral systems for cervical cancer treatment and care and implement it at all levels of healthcare delivery points in Ghana to prevent diagnosis and treatment delays of cervical cancer.
- Liaise with the ministry of health to acquire HPV vaccines for vaccination to all young girls and women in Ghana to help prevent the incidence of cervical cancer and other HPV related cancers in Ghana.

6.5.3 Non-Governmental Organisations and General Public

The Non-Governmental Organisations and General Public should:

- Advocate, provide and support the treatment of cervical cancer patients in Ghana.
- Take interest in cancer lessons especially health education on cervical cancer to improve cancer prevention knowledge in Ghana.
- Advocate, provide and participate in cancer screening exercises especially cervical cancer screening to aid early detection and treatment of cervical cancer in Ghana.

6.5.4 Nursing Researchers

Nursing Researchers should:

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- Utilise quantitative research approaches to assess the impact of stigma and discrimination on cervical cancer and its treatment and care in Ghana.
- Use quantitative research methods to investigate the effectiveness of the natural medicinal substances for cervical cancer treatment in Ghana.
- Investigate cause and effect of all substances purported to be used as intravaginal practices on the cervix in Ghana.

6.5.5 Nurses and Medical Doctors

Nurses and Medical Doctors in Ghana should:

- Provide adequate psychological preparations to all cervical cancer patients before, during, and after cervical cancer screening, and hysterectomy to reduce the impact of psychological worries experienced by cervical cancer patients.
- Use anaesthetic spray on the cervix before Pap smear testing in order to reduce pain experienced during the screening process.
- Device ways for the prevention of bleeding of the cervix during cervical cancer screening to minimize loss of blood during the procedure.

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APPENDICES

Appendix A: Background Information and Interview Guide

Code Number.....

1. Age:

2. Place of residence.....

3. Nationality

4. Marital status: Married []; Divorced []; Never married []; Separated []

5. If married/divorced, is this the first or second marriage?

6. Age of first sexual encounter?

7. Number of sexual partners you have had?

8. Have you ever had a sexual partner who had multiple sexual partners?

9. Number of children.....

10. Occupation

11. Level of education

12. Languages spoken

13. Religion

14. How long have you been diagnosed with cervical cancer?

15. Have you use traditional/herbal/indigenous medicine to treat your cervical cancer?

16. Are you still receiving treatment? Specify

17. Do you smoke?.....

18. Have you ever used a birth control method?

19. If yes to question 18 above, which type of birth control method did you use?

20. How long did you use this birth control method in question 19 above?

Interview Guide

Research Topic: Women's experiences with traditional and orthodox management of cervical cancer in the Accra Metropolis

Researcher: Asakitogum Ayangba David (MPhil. Nursing Student)

Address: School of Nursing and Midwifery, University of Ghana

Telephone: 0246612349

The questions are open-ended questions developed according to the objectives of the study to guide the conduct of the interviews. The participants' response will also elicit probing questions too.

SECTION A: Women Belief Systems of Cervical Cancer

1. Please, what do you think is the cause of your disease?

Probes: beliefs: Germ/virus, breaking taboos, extramarital affairs, and spiritual

2. Please, share with me what inform your decision to use traditional/herbal/indigenous medicine to treat your cancer.

Probe: availability, affordability, efficacy,

3. What causes your change of mind to seek orthodox/hospital treatment for your cancer?

Probe: Failures of traditional medicine, desire combine effect of traditional and orthodox treatment, dependability

SECTION B: Women Experiences with Cervical Cancer Diagnosis

4. What did the traditional healer say was the cause of your disease?

Probe: poisoning, witches have to remove your womb, works of the enemies, spiritual, breaking taboo

5. Please, share with me the ways by which the traditional healer used to arrive at what was wrong with you?

Probe: Dancing and Chanting, Look into Mirror or Calabash, Toss cowries or coin, Fasting and Prayers, Your feelings about it

6. Tell me what the Doctor in the hospital says was wrong with you?

7. What did the Doctor do in order to come to know what was wrong with you?

Probe: What test, Your feelings about it

SECTION C: Women Experiences of Cervical Cancer Interventions

8. Please, describe the kinds of treatment you received from the traditional healer in order to cure your disease.

Probe: herbs, prayers, massage, witchcraft removal, experiences (pain, cost, work, support)

9. What kinds of treatment did you receive from the hospital to cure the disease?

Probe: Surgery, Chemotherapy, Radiotherapy, experiences (pain, cost, the attitude of medical staff, support from family, friends)

SECTION D: Women Experiences with Cervical Cancer Treatment Outcomes

10. Share with me the results of traditional medicine usage on your disease?

Probe: worst, same status, psychological comfort, physical pain

11. How do you feel now with the hospital treatment?

Probe: same health status, partially cure, cure completely, concerns about fertility, concerns about sexuality, sad and loneliness, loss of resources

12. Please share with me your concerns about the future living with this disease?

Probe: Recommendations, Anything else

THANK YOU

Appendix B: Information Sheet

TITLE OF STUDY: Women's experiences with traditional and orthodox management of cervical cancer in the Accra Metropolis

Name of Principal Investigator: Asakitogum Ayangba David

Address: School of Nursing and Midwifery, University of Ghana

Tel. Number: 0246612349

Email: dasakitogum@yahoo.ca

Dear Participant,

I am a graduate student from the School of Nursing and Midwifery, University of Ghana, Legon.

I am investigating the experiences of women with the traditional and orthodox management of cervical cancer and you are invited to participate in the study. The study seeks to aid in the understanding of cervical cancer management from the patients' perspectives. Your experiences shared in this study will be valuable to health policymakers in the development of strategies to address the concerns of women living with the disease.

BI: Why am I doing this study?

I would like to seek information from women diagnosed with cervical cancer who have received traditional and orthodox management for it. This information will help me understand the plight of cervical cancer patients receiving treatment or have received cancer treatment. The information will help doctors and nurses to be able to provide satisfying care to people (women) living with cervical cancer. The information will also help me to get a masters certificate from the University of Ghana.

B II: What will happen during the study?

I will ask you questions and you will provide responses based on the information you have. It will take the form of a conversation between you and me. You are free to speak English, —Wi” or —Grune”. The conservation will take place in a location and time convenient to you and you are not obliged to respond to questions that you are not comfortable with. The dialogue will be on the things you have been doing to treat the disease since it has started. The interview will last between 45-90 minutes. A second interview may be rescheduled if necessary. You will be asked to sign or thump print a consent form to show that you are willing to participate.

B III: Will anyone know what you told me?

I am working with two supervisors. These are the only persons who will get to know about our conversation. I will record our conversation on a tape recorder but your name will not be recorded. I will write out the recorded information in words on paper and assign a code number with a false name to it. So in the report, readers will get to know the false name and you will not be identified. Any information that bears your name will be kept under lock and key at a separate place from the written information for 5 years after the study and then be discarded.

B IV: What are the possible gains and harm to you?

The study as at now might not have any direct benefit for you but going forward I believe that your participation and contribution will help other women affected with cervical cancer to understand the disease better. Your shared experience in the management of the disease will enable health workers to design programmes that will help adequately address the treatment concerns of the disease.

I do not anticipate any harm that you stand to get in participating in the study but you may feel emotional telling your own story. In the event of an emotional breakdown, there is pre-arrangement for a professional counselor and/or a clinical psychologist who will talk to you to relieve and heal you of your emotions for a fee free of charge.

B V: Can you withdraw from the study?

You are at liberty to leave the study at any time you wish even after you have agreed to be part of the study. Your withdrawal will not affect the health care you are receiving or will be receiving in the future from the hospital. Also, you will not be expected to give reasons for your exit.

Appendix C: Consent Form

022/17-18

CONSENT FORM

Title: Women's Experiences with Indigenous and Orthodox Management of Cervical Cancer in the Accra Metropolis

Principal Investigator: Asakitogum Ayangba David

Address: School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Legon.

Email: dasakitogum@yahoo.ca Tel. Number: 0246612349

General Information about Research

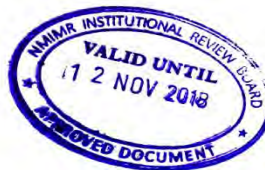
I am a graduate student from the School of Nursing and Midwifery, University of Ghana, Legon. This study seeks to understand how your life has been following the diagnosis and treatment of your cancer. Whatever information you are going to provide will be audio-recorded. You are invited to be part of the study because you have used both home/ traditional and hospital treatment for it, and can speak English, Ga, Twi, or Grune. If you agree to participate, you will be required to sign or thumbprint an agreement form and give answers to questions asked. The interview will last between 45 to 90 minutes. There is no wrong or correct answer to any of the questions asked; you are therefore encouraged to express yourself freely in whatever manner you so wish. You have the right not to answer questions which make you uncomfortable and the right to refuse to participate in the study without any change in your care.

Possible Risks and Discomforts

I do not anticipate any harm that you stand to get in participating in the study but you may feel emotional telling your own story. In the event of emotional breakdown, there is pre-arrangement for a professional counselor and/or a clinical psychologist who will talk to you to relieve and heal you of your emotions without any fee.

Possible Benefits

The study as at now might not have any direct benefit for you but going forward I believe that your participation and contribution will help other women affected with cervical cancer to understand the disease better. Your shared experience on the management of the disease will enable health workers to design programmes that will help adequately address the treatment concerns of the disease.



Traditional & Orthodox Management Experiences of Cervical Cancer

Confidentiality

I am working with two supervisors. These are the only persons who will get to know about our conversation. However, if you will not feel comfortable talking to me directly, a female research assistant will interview you. I will record the conversation on a tape recorder but your name will not be recorded. I will write out the recorded information into words on paper and assign a code number with a false name to it. So in the report, readers will get to know the false name and you will not be identified. No information will bear your name.

Compensation

There are no direct benefits and no compensation package for participating in this study. If for any reason a participant becomes exhausted within the stated time of interviewing, the interview will be stopped and continued at the convenience of the participant. Such a participant will be given a can of Malta drink at a cost to the researcher, to revitalize the participants' loss energy.

Voluntary Participation and Right to Leave the Research

You are at liberty to leave the study at any time you wish even after you have agreed to be part of the study. Your withdrawal will not affect the health care you are receiving or will be receiving in the future from the hospital. Also you will not be expected to give reasons for your exit.

Contacts for Additional Information

If you have any concerns you can send an email or phone the researcher or his supervisors using the contact addresses:

Asakitogum Ayangba David: dasakitogum@yahoo.ca Phone number: 0246612349

Dr. Lydia Aziato: aziatol@yahoo.com Phone number: 0244 719 686.

Ms Lillian Akorfa Ohene: akorfaohene11@yahoo.com Tel: 0246395696

Dr. Samuel Atindanbila, Clinical Psychologist: satindanbila@ug.edu.gh Tel: 0206950117

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh



Traditional & Orthodox Management Experiences of Cervical Cancer

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title "*Women's Experiences with Indigenous and Orthodox Management of Cervical Cancer in the Accra metropolis*" has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained Consent



RESEARCH ASSISTANT AGREEMENT

I have been given adequate training on how to collect interview data in English, Ga, and Twi languages on the above document describing the procedures for the research title "**Women's Experiences with Indigenous and Orthodox Management of Cervical Cancer in the Accra Metropolis**". I agree to participate as a research assistant. I further agree and pledge to keep participants information confidential, ensure their anonymity, and autonomy during and after the data collection according to the dictates of research ethics.

Date

Name Signature of Research Assistant

I certify that the recruitment criteria and training on how to collect interview data associated with conducting this research have been explained and conducted to the above individual.

Date

Name Signature of Person Who obtained Consent



Appendix D: Introductory and Permission Letter



UNIVERSITY OF GHANA SCHOOL OF NURSING

SON/C/33
Ref. No.:

October 4th, 2017

The Ethics Review Committee
Ghana Health Service
Accra

Dear Sir/Madam,

INTRODUCTORY LETTER – MR. DAVID AYANGBA ASAKITOGUM

I write to introduce Mr. David Ayangba Asakitogum, an MPhil student of the University of Ghana School of Nursing and Midwifery, who wants his proposal reviewed by your institutional Review Board. This is to enable him collect data at one of your facilities – the Ridge Hospital, Accra.

He has completed his proposal and the School approves of it.

I should be grateful if you could review his proposal as submitted.

Thank you.

Yours faithfully,

A handwritten signature in black ink, appearing to read 'Lydia Aziato'.

Lydia Aziato (PhD)
Ag. Dean
laziato@ug.edu.gh

COLLEGE OF HEALTH SCIENCES

P. O. Box LG 43, Legon, Accra, Ghana.
• Tel: +233 (0) 302 513 250 / 0289 531 213 • Email: son@chs.ug.edu.gh • Website: www.nursing.ug.edu.gh

file.

Research - 200

Presbyterian Nurses Training College: Bawku
P. O. Box 45
Bawku, UER.



The Medical Director
Greater Accra Regional Hospital, Ridge
Ridge, Accra.

Dear Sir,

PERMISSION TO ACCESS PARTICIPANTS FOR A STUDY

I wish to apply for permission to access participants from your Hospital for academic study. I am an MPhil Nursing student, University of Ghana. The title of the study is "Women's Experiences with Indigenous and Orthodox Management of Cervical Cancer in the Accra Metropolis". The study is in partial fulfillment for the award of masters' certificate from the University.

I am counting on your kind consideration.

Thank you.

Yours faithfully,

Asakitogum Ayangba David
(dasakitogum@yahoo.ca 0246612349)

Cc:

The Chairperson

Ghana Health Service Ethical Review Committee

Ghana Health Services

Accra.

Head of Public Health
Unit,
Approved
Please open as
necessary by
signature
14/11/17

Appendix E: Ethical Clearance from Nuguchi- IRB

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH *Established 1979A Constituent of the College of Health Sciences*

Phone: +233-302-916438 (Direct)
+233-289-522574
Fax: +233-302-502182/513202
E-mail: nirb@noguchi.mimcom.org
Telex No: 2556 UGL GH

INSTITUTIONAL REVIEW BOARD



University of Ghana

Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

1st November, 2017

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

IRB 00001276

NMIMR-IRB CPN 022/17-18

IORG 0000908

On 1st November, 2017 the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : Women's experiences with indigeneous and Orthodox management of cervical cancer in the Accra Metropolis.

PRINCIPAL INVESTIGATOR : Asakitogum Ayangba David, MPhil Cand.

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 31st October, 2018. You are to submit annual reports for continuing review.

Signature of Chair:
Mrs. Chris Dadzie
(NMIMR – IRB, Chair)

Appendix F: Ethical Clearance from Ghana Health Services-ERC

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.



Your Health. Our Concern.

MyRef. GHS/RDD/ERC/Admin/App/825
Your Ref. No.

Asakitogum Ayangba David
University of Ghana
School of Nursing and Midwifery
Legon, Accra

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com
26th October, 2017

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	GHS-ERC: 011/10/17
Project Title	Women's Experience with Indigenous and Orthodox Management of Cervical Cancer in the Accra Metropolis
Approval Date	21 st October, 2017
Expiry Date	20 th October, 2018
GHS-ERC Decision	Approved

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

Traditional & Orthodox Management Experiences of Cervical Cancer

Appendix G: Demographic Profile of Participants

Table 4.2: Participants Demographic Data

Code	Age	Residence	Marital Status	No. of Sexual P	Age at First Sex	Suspect Partner	No. Children	Level of Edu.	Occupation	Languages Spoken	Religion	Length of CC	Treatment Used	Health Status	Sm	F P	FP Met.
C1	35	Osu	Married	5	18	Yes	2	Tertiary	Business Owner	English, Twi, Ga	Christian	2 years	Herbal, Chem, Surg.	Improve Orth.	No	Yes	Inj
C2	38	Madina	Divorced	5	11	Yes	2	Tertiary	Store Managress	English, Twi, Grune	Hinduism	5 years	Herbal, Surg.	Cured Infertility Pelvic P	No	Yes	Inj
C3	62	East Legon	Divorced	3	23	Yes	4	Tertiary	Nurse	English, Twi	Christian	4 years	Dietary M., Infrared Radio	Cured	No	Yes	IUD
C4	63	Adabraka	Widow	3	21	No	4	O. Levels	Crew Managress	English, Twi, Fante	Christian	18 months	Herbal, Chem., Surg.	Improve Orth. Adhesion	No	No	NA
C5	54	Accra New T	Divorced	10	15	Yes	4	SSS	Evangelist	English, Twi, Ga, Krobo	Christian	16 months	Herbal, Chem, Radio., Prayer Insertion	Incomp.	No	No	NA
C6	68	Osu	Widow	1	18	No	3	Form 4	Trader	English, Ga	Christian	6 years	Prayer, Chem., Radio	Cured	No	Yes	Tablets
C7	44	Kasua	Married	3	16	Yes	8	Primary	Trader	Twi, Fante	Christian	2 years	Prayer, Herbal, Chem., Radio	Incomp.	No	Yes	Inj
C8	64	Dome	Married	1	28	Yes	3	Standard 7	Trader	English, Twi, Nzema	Christian	3 years	Prayer, Surg.	Improve Orth.	No	No	NA
C9	62	Kasua	Married	1	28	Yes	3	Form 4	Trader	English, Twi, Ewe	Christian	4 years	Prayer, Surg.	Improve Orth.	No	Yes	IUD
C10	54	La	Married	2	25	Yes	3	SSS	Fashion Designer	English, Twi, Ga	Christian	5 years	Prayer, Chem.	Cured	No	Yes	Tablets

Traditional & Orthodox Management Experiences of Cervical Cancer

C11	40	La	Married	4	14	Yes	3	Tertiary	Teacher	English, Ga	Christian	3 years	Vagiva Ins., Surg., Prayer, Herbal	Improve Orth. Infertility	No	Yes	Inj
C12	60	Dansoma	Widow	5	12	Yes	5	Form 4	Trader	English, Ga, Twi	Christian	4 years	Vagiva Ins., Surg., Prayer, Herbal	Improve Ortho.	No	No	NA

Keys: CC – Cervical Cancer, IUD – Intra-uterine device, Sm – Smoking, Ortho – Orthodox treatment, Chemo. – Chemotherapy, Surg. – surgery, vagina Ins. – vagina insertion, Radio. – Radiotherapy, NA –not applicable, Level of edu. – Level of education, Inj. – injectable, Incomp. – Incomplete, FP – Family Planning, FP met. – Family Planning Method, SSS – Senior Secondary School, O' levels – Ordinary Level