

CENTRE FOR SOCIAL POLICY STUDIES

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**RESPONDING TO BREAST CANCER IN GHANA: THE ROLE
OF STATE AND NON STATE ACTORS**

BY

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DECLARATION

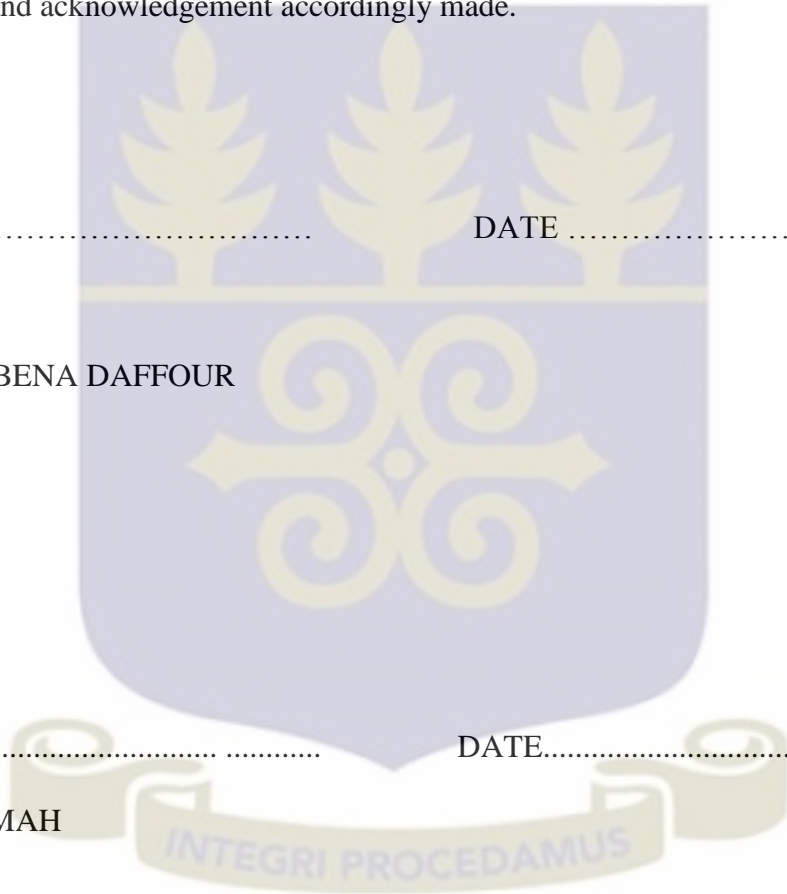
I, Philomena Abena Daffour, do hereby declare that this dissertation is the result of my own research work carried out under the supervision of Mr Ralph Armah and that, to the best of my knowledge, it contains no materials previously published or submitted by another person for the award of any other degree by this institution or any other institution, except where references have been made and acknowledgement accordingly made.

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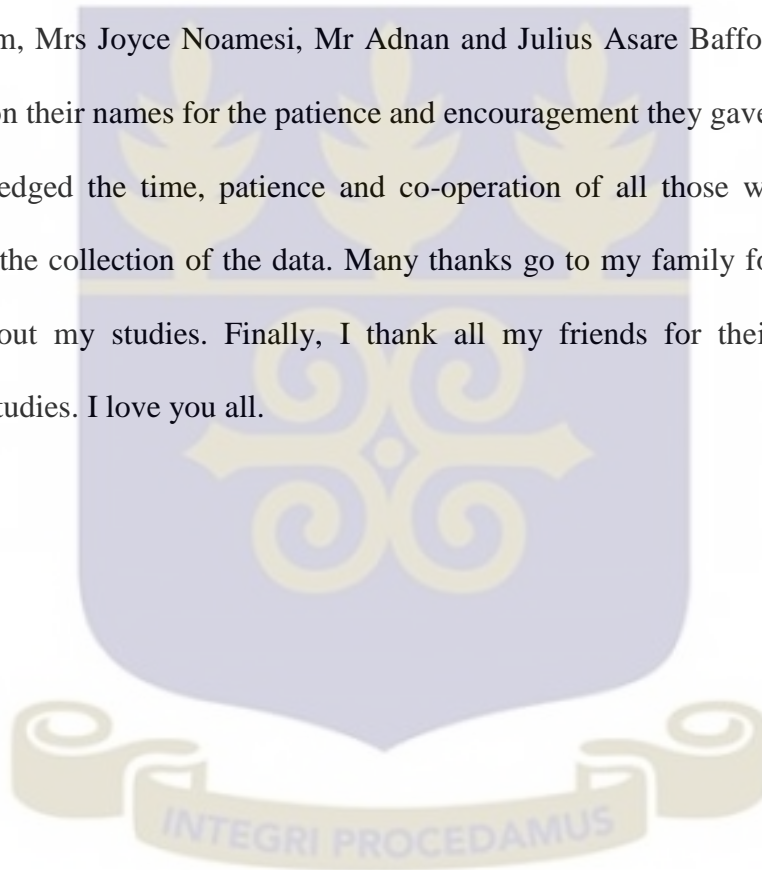
DEDICATION

This project is dedicated primarily to God Almighty (the all Seeing Eye of the universe) who has brought me this far.



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I would like to express my profound appreciation to the Almighty God who protected me throughout these years of studies. I wish to also thank my supervisor, Mr Ralph Armah who gave me the necessary guidance that enabled me to complete this research. I am grateful to all the lecturers and my colleagues at the Centre of Social Policy Studies for their support. I am especially grateful to Mr. Samuel Akafia, Kelly Akafia, Delali Akafia, Dzidzorm Akafia, Mrs. Paulina Bioh, Mr. Courage Awusanya Doe, Mrs. Theresa Kpontsu, Mrs. Gifty Opong, Mr Charles Anim, Mrs Joyce Noamesi, Mr Adnan and Julius Asare Baffour and all those I could not mention their names for the patience and encouragement they gave me. I would like to also acknowledged the time, patience and co-operation of all those who helped me in diverse ways in the collection of the data. Many thanks go to my family for their enormous support throughout my studies. Finally, I thank all my friends for their encouragement throughout my studies. I love you all.



ABSTRACT

This is a qualitative study of the role of state and non-state actors in responding to breast cancer in Ghana. In depth interviews were conducted with eight purposively sampled actors comprising five and three actors from state and non-state actors respectively. The objectives of the study is to investigate the perspectives of State and Non-State actors on the causes and risk factors of breast cancer in Ghana, identify the roles they play in responding to the issue of breast cancer in Ghana, assess the policy interventions towards aiding individuals with Breast Cancer and their challenges. Findings from the study reveal biological and lifestyle practices that put women at risk of having breast cancer, state and non-state actors played very important roles in addressing breast cancer issues in Ghana, The study further discovered that both state and non- state actors contributed to the development of interventions that were directly or indirectly adopted into health policies. Financial constraints and socio-cultural beliefs and practices were identified to be the most dominant challenges to the impact of both state and non-state actors in their efforts in addressing health issues relating to breast cancer health. The study identified collaborative efforts between both set of actors in public health initiatives with very significant contributions from the media. The study provides evidence of the need to put in place policies towards addressing social, technological and structural challenges faced by these actors. The study found the major roles played by the state and non-state actors, it included awareness creation, late detection, NGOs playing a critical role in addressing issues that were overlooked or ignored by government, resource challenges, perceptions, beliefs and cultural practices; ignorance and stigmatization, financial constraints, lack of professionals, public misconceptions about breast cancer and lack of scientific and epidemiologic information. The study recommends opportunities to change the negative perceptions of the public concerning breast cancer via awareness creation, and capacity building was recommended. In sum the study shows that both state and

non-state actors among other things play a key role in the country's quest to address breast cancer.



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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Globally, cancer is known to be as one of the leading causes of death and disability (Agyei-Mensah S, de- Graft Aikins A. 2010). About 12 million cancer cases are recorded annually, most of the reported cancer cases are breast cancer and are found in developing regions of the world (PACT, 2008). Breast cancer is predominant among women and poses a major public health concern especially in developing countries. Although breast cancer can be well managed when detected early most women in Ghana do not have regular breast examination due to fear of being diagnosed with the condition (Opoku, Benwell and Yarney, 2012).

Breast cancer has been a major challenge for countries. Breast cancer is one of the most common health challenges in women in developing world. In China, the prevalence rate of breast cancer has been lower as compared to that of the United States, Parkin et al., (2005) estimated that the prevalence rate is about 11.8 per 100,000. They however found that the incidence rate in the United States of America is 86.3 per 100,000 (Opoku, Benwell and Yarney, 2012). In pathological studies of women in Ghana, breast cancer is frequent and its incidence is ever growing (Wiafe-Addai, 2004).

In 2010, over two thousand women were diagnosed with breast cancer in Ghana, the same study ranks Ghana 10th in burden of breast cancer disease in Africa (GLOBOCAN, 2012). Breast cancer is a public health challenge in Ghana. Studies on breast cancer in Ghana in the late 1960s and early 1970s provided initial insights into the disease. One of the first studies that analyzed the issue of breast cancer was at the Korle Bu

Teaching Hospital (KBTH) which established that cancer of the breast was predominantly a female health condition (Aidoo, 1993).

The rate at which breast cancer is affecting the labour force (more especially women) has drawn the attention of both state and non-state institution to help put policy and programme interventions in place to help address this public health challenge(Okorie, 2013). A variety of strategies have also been identified in efforts to address breast cancer, the mass media serve as effective health communication channels in Nigeria (Grey and McMikel2012). Non-governmental Organizations, Community-based organizations and civil societies have been dedicated to advocacy, research and education on breast cancer. Thus, they often organize lobbying events and grassroots campaigns on breast cancer and other local and national issues (Okorie, 2013). The International Agency for Research on Cancer(IARC), a specialised cancer agency of the WHO, and GLOBOCAN 2012, has it that an estimated 14.1 million new cancer cases and that 8.2 million cancer – related deaths occurred in 2012, as compared with 12.7 million in 2011 and 7.6 million in 2010.

Prevalence estimates for 2012 shows that 32.6 million people (over the ages of 15 years) alive had had a cancer diagnosed in the previous five years. With breast cancer having 1.7 million people adding up to 11.9%.

Projections based on GLOBOCAN 2012 estimates predicts a substantive increase to 19.3 million new cancer cases by 2025 due to growth and ageing of the global population. More than half of all cancers (56.8%) and cancer death (64.9%) in 2012 occurred in less developed regions of the world and these proportions will increase further.

In 2012, 1.7 million women were diagnosed with breast cancer and there were 6.3 million women alive who had been diagnosed with breast cancer in the previous five years. Breast

cancer has increased by more than 20% while mortality has increased by 14%. Breast cancer is the common cause of cancer death among women (522,000 deaths in 2012) and the frequently diagnosed cancer among women, in 140 of 184 countries worldwide. It now represents one in four of all cancers in women.

Breast cancer is a leading cause of cancer deaths in the less developed countries of the world. This is partly because a shift in lifestyles is causing an increase in incidence, and partly because clinical advances to combat the disease are not reaching women living in these regions and that developing countries going through rapid societal and economic changes, shift towards lifestyle of typical industrialized countries leading to a rising burden of cancers associated with reproductive, dietary and hormonal risk factors and also huge inequalities between rich and poor countries.

Incidence rates remain highest in more developed regions, but mortality is relatively higher in less developed countries due to lack of early detection and access to treatment facilities.

For example, in Western Europe, breast cancer incidence has reached more than 90 new cases per 100,000 women annually, compared with 30 per 100,000 in eastern Africa. In contrast, breast cancer mortality rates in these two regions are almost identical, at about 15 per 100,000, which clearly points to a later diagnosis and much poorer survival in eastern Africa.

Other authorities have emphasised the roles played by state institutions in addressing breast cancer globally. Ministries and governmental agencies responsible for health have the responsibility to put up policies and programmes to help improve breast cancer care (Zelle et al., 2012; Agyei-Frimpong, Darko and Wiafe-Addai, 2008). It is worth noting that strong partnership among the state and non-state actors perhaps will help yield the needed results

since each will give out its best to promote quality breast cancer care among women (Darko and Wiafe-Addai, 2008).

1.2 Statement of the Problem

Globally, breast cancer comprises about 16% of all cancers, and it is thought to be a disease of the developing world (WHO, 2004). This notwithstanding, developing countries such as Ghana is faced with this public health challenge. In Ghana, breast cancer is the commonest cancer among women (Badoe and Baako, 2000). Females in Ghana constitute more than Half of the population (GSS, 2010)

Also women in Ghanaian society are key development partners and agents of socialization, so it is very important for all to come together to fight against the public health challenge that breast cancer presents, in order to get a very healthy population. Additionally, state and non-state actors are very important in addressing the issue of breast cancer in Ghana. Perhaps Ghana has not been able to do much with respect to reducing breast cancer due the lack of focus on effectively coordinating the efforts and roles of both state and non-state actors (Opoku, Benwell and Yarney, 2012).. The actors face challenges emanating from factors such as financial constraints, non-performance of roles, cultural beliefs and practices and myths about breast cancer (Opoku, Benwell and Yarney, 2012). Despite the fact that the roles and challenges of these actors are clear, they are not well defined by evidence. In fact, studies on the roles and challenges of state and non-state actors in responding to breast cancer as it relates to Ghana have been given the necessary attention.

The issue is that, there are several state and non-state actors responding to breast cancer in Ghana; but what roles do they play? What are their perceptions, knowledge and attitude on breast cancer? What challenges are they facing in their quest to address breast cancer in

Ghana and what are the policy implications of these roles and challenges? In order to effectively fight any problem and boost the capacity of the various stakeholders, awareness of their roles and possible challenges they face is very important. It is therefore against this background that this study seeks to explore the role of state and non-state actors in addressing the burden of breast cancer in Ghana.

1.3 Objectives of the Study

The aim of this study is to explore the roles of state and non-state actors in responding to breast cancer in Ghana.

To achieve the overall objective, the study has these specific objectives:

- To investigate the perspectives of State and Non-State actors on the causes and risk factors of breast cancer in Ghana.
- To identify the Roles State and Non-state actors play in responding to the issue of breast cancer in Ghana.
- To assess the policy interventions of State and Non-State Actors in aiding individuals with Breast Cancer.
- To investigate the challenges that the State faces in improving breast cancer care.
- To identify the ways through which the challenges faced by these Actors can be addressed

1.4 Research Questions

- i. What are the perspectives of state and non-state actors on the causes and risk factors of breast cancer?
- ii. What roles do state and Non-state actors play in responding to the issue of breast cancer in Ghana.

- iii. What policy interventions are State and Non-State Actor putting in place to aid individuals living with Breast Cancer?
- iv. What challenges do the state and non-state actors face in aiding to improve breast cancer care?
- v. How can the challenges faced by the actors be addressed?

1.5 Significance of the Study

There have been previous studies conducted on breast cancer in Ghana (de-Graft Aikins et al, 2010, Opoku et al., 2012, Atobrah, 2012, 2013). Despite the fact that some of these studies have explored cancer experiences and provided insights into social support systems including advocacy, very few have examined the challenges that confront state and non-state actors in addressing the breast cancer burden in Ghana and a limited number have adopted qualitative methods for their studies. This study departs from previous studies to explore the policy interventions and challenges of these actors through the use of qualitative research methods. The significance of a study should at least be projected in three domains which include its contribution to research, policy, and professional practice (Creswell, 1998). It is anticipated that the findings from this study will have significance along these domains.

First, it is anticipated that the results of a study of this nature would make a contribution to the development and formulation of policy and programmes by shedding light on challenges faced by non-state and state actor in their quest to address breast cancer issues in Ghana. The study provided evidence of the need to put in place policies towards addressing social, technological and structural challenges faced by these actors. It dwelt on policies and practices that initiated discussions surrounding the inclusion of a national policy on free breast cancer testing which will be community-centred in Ghana. The study would generate

interest and debate among social scientists, policy analysts, public health workers and all human service workers and become a tool for advocacy and social action available to Non-governmental and governmental agencies engaged in breast cancer care. Policy makers may also make direct reference to information from this research to aid them in planning breast cancer related programmes.

Again, with regards to research, it is anticipated that the findings will add to the literature on breast cancer in Ghana. The findings would also provide evidence to support the need for further investigation into issues relating to breast cancer in Ghana. In addition, the findings can also help shift the focus of future researchers to explore interventional practices with the potential of improving the conditions of breast cancer patients. The use of qualitative research methods will ensure an enriched and comprehensive set of data to generate informed recommendations to stakeholders.

1.6 Theoretical Framework

The Explanatory model approach was used for this study (Kleinman, 1980). Specifically, the explanatory model was used to provide a framework which can help to best understand and assess the perceptions, knowledge, roles and relationship among the state and non-state actors in addressing the breast cancer burden in Ghana.

1.6.1 The Explanatory Model

Researchers create and implement interventions as a major means by which to disseminate knowledge and increase awareness about a given health problem, such as breast cancer. Explanatory models assist researchers by organizing their inquiry into what people think have caused certain health problems, their thought about problem, the kind of treatment available

and why people do or do not engage in specific health behaviours (Kleinman, 1980; NCI, 2005). The Explanatory Model considers one's overall perceived risk factors and causes of an illness as a precursor to positive, preventive behaviour (Wendt, 2005; Janz et al 1984; Weinstsin and Sandman, 1992). The explanatory model was propounded in the 1980s by Kleinman. Individuals' perceptions about the severity and causes of public health challenges as well as perceived barriers, and cues to actions towards addressing those challenges are the core components of the model. For some decades, several authors and researchers have added other components and made attempts to clarify and critique it (Basu et al 2005).

The fundamental premise of the explanatory model is that an individual's thought consist of the severity, causes and risk factors as well as barriers and cues to action to attempt to reduce overall risk for a particular illness or disease and these are very important in addressing public health challenges (Glanz et al, 2002). It is worth noting that the explanatory model looks at two key models of diseases – expert and lay explanatory models. Kleinman (1980) indicates that treatment outcomes, patient's willingness to access services or continue treatment is partly dependent on the disparities between the expert and lay models of diseases.

Explanatory Model as explained by Kleinman (1980) delves into how the victim must think about the cause of the disease, that is, how the disease might have come about, how it came about and what the disease does to them.

It gives the physician knowledge of the beliefs the patient holds about his illness, the personal social meaning he attaches to his disorder, his expectations about what will happen to her and what the doctor would do, and engages with patients in comprehensively understanding their live illness experience and elicits the patient's own therapeutic goals.

Researchers in the 1990's have refined Kleinman model, such as the explanatory interview catalogue which has been used to cure leprosy and mental health in India. Other uses include understanding HIV related stigma, causes of youth violence, perceptions of mental illnesses, diseases such as Type2 diabetes

Explanatory Model provides researchers with an idea of how patients experiences and interprets their disease. It improves quality of care. It also helps researchers design appropriate therapies and interventions and explains why some breast cancer patients reject medications or refuse to comply with a prescribed therapy. It also reveals how people make sense of their illness. The model was proposed to organise illness and help with socio-cultural contexts. It investigates explanations of sickness, social realities that are culturally shaped and influences how individuals experience diseases.

Explanatory Model is used to explain how people view their illness in terms of how it happens, what caused it, how it affects them and what will make them feel better. It guides the perceptions of researchers by emphasising the importance of examining your health, health seeking behaviours and medicinal decision making within a cultural context.

Kleinman's model contains 8 questions which are;

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness will do to you?
4. How severe is your sickness? Will it have a long or short course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your sickness has caused for you?
8. What do you fear most about your sickness?

The explanatory model is used by the researcher to understand the actors thought about the risk factors, their roles and the challenges they face in addressing the breast cancer burden in Ghana with much focus on preventive health behaviour which is central in health education.

The Explanatory Model originally had four constructs representing perceived threat and net benefits. Later, other components were added. The components are: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, other variables or modifying factors, cues to action, and self-efficacy (Stout, 1997). The first component of the Explanatory Model is susceptibility; the degree an individual feels personally is susceptible to contracting the condition (Stout, 1997). For example, how susceptible does a woman feel she might get breast cancer? Applying this to breast cancer prevention includes a woman knowing that breast cancer is a possibility, and she can get breast cancer, unless she addresses some of the risk factors.

The second component is severity, or seriousness, or the degree the condition is viewed as serious (Stout, 1997). A woman will adopt preventive lifestyle if she understands the realistic and unrealistic optimism of escaping breast cancer. The third concept is perceived benefits, the degree to which an individual believes that taking a specific action to prevent a condition will be beneficial and effective (Rosenstock, 2005). The fourth component of the Explanatory Model is perceived barriers to action (Rosenstock, 2005). Barriers stakeholders pursuing breast cancer in Ghana might encounter include financial constraints, conflict of interests, cultural beliefs and practices (Attobrah, 2012). These barriers may hamper the efforts of these actors.

The fifth and sixth components of the Explanatory Model are other variables (modifying factors) and cues to action. Other variables are demographic factors (age, income, education, and marital status), socio-psychological (beliefs, attitudes, culture) and structural variables

that make up an individual's perception of susceptibility, severity, benefits and barriers. The cues to action are merely triggers that prompt an individual to action (Rosenstock, 2005).

The seventh component is self-efficacy. Self-efficacy is an individual's confidence that he or she can perform a specific action (Rosenstock, 2005). Do the actors believe they have the capacity to help address the breast cancer burden? Do they have the required knowledge, education and skills in order to successfully work towards addressing the cancer burden in Ghana? The Explanatory Model fits the focus of this project for it incorporates the experts' views on breast cancer and seeks to change negative perceptions about breast cancer as well as promote health behaviours (including change of lifestyles, beliefs and perceptions and preventive practices).

1.7 Definition of Terms

The following key concepts which have been predominantly used in the study are explained for clarification:

Attitude - a learned predisposition to think, feel and act in a particular way towards breast cancer

Breast cancer - a malignant tumor that starts in the cells of the breast. The disease occurs almost entirely in women, but men can get it, too

Breast Cancer Treatment - Measures aimed at curbing the disease, prolonging life, and improving the quality of remaining life after the diagnosis of breast cancer. There are four standard methods of treatment for cancer: surgery, chemotherapy, radiation therapy, immunotherapy and biologic therapy.

Diagnosis - refers both to the process of attempting to determine or identify a possible breast cancer.

Knowledge - is a familiarity with issues concerning breast cancer, which can include information, facts, descriptions, and/or skills acquired through experience or education. It refers to the theoretical or practical understanding of breast cancer

Perception - is the process of attaining awareness or understanding of breast cancer by organizing and interpreting sensory information.

Survival - the probability of surviving. It is typically stated as a rate over a particular period of time since diagnosis with breast cancer.

Treatment delay - is the interval between first detection of symptom and first medical consultation. This is a period of more than three months.

NHIS - National Health Insurance Scheme. It is a scheme instituted by the government to help alleviate the financial burden of patients in that they can be able to pay for their health care.

1.8 Organisation of the Study

This study is structured into five main chapters. Chapter one introduces the study and gives a brief summary on the major key issues that form the core objectives of the study. The background to the study, statement of the problem, objectives of the study, research questions, significance of the study and definition of terms are presented in this chapter. This chapter is concluded with an overview of the structure of the study.

The second chapter encompasses a review of relevant literature from current academic publications. The research methodology is presented in chapter three and provides the specific methods employed in carrying out the study. This chapter also covers the research process and methodological issues in qualitative research. Chapter four presents the findings

of the study and a discussion of the major findings. The final chapter is the summary of the main findings of the study, and conclusions based on those findings. It also presents recommendations, based on the conclusions arrived at.



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews related literature and theoretical foundation by different authors. It reviews literature on types of cancer, the Ghanaian situation on breast cancer, causes of the disease, the effects on the individual and family and how the disease is diagnosed, how social policies can help to respond and address the breast cancer challenge in Ghana. This chapter also discusses how the disease can be prevented and the various means by which it can be treated and how state and non-state actors respond to it.

2.2 Causes and risk factors of Breast Cancer

Globally, breast cancer is of great concern to both developed and developing countries. The irony of the situation is that there is a dearth of attention given to breast cancer in developing countries as compared to developed countries by scholars. Despite this, most developing countries of which Ghana is no exception are witnessing a great increase in the detection and reporting rate of cancer and other non-communicable diseases (Parkin et al., 2005; de Graft Aikins et al., 2010). According to WHO, GLOBOCAN on the burden of the disease, in 2004 breast cancer accounted for 16% of all female cancers with majority 69% of breast cancer deaths occurring in developing countries. 70% of women who were diagnosed with breast cancer in Ghana are in the advanced stage of the disease.

According to WHO a total of 2,260 Ghanaian women were diagnosed of breast cancer in the year 2012 and 2914 in 2013. The report indicated that 1,000 of the figure represent 50% of the breast cancer cases died and so there is an increasing danger of complication for women in Ghana and the whole of Africa.

Breast cancer has been identified as the second leading cause of cancer deaths in Ghana, with about 2,900 cases being diagnosed annually and at least one of eight women with the disease dying. According to Beatrice Wiafe-Addai President of Breast Care International, a woman dies every 69 seconds somewhere around the world from breast cancer. According to her, global incidence and mortality of breast cancer is on the rise and Ghana is no exception as 2,260 Ghanaian were diagnosed with the disease in 2012.

A total number of 19,423 patients were seen and it was established that 3,330 (11.7%) were diagnosed to be breast cancer patients. However the number of males was 10. It showed that men are now being diagnosed with breast cancer.

However in Ghana data on breast cancer is now being made aware to the public through public awareness and education. This disease is a common cause of hospital admissions and mortality among Ghana women.

The major challenge is the early reporting and detection rate in developing countries tend to be low. This late detection and reporting rate of the disease has led to low survival rates notwithstanding the curable nature of cancers when detected early (Clegg- Lamptey et al 2009). Most authors in Ghana have associated the misconceptions of people surrounding any type of cancer to low survival rates as a result of late detection (Quarthey-Papafio, 1997, 1980; Clegg- Lamptey et al). Stark et al (2010) and Clegg- Lamptey et al, (2009) expand on this by positing that the most challenging part in handling or treating breast cancer is late reporting which often results in late detection, discouraging treatment results, poor prognosis and poor health service utilization. These factors adversely affect treatment and prognosis.

Nyabor, (2014, p. 1) posits that “about a third of people diagnosed as having breast cancer die annually”. He further claimed that these rates of death are due to ignorance and delay in

reporting the health condition to health facilities for treatment. A state's capacity to effectively prevent and treat breast cancer hinges on people's awareness of the causes and risk factors of the disease.

Several authors have found hereditary to be a major risk factor or cause of breast cancer (Insel and Roth, 2004; Ghartey, 2004; Fentiman, 2001). A woman whose family has a history of breast cancer increases her risk of developing the disease. According to Dumitrescu and Cotarla (2005), a woman is considered to be at risk if her close family member has ever had breast cancer. They further add that whether the person had multiple primary cancers or not determine whether a member of the family has high risk of developing breast cancer.

According to Mayo, et al. (2003), breast cancer can be hereditary. That is breast cancer can be caused by inherited gene mutation. This they conclude to account for about 5-10% of all breast cancers.

Evidence shows that certain therapies and surgeries also put women at a high risk of getting breast cancer. It has been established that hormone replacement therapy (HRT) and prophylactic surgery increase the risk of breast cancer. According to (Wiafe Addai, 2004) the use of combined hormone replacement therapy has the potential of increasing the risk of breast cancer. The United States preventive services task force (2002) has confirmed that the repetitive use of hormone replacement therapy (HRT) for the prevention of alcohol diseases after menopause has the potential of exposing women to breast cancer.

Prophylactic surgery also is considered to put women at a very great risk of breast cancer. Women at very high risk of breast cancer may elect preventive mastectomy. This operation removes one or both breasts before cancer has been discovered. Mayo, et al. (2003) on the other hand reported that prophylactic surgery is beneficial to women who are genetically

susceptible to breast cancer. Other studies have confirmed that prophylactic surgery is beneficial to genetically susceptible women. That is the surgery helps to reduce the risk of breast cancer from genetically susceptible women. While the operation reduces the risk of breast cancer, it does not guarantee that cancer won't develop in the small amount of breast tissue remaining after the operation.

Most authors have found environmental forces to be the major cause of the rising incidence of breast cancer. For instance, Okorie, N. (2013) in his study revealed that environmental pollutant have a great potential of exposing women to breast cancer. Women's exposure to ionizing irradiation, X-ray (MacMahon, 2006), certain cosmetics and phytoestrogens (Safe and Papineni, 2006) increases the risk of developing breast cancer.

Moreover, hormones and pregnancy related factors also pose a great risk of breast cancer. The high levels of estrogen in women has been found by several authors to be a major cause of breast cancer Basu and Rowan, (2005), 2006; Badoe, E. A., Baako, B. N. (2000). The Breast is one of the sensitive organs in women. In Badoe E. A. Archampong, E. Q, some of the hormones and pregnancy related factors claimed by most authors put women at a higher risk of breast cancer, it includes early start of menarche, late menopause and first pregnancy at an older age.

Furthermore, age is considered as one of the major factors that expose women to breast cancer. According to Newman (2005) and Polite and Olopade (2005) the rate of breast cancer upsurges with age. They further found that the incidence rate of breast cancer among women below 20 is negligible. Various studies have found breast cancer to occur most to African and African-American women before menopause Clegg-Lampsey J, Dakubo J, and Atobra. That is most African women develop breast cancer within their reproductive years.

Another demographic factor that is considered as a risk factor for breast cancer is sex. According to Fentiman, Fourquet and Hortobagyi (2006), breast cancer is more common in women than in men. They further found that male breast cancer accounts for less than 1% of all breast cancer cases in the United States and less than 1% of cancer mortality in men (Fentiman, Fourquet and Hortobagyi, 2006). However in Uganda and Zambia, Fentiman et al (2006); found that 5-15% of breast cancer occur in males. In fact, being female is the single greatest risk factors for breast cancer. Although men develop the disease, it is far more common in women.

In sum, all the risk factors and causes of breast cancer can be grouped into two – factors that can be altered by change in lifestyle including obesity, alcohol intake, tobacco and factors which cannot be altered (age, genetic, early onset of menopause and menarche, sex) (Fentiman, 2001).

2.3 Breast Cancer Burden in Ghana

One of the major public health issues in Africa is cancer. In Africa, over 700,000 new cancer cases of cancer and over 500,000 cancer deaths occurred in 2008 (Ferlay et al 2010). It is projected that by 2030 there will be close to 1.28 million new cancer cases and 970,000 cancer deaths (World Health Organization [WHO], 2008). These projected figures can be attributed to the aging and growth of the population (Ferlay et al 2010), with the potential to be even higher because of the adoption of behaviours and lifestyles associated with economic development, such as smoking, unhealthy diet, and physical inactivity (WHO, 2008).

Ghana has a complex public health burden with a high prevalence of both infectious and chronic diseases. It is estimated that annually, chronic Non-Communicable Diseases (NCDs) kill over 78 thousand people in Ghana (WHO, 2011). That is the annual mortality rate that

results from NCDs is about 354 deaths per 100,000 population (constituting about 34% of total death in Ghana) (WHO, 2011, WHO, 2008). Cancers (including breast cancer) are one of the many chronic non-communicable diseases that affect the adult population of Ghana. It is established that one major leading malignancy in Ghana is breast cancer (Badoe and Baako, 2000). Badoe and Baako, (2000) found breast cancer to account for about 15.4% of all public health challenges. They concluded that this figure appears to be on the increase. It was found in Korle-Bu Teaching Hospital alone that in 1996, over 12.8% of all admissions were for breast cancer (Biritwum, Gulaid and Amaning, 2000 as cited in Clegg-Lamprey and Hodasi, 2007).

Despite the fact that the prevalence of breast cancer in Ghana is high, the prevalence of other NCDs such as hypertension, stroke, and diabetes far outweighs it. For instance, hypertension has a national prevalence of 28.7% (World Health Organisation, 2011), and type 2 diabetes also affects over 6% of urban adult population in Ghana (Anderson et al, 2006). These differences have resulted in structural challenges with regards to breast cancer care. Various studies in Ghana have shown that many constraints and difficulties hinder the adequate breast cancer care and advocacy.

Over 50% of Ghanaians who are diagnosed with breast cancer in Ghana report to the hospitals in the advanced stages of the disease (Archampong, 1997; Asumanu et al 2000). Averagely, individuals diagnosed with breast cancer often report more than 8 months after the diagnosis (Asumanu et al , 2000). Recent study has shown that women in Ghana are more likely to be diagnosed with high-grade tumours which results in higher breast cancer mortality rates (Okorie, N, 2013). The delays in reporting breast cancer in Ghana have been attributed to several factors which include the cost of, and access to, and routine screening mammography (Mayo et al, 2003). One woman dies of breast cancer every 69 seconds

globally. In Ghana it is the leading cause of cancer related deaths. The stark reality is that many women who have died from cancer in Ghana reports late to the hospital making surviving very slim for many women (Britwum, Gulaid and Amaning, 2000 as cited in Clegg-Lampsey et al, 2007).

In Ghana, it has been established that breast cancer occurs in women of all ages. According to Wiafe-Addai (2004) breast cancer is much evident among Ghanaian women who are 15 years and over. Mammocare (2010) on the other hand found that the average age at diagnosis for breast cancer patients in Ghana is 27 years. Further analysis of these findings and figures in comparison with findings from other African countries such as Nigeria and Kenya revealed that Ghanaian women may develop breast cancer far earlier than their counterparts in the said countries (Ghartey, 2009).

This high incidence of breast cancer among Ghanaian women is certainly a burden on the state, individual, and the government because treating cancer victims is very expensive, and requires resources which are not available. For instance, Zelle et al (2012) found breast cancer treatment to be very expensive and recommend that various stakeholders need to help in reducing and preventing all the risk factors. The rate at which breast cancer is gaining root in Ghana makes it incumbent on all stakeholders both state and non-state actors such as NGOs, CBOs, CSOs, government institutions and agencies as well as individuals with breast cancer and their families to help treat, reduce and prevent this menace. Non state actors including Mammocare and Breast Care International have for some years now championed the awareness creation of the disease.

Table 2.3.1 Ghana's Policies and Programs towards Addressing the Burden of Breast Cancer

Policy/Program	Date	Focus
Ratification of the Framework Convention on Tobacco Control	2004	Framework for the design and implementation of appropriate policies and programs to control tobacco-related diseases such as breast cancer.
Tobacco Control bill and Ministry of Health's Tobacco Control Directives	2005 and 2007	Legislative instrument to mandate the development of programs and policies to control the use of tobacco to reduce the NCD burden of the country.
National Strategy for cancer control	2012 – 2016	Give strategic direction to Government and various stakeholders to help in reducing the cancer burden in Ghana by 2016
Health Sector Medium Term Development Plan (HSMTDP)	2010 - 2013	The intensification of the prevention and control of communicable and non-communicable diseases including breast cancer and improving service delivery.
National Policy for the Prevention and Control of Chronic Non-Communicable Diseases in Ghana	2012	Provision of framework for the implementation of breast cancer-related programs as well as other NCD-related programs.
National Health Insurance Scheme (NHIS)	2003	Accessibility of health care services and treatment of diseases including NCDs to Ghanaians.
The Regenerative Health and Nutrition Programme (RHNP)	2006	Prioritization of the promotion of healthy lifestyles and healthy environments and the Provision of health and nutrition services to help control NCDs including breast cancer

Source: Ghana Health Services.

2.4 Treatment and Prevention of Breast Cancer

In order to reduce, treat and prevent any sickness from affecting the total wellbeing of the people, giving the needed attention to efforts towards minimising or eradicating risk factors is very important. It has been established by most authors that there are several risk factors associated with breast cancer. It is therefore important that both state and non-state actors in

Ghana make addressing these risk factors their priority in the prevention of breast cancer. Accordingly, some degree of prevention is possible when factors such as diet, alcohol use, physical activity, contraception decision-making and occupational exposure to toxins are well-thought-out (Payne, Hahn and Mauer, 2005)

The best treatment for cancer is prevention-by leading a wellness lifestyle (Anspaugh, Hamrick and Rosato, 2003). The adoption of the right way of life may reduce one's risk of getting breast cancer (Anspaugh, Hamrick and Rosato, 2003). It has been established that a healthy diet and avoidance of tobacco products and alcohol consumption have the potential of reducing the risk of developing breast cancer (Fentiman, 2001).

Despite the need to address the risk factors, detection through breast examination is very important. Breast examination and the adoption of appropriate early detection tools such mammography to identify breast abnormalities that may be cancer at an early stage, before physical symptoms develop have been recommended by several authorities (Payne et al 2006; Insel and Roth, 2004). Another new way of detecting breast cancer is through the use of "sure touch". Sure touch is new breast cancer device which is used by doctors to conduct a pain free testing of the breast through scanning, thereby making it easy for doctors to detect the disease at its very early stage (Breast Care International, 2010). Unlike mammogram, which rigidly compresses the breast and exposes it to dangerous radioactivity, 'sure touch' is painless but also radiation free. Another advantage of the "sure touch" is its ability to provide the opportunity for doctors to electronically manage and move images around through e-mail (Breast Care International, 2010).

Again, a major means of early detection of breast cancer has been breast cancer self-examination (BSE). Breast self-examination (BSE) allows a woman to become familiar with her own breast and be able to report to her health care provider on the slightest suspicion

(Insel& Roth, 2004). It needs to be emphasized that treatment is effective with early detection (Atobrah, 2012).

With regards to treatment, the choice of effective treatment for breast cancer is largely determined by the stage of the disease when it is presented to the surgeon for treatment. Based on research, it is also a fact that the larger the breast tumour the more expensive and difficult it becomes to treat (Mammocare, 2014). Findings by Mammocare analysis of breast tumour, size and weight at presentation for treatment data from 1999-2004 showed that the majority of breast cancer patients in Ghana had bulky breast tumour weighed 18g and the largest weighing 17.80g.

Scientifically it has been established that breast cancer kills when it is able to spread to other vital organs of the body such as the bone, brain, lungs and liver. Usually the spread of the cancer is dependent on the size of the tumour (Ghartey, 2004). There are different surgeries that are used to treat breast cancer. These surgeries include Lumpectomy (this procedure involves only the breast lump and normal tissues around it and is followed by weeks of radiation treatment); partial mastectomy (the removal of the breast tissue and is followed by weeks of chemotherapy); Total mastectomy (the removal of the entire breast); Modified radical mastectomy (the removal of the entire breast and some of the lymph in it); and Radical mastectomy (the removal of the whole breast, lymph nodes and the chest wall muscle) (Safe, S. And Papineni, S). The modified radical mastectomy has proved to be effective, with less disfigurement and fewer side effects (The American cancer society, 2003).

Aside the surgeries several therapies are also used in treating breast cancer. The first form of therapy is chemotherapy. Chemotherapy is the use of drugs and hormones to treat cancers. Close to a decade now, there has been a steady increase in the development of drugs as potential anticancer agents (Anspaugh et al 2003). Some of the most important advances in

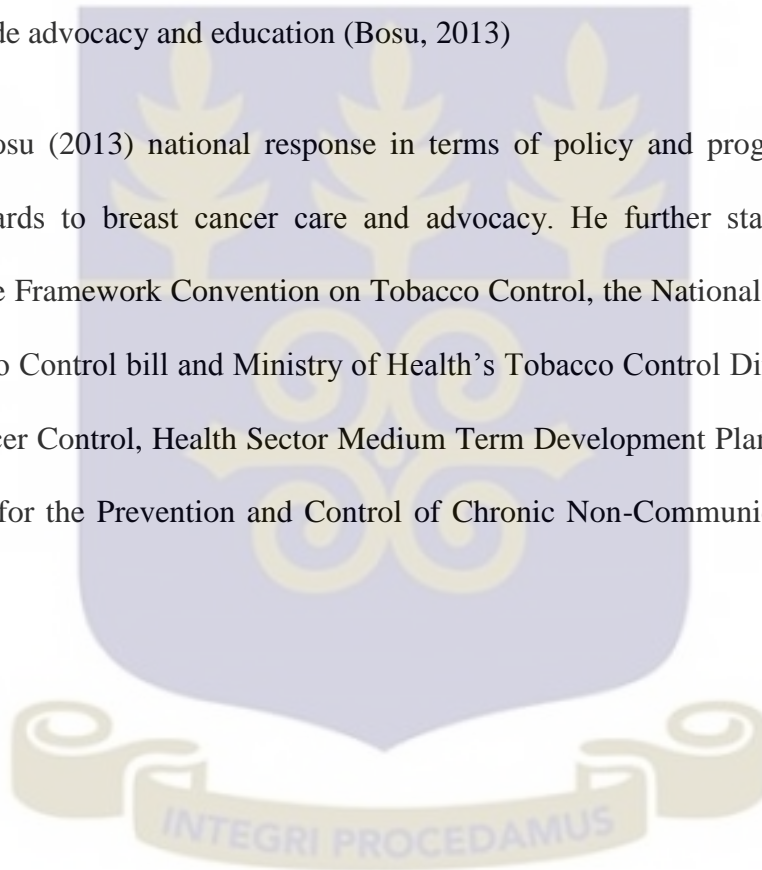
the treatment cancer have been in the area of chemotherapy. Most of the chemotherapeutic agent work by destroying the cancer cells ability to carry out cell division and replication (Anspaugh et al 2003). The other most widely used therapies are hormone therapy, radiotherapy and immunotherapy (Anspaugh et al 2003).

Unfortunately, these therapies or treatments may have side effects which include suppression of the immune system, diarrhoea and hair loss. Modern drugs have fewer and less severe side effect than traditional chemotherapy. With radiotherapy the individual may experience side effects such as diarrhoea, itching and difficulty in swallowing as a result of the radiation (Wiafe Addai, 2004). It should be noted that treating breast cancer is not only about treating the breast but rather ensuring that the well-being of the individual is enhanced. The decisions involving systematic treatment are most critical. This is because it treats the rest of the body to get rid of the microscopic cancer cells that may be there (Wiafe Addai, 2004). Records have it that millions of people are living with cancer or have not been cured of the disease (Wiafe Addai, 2004).

With regards to policy, breast cancer is not given the needed attention because other chronic non-communicable diseases have prevalent rates which are far higher than that of breast cancer (Clegg-Lamptey et al 2009). For the past three years, Non-Communicable Diseases have been a public health agenda globally (Badoe, E. A., & Baako, B. N. (2000). Since the first ministerial conference and the UN General Assembly on Non-Communicable Diseases' control in 2011, there have been several regional and national meetings, conferences and summits on NCDs (Bosu, 2013). Globally, the United Nations and its' allies such as the World Health Organization have been predominant in the provision of policy frameworks for the reduction of breast cancer and other chronic non-communicable diseases.

One major policy intervention geared towards addressing breast cancer and other NCDs is the establishment of the Non-Communicable Diseases Control Programme. According to Bosu (2013) the Ghana Health Service in the 1970s established a lymphoma centre to address the cancer burden of Ghana and other cardiovascular diseases. The centre was located at the Korle-Bu Teaching Hospital (KBTH). This centre and the successes it achieved influenced the Ministry of Health's initiation and implementation of the Non-communicable Diseases Control and Prevention (NCDPC) Programmes including cancers. The major roles played by the NCDC include advocacy and education (Bosu, 2013)

According to Bosu (2013) national response in terms of policy and programming are not strong with regards to breast cancer care and advocacy. He further stated that Ghana's ratification of the Framework Convention on Tobacco Control, the National Health Insurance Scheme, Tobacco Control bill and Ministry of Health's Tobacco Control Directives, National Strategy for cancer Control, Health Sector Medium Term Development Plan (HSMTDP) and National Policy for the Prevention and Control of Chronic Non-Communicable Diseases in Ghana.



CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents a description of the methodology that was used in the study. That is the procedures used in gathering and handling the data for the study. This chapter specially looked at the following: research design, institution of study, population of the study, and sample size. It also looked at sampling design, methods of data collection, analysis and ethical considerations. It is an exploratory study as well as qualitative in nature. The investigation and study however evolved from a genuine desire to know and wish to bring issues and challenges to bear. The objective is to discover and explore knowledge, perceptions and attitudes of state and non-state actors towards the disease and how state and non- state actors act and respond to the disease (breast cancer).

3.2 Institution Studied

The study was conducted in four institutions. Representatives of these institutions were selected purposively to share their views on the roles and challenges of their institutions in addressing the breast cancer burden in Ghana. The four institutions included two state institutions (Ghana Health Service, and Ministry of Health) and two non-state institutions (Breast Care International, and Mammocare Ghana).The study showed that these institutions which comprises of state and non-state actors do their best to respond to breast cancer issues in Ghana. Hence conducting the study in these institutions will help address the objectives of the study.

3.2.1 The Ministry of Health (MoH)

The Ministry of Health was formed in 1957. Its jurisdiction is the Republic of Ghana, with its Headquarters in Accra with Dr. Alex Segbefia as the current minister. The MoH is a government ministry of Ghana that is responsible for the Health. It is involved in providing public Health Services, managing Ghanaians healthcare industry and building Ghana's hospitals and medical education systems. It has a lot of agencies which include the Pharmacy Council, Ghana Nurses and Midwives, and the Ghana Health Services.

As a critical sector of the economy, MoH seeks to improve the health status of all people living in Ghana through the development and promotion of pro-active policies, provision of universal access to basic health service and the provision of quality and affordable health care services. It has specific mandate to access and monitor the country's health status, advice central government on health policies and legislation, formulate strategies and design programmes to address health problems of the country and collaborate with other related sectors and agencies.

3.2.2 The Ghana Health Service (GHS)

The Ghana Health Services (GHS) is a public service body established under act 525 of 1996 as required by the constitution. It is an autonomous Executive Agency responsible for implementation of national policies under the control of the Ministry of Health through its governing council- the GHS council. Dr. Ebenezer Appiah Denkyira is the Director of Ghana Health Services. The independence of the GHS is designed to ensure that staff have a greater degree of managerial flexibility to carry out their responsibility. This establishment of GHS service is an essential part of the key strategy identified in the Health sector reform process, as outlined in the Medium Term Strategy (MTHS) which are necessary steps in establishing a more equitable, efficient, accessible and responsive health care system.

The reforms build on the re-organization of MoH that began in 1993, which was explicitly designed to set the scene for the establishment of the GHS. The reform also provides a sound organization framework for the growing degree of managerial responsibility that has been delegated to districts and hospitals.

3.2.3 The Breast Care International (BCI)

Breast Care International (BCI) is located in the premises of Peace and Love Hospital, Kumasi in the Ashanti Region of Ghana, West Africa. BCI operation is to help in creating awareness of breast cancer. Its mission is to involve community participation, consumers' satisfaction, and education on awareness and initiate policies that would help curb breast cancer menace.

The Breast Care International (BCI) was conceived and formed in October 2002. BCI is an NGO dedicated to the establishment of breast cancer awareness throughout the country to create Breast Cancer awareness among Ghanaian women especially the rural women since they form the majority.

BCI educates women on the existence of Breast Cancer, educates them to undertake screening exercises, diagnosis, counselling, treatment, rehabilitation as well as researches into the various breast pathologies especially on Breast Cancer in Ghana. Since then it has taken a series of activities that shows that they are committed to their work. The director for Breast Care International is Dr. (Mrs.) Beatrice Wiafe Addai.

3.2.4 Mammocare Ghana

Mammocare was established in May 1997 as the premier breast awareness and screening service in Ghana. Mammocare Ghana is an NGO committed to embarking on addressing Breast Cancer menace in Ghana. It is located at Kotobabi, Accra. In an effort to help address

the issues in Ghana, Le maxque (an agency) in partnership with the Ministry of Women and Children Affairs (Ghana) is partnering with Mammocare Ghana. Mr. Frank Ghartey, is the Executive Director of Mammocare Ghana. It is an NGO committed to creating awareness and helping address the breast cancer burden in Ghana. It has also partnered with “Reach for Recovery”, an NGO and the Korle-Bu Breast Clinic to embark on an innovative 4 years campaign to educate women on the urgent need to take a second look at the importance of the breast. The event is code named “The Romantic Killer, Ghana 2013 and beyond”.

3.3 Research Design

The study used an exploratory and descriptive research design aimed at finding the roles of state and non-state actors in responding to breast cancer issues in Ghana. That is the study used the qualitative research methods which provide a window through which we see and comment on significant social issues (Maxwell, 2005). Denzin and Lincoln (2005) add that a qualitative research employs interpretive and naturalistic approaches to study issues and locates the researcher in the natural world of the participants. This means that, qualitative researchers study things in their natural settings, attempting to make sense of or interpret experiences and events based on the meanings people give to them. According to Creswell (2004) qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explores a social or human problem. The use of the qualitative method therefore provided the opportunity to capture the voices of the participants as it reflects the role they play, challenges they face and policy interventions they have implemented. Thus it helped the researcher find answers to in-depth and rich experiences of the state and non-state actors. Generally, the use of this approach helped to describe the life-world of the participants from their own perspectives and how they would be able to face

menace and challenges. The research helped the researcher to release that there are solutions to breast cancer issues.

On a whole, the study adopted a qualitative approach because an understanding of the issue under study from the perspective of the participants was of paramount importance. Playing an outsider role and using concepts to explain the phenomenon was deemed insufficient since the voices of the participants were considered crucial to the usefulness of the research as it may be applied to different aspects of policy making, service delivery and advocacy.

3.4 Study Population

The research targeted state and non-state actors who work with persons with breast cancer. The study population was made up of officials of the Ministry of Health, Ghana Health Service, Mammocare Ghana and Breast Care International. It also included other key informants from the Tema General Hospital and Korle-Bu Teaching Hospital.

3.5 Sample Size

The researcher used non-probability sampling techniques to select respondents for the study. The researcher specifically made use of the purposive sampling techniques to select the respondents for the study. The reason of selection of participants was due to the challenges in getting the health practitioners because most of them did not want to air their views to the issues at stake.

A sample size of 8 participants was available to the researcher and they assisted in having a statistical generalization and an in-depth in understanding of the experiences and perspectives of State and Non-State Actors.

Table 3.5.1 Distribution of Institutions

Institution	Number of Personnel
Ministry of Health (MoH)	2
Ghana Health Services	2
Breast Care International	1
Mammocare Ghana	1
Tema General Hospital	1
Korle-Bu Teaching Hospital	1
TOTAL	8

3.6 Sampling Design

The purposive sampling technique helped the researcher to select or identify respondents who satisfy the characteristics of the phenomenon under investigation and could provide the needed information to help achieve the objectives of the study.

Since this study seeks to explore the role of state and non-state actors in responding to breast cancer, purposive sampling technique is deemed appropriate to select key informants (actors) who can provide adequate information for the attainment of the objectives of the study. Thus, the purposive sampling technique is preferred to select the key informants because it gave the researcher the opportunity to select participants who fall within the category of respondents needed and have in-depth knowledge of the study matter.

3.7 Methods of Data Collection

Data for this study were collected from both primary and secondary sources. The secondary source of data used by the researcher included books and journal articles. The secondary source helped to cross-check official information on the issues of breast cancer and the role of key actors.

The primary sources of data for the study comprised qualitative tools of data collection. The primary data comprised field data gathered from respondents using an interview guide.

3.8 Data Collection Instrument

Interview guides were used for data collection. The interview guide was structured to address research questions to be able to source information to attain the study's objective.

3.8.1 Semi-Structured Interview

However, some forms of interviews were used to help probe further into issues, they include the informal conversational interview; the semi-structured general interview guide approach; and the standardized open-ended interview. Each type differs in purpose. For the purpose of the study the semi-structured general interview guide approach was used. The guide has lists of topics and suggests probes to help elicit further detail from the respondents. It was appropriate because of its flexibility. It created room for modifications throughout its use with probes or whole topics being added these helped to emerge facts during the interview process.

The interview guide was structured based on the objectives of the study. There was a high level of flexibility in the interview process. King (2004) posits that flexibility is the most important factor in successful qualitative interviewing and advises that the interviews needs only to start with a common opening question, after which topics and probes must follow to be able to collect in-depth information about the research problem.

According to King (2004) there are two major epistemological positions underlying qualitative approaches to interview methodology – the realist approach and the radical

constructionist approach. For the purpose of this study the researcher made use of the realist approach in that health practitioners bear direct relationship to their real experiences.

That is the interview responses given by health practitioners was taken to provide insight into their roles and the challenges they face in responding to breast cancer issues in Ghana.

In terms of recruitment of participants for the interview, this study included health practitioners representing their distinct stakeholder groups within their institution who assisted in getting in-depth of what is happening. Eight (8) participants were available from the state and non-state stakeholder groups.

Interviews were conducted on a face-to-face basis. A voice recorder and field notes were used to record the interviews. The interviews were conducted in the offices of the interviewees.

3.9 Reliability and Validity of the Instrument

Reliability is the likelihood that a measurement will yield the same results at subsequent time while validity on the other hand encompasses the ability of an instrument to adequately measure what it is supposed to measure (Maxwell, J. A.(2005). In terms of validity, the content and validity of the interview guide was determined by the literature review and the researcher's supervisor at the Centre for Social Policy Studies, University of Ghana. With respect to the data, reliability and validity were checked.

3.10 Data Handling and Analysis

The data collected from the field were handled and analysed based on the principle the thematic analysis. This approach to qualitative data analysis helps the researcher to effectively handle data thematically. The methodical and thematic nature of data analysis which the thematic approach employs is its major advantage as the steps involved are clearly

visible for anyone to see Creswell, J.W. (2004). It was based on these understandings and advantages that the approach was adopted for data analysis.

The researcher familiarized herself with the data collected from the health practitioners. The researcher immersed herself in the data in order to be familiar with the depth and breadth of the content. The familiarization process began with the transcription of the verbal data. King (2004) argues that the process of transcription can be an excellent way to start familiarizing oneself with the data. Researchers such as King (2004) argues that transcription is “a key phase of data analysis within interpretative qualitative methodology” where meanings are created, rather than simply a mechanical one of putting spoken sounds on paper . After the transcription, the researcher repeated read the data in search for meanings and patterns. During this phase, the researcher took notes and mark ideas for coding.

After the researcher has read and familiarized with the data, and have generated an initial list of ideas about what is in the data and what is important about them. The study produced initial codes from the data. Taking cognizance of the process of coding is part of analysis and it helped in organizing the data into meaningful groups. The Study paid much attention to this process.

When all data have been coded & collated, the researcher then searched for themes. The researcher at this stage sorted the different codes into potential themes, and collated all the relevant coded data extracts within the identified themes. At this phase, the researcher used tables to help sort the different actors.

After searching for the themes, the researcher went ahead to review and refine the themes. At this point the researcher read all the collated extracts for each theme, and considered whether they appear to form a coherent pattern. New themes emerged and the researcher also searched

for 'a home' for those extracts that did not work in already-existing themes. The themes were further defined and refined.

The final stage was the production of the report. After worked-out themes were fully set, the final analysis and write-up of the report was done. The task of the write-up of the thematic analysis was to tell the complicated story of the data in a way which convinces the reader of the merit and validity of the analysis. At this stage, the researcher critically analysed the data by drawing linkages between the themes, sub-themes and the recurring and related patterns within the data. References were also made to reviewed literature to either support or record a contradiction of findings where necessary.

3.11 Ethical Considerations

Considering that this study involved people, it required the researcher to be ethically conscious in order not to breach the basic principles of social research. As a result, the study was done in consonance with ethical principles that guide social science research. The researcher observed the research value of voluntary participation and informed consent of respondents. The researcher sought the consent of the research participants that were engaged in the study. This was done by using a written consent form where participants read and endorsed as indication of their consent. Permission was also gained before the conversations with participants were recorded. Consent was however preceded by an explanation of the nature and purpose of the study to the participants. Participants who gave their consent to take part in the study were assured that their participation was voluntary and they could opt out at any point. No participant was therefore forced to be part of the study. Before the researcher started with the actual fieldwork, an introductory letter was secured from the Centre for

Social Policy Studies, University of Ghana. The letter was used to state the credibility of the researcher as a student from the University of Ghana.

Also, the researcher ensured confidentiality and anonymity of the respondents. To ensure confidentiality, the researcher did not report private information that identifies respondents. Information such as names of respondents was obliterated from the instrument. This ensured that the identities of the subjects were protected. During the data analysis stage of the qualitative data, the researcher used pseudonyms for individual participants to protect their identity.



CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION

4.1 Introduction

This chapter presents the process of data analysis that was used in analysing data and discusses findings related to the study objectives. The results are presented in three sections. The first section displays the analysis of the socio-demographic characteristics of the respondents in the study. The second section presents the qualitative analysis of the causes and risk factors of breast cancer in Ghana; the roles of state and non-state actors in responding to breast cancer; the policy interventions of the state and non-state actors; and the challenges faced by these actors. The final section encompasses the discussion of major findings of the study.

4.2 Socio-Demographic Characteristics of Respondents

The demographic features captures the age, sex and type of institution, name of institution and the numbers of years the respondents have worked with the institution as shown in the table below:



Table 4.1: Profile of Respondents

Respondent	Gender	Age	Type of Institution	Position	Name of Institution	Number of years in Institution
1	M	46	State Actor	Senior Co-ordinator	GHS	8 years
2	F	35	State Actor	Public Relation Officer	MoH	4 years
3	M	50	Non-State Actor	Frontline Administrator	Mammocare	12 years
4	M	43	State Actor	Senior Co-ordinator	MOH	6 years
5	M	48	State Actor	Senior Co-ordinator	MOH	3years
6	F	47	State Actor	Public relation Office	GHS	10 years
7	F	42	Non-State Actor	Senior Specialist	Korle-Bu Teaching Hospital	8 years
8	M	39	Non-State Actor	Quality Care Administrator	Breast Care International	5 years

4.3 Institutional challenges in tackling Breast Cancer in Ghana

Institutional and cultural challenges were identified in state and non-state attempts at addressing breast cancer. Financial constraints were reported by all respondents as the most dominant challenge encountered in the process of addressing health concerns relating with breast cancer. This categorization of challenges was captured in interviews by respondents from the various institutions who opined that:

“... Financial Constraints is our biggest challenge. We don't have money to take care of all breast cancer patients and there is no budget allocation for breast cancer victims compared to other diseases and also with individuals there is delay in lab results and the numbers keeps increasing ...lack of political will on the part of government to fund the prevention and treatment of breast cancer is a major challenge...”R.4.

Belief systems were highlighted as part of cultural practices that challenged efforts in addressing breast cancer. Cultural perceptions about breast cancer included stigmatization and fears and lay representation of breast cancer as a health condition, which is a major burden into tackling breast cancer care. Perceptions about the disease is also a major factor, beliefs and cultural practices; ignorance and lack of knowledge on the part of the victims really posed difficult challenges because were not aware as to what was happening to them and why it should happen to them. Sometimes they seem not to know what is happening to them. Apathetic attitude of men on the other side was really a huge factor, because it does not affect them directly they just do not care. Stigmatization was really a problem These findings concur with Anderson et al. (2006) finding that countries with limited resources face numerous challenges in designing and implementing programs to improve cancer care. They further found that financial constraints, lack of professionals, public misconceptions about breast cancer and lack of scientific and epidemiologic information are obvious barriers to improving breast cancer outcomes. The study further found the role of state and non-state in their quest to financially support breast cancer victims was a challenge. The financial constraints they encounter to go through breast cancer care was really tough.

While the non-state actors go through thick and thin to support breast cancer victims state actors (they do paper work and avoid contact with the victims) they just have their services and finding on paper to the detriment of the victims. Breast cancer care should be free and money's immediately made available to breast cancer patients if the diagnosed with the disease so that we do not lose our women. Breast cancer is a critical public health concern in the sense that if greater care is not taken into addressing it, it would come to a time when most of our women would be lost to cancer. Breast cancer must be addressed by all communities, stakeholders ,individuals must all get involved. There is an increasing global cancer disease due to women and victims ignorance, our life style and lack of

education during initial stages of one, s life. The researcher found out that another issue was lack of political will on the part of government to fund the prevention and treatment of breast cancer is a major. The fact is that Government's source of funds is not geared towards the right channel and its citizenry in the sense that women form majority of the populace and if they are watched on to die in e name of breast cancer then we really have a long way to go because the government cannot take tough decisions to protect the women. On the contrary, the money is used for political campaigns and its misappropriated.

4.4 Risk Factors of Breast Cancer in Ghana

The study shows that there are several factors that predispose most women to breast cancer in Ghana. Through interviews with respondents, the study identified some factors which increases an individual's risk of getting breast cancer. These categories of factors as identified by participants are lifestyle, physiological, genetic and environmental factors. This categorisation of risk factors was captured in an interview by a respondent who said:

"...My sister, there are two major issues or factors that can make one get breast cancer. One is... aamm... about our lifestyle while the other is...eehh..Inheritance. The kind of life we live can make one get breast cancer and the same way if one of your close relatives has ever gotten breast cancer you are also at risk..." R7

Respondents highlighted on issues or factors that can make one get breast cancer. It included lifestyles and Inheritance. Here it is obvious that the kind of life we live can make one get breast cancer in that when we take alot of unhealthy foods like taking a lot of oily foods and not eating a lot of fruits can bring about breast cancer. Also close relatives also get breast

cancer because they are at risk of getting the disease. Here respondents are saying that if family members have ever suffered from the disease the possibility of you getting it is high.

More than half of the respondents attributed breast cancer to genetic factors. The respondents indicated that breast cancer may be inherited. Below are some of the illustrative quotes

“...Oohh...some breast cancer cases can be hereditary, that is the result directly from gene defects inherited from a parent. Ladies who have close relatives such as mother or sister with breast cancer...(looking very serious)... are at greater risk of getting breast cancer. To be frank, less than 15% of women with breast cancer have a family member with this disease...” (R3)

“Any woman who has a close relative with breast cancer has a greater risk” (R1)

“... breast cancer can be inherited ...” (R8)

Majority of respondents indicated that lifestyles of individuals have the potential of putting them at a high risk of getting breast cancer. These lifestyles as indicated by respondents include alcohol intake, childhood diet and obesity. This is supported by the quotes below:

“...The kind of life we live can make one get breast cancer...” (R4)

“Excessive intake of alcoholic beverages ... puts women at risk of breast cancer

“...lack of exercises on the part of women as well as the use of certain kind of deodorants can predispose women to breast cancer...” (R3)

A minority report cited that environmental factors such as individual's exposure to certain chemicals can put them at risk of breast cancer.

“...when women are exposed to certain chemicals such as taking of anti-miscarriage drugs may make them have a risk of developing breast cancer...” (R4)

“... exposure to chemicals in the air we breathe, the food and beverages we consume, and the chemicals that come in contact with our skin may influence breast cancer risk...” (R6) some breast cancer cases can be hereditary, that is the result directly from gene defects inherited from a parent. Ladies who have close relatives such as mother or sister with breast cancer...(looking very serious)... are at greater risk of getting breast cancer. To be frank, less than 15% of women with breast cancer have a family member with this disease...” (R3)

“Any woman who has a close relative with breast cancer has a greater risk” (R1)

“... breast cancer can be inherited ...” (R8)

Majority of respondents indicated that lifestyles of individuals have the potential of putting them at a high risk of getting breast cancer. These lifestyles as indicated by respondents include alcohol intake, childhood diet and obesity. This is supported by the quotes below:

“...The kind of life we live can make one get breast cancer...” (R4)

“Excessive intake of alcoholic beverages ... puts women at risk of breast cancer

“...lack of exercises on the part of women as well as the use of certain kind of

A minority report cited that environmental factors such as individual’s exposure to certain chemicals can put them at risk of breast

“...deodorants can predispose women to breast cancer...” (R3).

“...when women are exposed to certain chemical such as taking of anti-miscarriage drugs may make them have a risk of developing breast cancer...” (R4)

“... exposure to chemicals in the air we breathe, the food and beverages we consume, and the chemicals that come in contact with our skin may influence breast cancer risk...” (R6)

Almost all respondents attributed the high incidence of breast cancer in Ghana to physiological factors. Some of the physiological factors that came up during the interview include early onset of menstruation, late onset of menopause and obesity. Below are illustrative quotes in support of this finding:

“... having menopause very late put women at risk of breast cancer...” (R8)

“...women who are obese can get breast cancer...” (R4)

“...a woman who starts menstruation and continues to menstruate into her late 50’s has higher risk for breast cancer...” (R5)

Half of the respondents also attributed breast cancer to multiple of causes. This is revealed in the quotes below:

“...It is worrying...eemm... that most of the factors that make people acquire this disease are avoidable. ... The causes of breast cancer include alcoholic intake, obesity, early onset of menstruation, late onset of menstruation, certain chemicals in deodorants, unhealthy activities, use of bleaching brassier, exposure to estrogen and occupational exposure...”(R3)

“...aamm...being exposed to smoke and carbon dioxide and a person who has two family members affected that is first and second degree relative. It is worth mentioning that individuals’ engagement in healthy lifestyles, individuals having alot

of exercises and individuals adapting breast cancer check-ups regularly have the potential of preventing and controlling some of these risks...” (R4)

“...Women with sisters who have breast cancer may share the same genes and be exposed to the same environmental risk factors which invariably put them at a higher risk of developing the disease...” (R2)

“...Whenever I am asked about the risk factors of breast cancer, what come to mind are ages (35-50), sex (Female), first line relatives and even our own oral contraceptives pills which is supposed to help us in spacing of child bearing now brings us breast cancer. We don't say causes because we don't know the cause of it rather it's a risk factor.” (R 3)

“...millions of people globally have been have been diagnosed with various cancers, while in Ghana ^^...16,000...cases of cancer are reported each year and are killing more than HIV/AIDS, tuberculosis and malaria. It is very important to know their causes and risk factors in order for us to be able to prevent the high prevalence of cancer in Ghana”.(R4)

4.4.1 Summary of discussion

This discussion of the major findings of the study co-relates with literature. Thus the study indicates that women are at greater risk of getting breast cancer. From the respondents perspectives it is clear that a major significant finding of the study is that environmental factors that is (Exposure to certain chemicals), lifestyle factors (alcohol intake, childhood diet), physiological factors (obesity, early onset of menstruation) and genetic factors (a family member having breast cancer) predispose most women to breast cancer in Ghana. This

implies that the lifestyles of an individual among other things are likely to him/her at a higher risk of breast cancer. This finding is in line with Raaschou-Nielsen, Pavuk and LeBlanc (2005) who found a strong relationship between the rising breast cancer incidence in the latter half of the 20th century and environmental forces. Insel and Roth, (2004), Gharthey, (2004) and Fentiman, (2001) however found hereditary to be a major risk factor or cause of breast cancer

According to respondents there are factors that can make one get breast cancer. One is about our lifestyle while the other is Inheritance. The kind of life we live can make one get breast cancer and the same way if one of your close relatives has ever gotten breast cancer you are also at risk of getting it. Here it is obvious that the kind of life we live can make one get breast cancer in that when we take a lot of unhealthy foods like taking a lot of oily foods and not eating a lot of fruits can bring about breast cancer. Also close relatives also get breast cancer because they are at risk of getting the disease. Here respondents are saying that if family members have ever suffered from the disease the possibility of you getting it is high.

More than half of the respondents attributed breast cancer to genetic factors. The respondent indicated that breast cancer may be inherited. Some breast cancer cases can be hereditary, that is the result cancer can be got directly from a gene defect inherited from a parent. Ladies who have close relatives such as mother or sister with breast cancer are at greater risk of getting breast cancer. Indeed, 15% of women with breast cancer have a family member with this disease.

Respondents also indicated that lifestyles of individuals have the potential of putting at a high risk of getting breast cancer. These lifestyles as indicated by respondents include alcohol intake, childhood diet and obesity. The kind of life we live can make one get breast cancer. Excessive intake of alcoholic beverages puts women at risk of breast cancer, lack of exercises

on the part of women as well as the use of certain kind of deodorants can predispose women to breast cancer. Obesity is now on the increase so women have to take care of themselves.

Reports cited that environmental factors such as individual's exposure to certain chemicals can put them at risk of getting breast cancer. When women are exposed to certain chemical such as taking of anti-miscarriage drugs that makes them have the risk of developing breast cancer. Exposure to chemicals in the air we breathe, the food and beverages we consume.

Exposure to chemicals in the air we breathe, use of bleaching brassier, exposure to estrogen and occupational exposure certain chemicals in deodorants, unhealthy activities, being exposed to smoke and carbon dioxide and chemicals that come in contact with our skin may influence breast cancer risk.

It is worrying that most of the factors that make people acquire this disease are avoidable but human beings as we are we just do not care. An individual who has two family members affected that is first and second degree relative is also at risk. Women with sisters who have breast cancer or share the same genes and be exposed to the same environmental risk factors which invariably put them at a higher risk of developing the disease.

It is worth mentioning that individuals' should engagement in healthy lifestyles, have alot of exercises, adapt breast cancer check-ups regularly, all these have the potential of preventing and controlling some of these risks. First line relatives and even our own oral contraceptives pills which is supposed to help us in spacing of child bearing now adds up or brings us breast cancer.

The study showed that we don't say causes because we don't know the cause of the disease but rather we say risk factors and that from the interview it was also realised that millions of people globally have been diagnosed with breast cancer.

In Ghana 16,000 cases of cancer are reported each year and it is killing more than HIV/AIDS, tuberculosis and malaria. It is very important to know their causes and risk factors in order for us to be able to prevent the high prevalence of cancer in Ghana.

4.5 Roles of State and Non-state Actors in addressing breast cancer in Ghana

There was an indication that the various stakeholders play unique roles in responding to breast cancer issues. The roles as found by the study include education and early detection, equipping and resuscitation of breast cancer care providers, drafting and implementation of policy interventions.

More than half of the total respondents indicated state actors often provide resources for and also partners with non-state actors to provide quality breast cancer care for patients. For instance the MOH partnered with Breast Care International to raise awareness on the disease by participating and engaging in breast cancer awareness walk in which the former President of Ghana John Agyekum Kuffour took part in Kumasi. The quotes below illustrate the resource provision role of the state actors:

“...We have been doing our best to provide resources to boost the capacity of providers of breast cancer care...” (R5)

“...support offered to help patients of breast cancer are financial support, free treatment for patients, assurance that the disease is curable, and decreasing the cost of treatment/ medicines for patients...”(R8)

Almost all of the respondents pointed out the education of the general public on breast cancer as a major role of the state and non-state actors. This is supported by the quotes below:

“...our department educates the community members about the risk factors and the essence of early detection. We go to the extent of teaching women how they can detect breast cancer themselves... some of our staff feature on talk shows on radios to the extent that they tell people where they can locate specialist and breast care clinics...”(R7)

“...the Media often partner other stakeholders such as the health professionals and other institutions in expanding knowledge and education on the dangers of the disease. The sources of which individuals hear of breast cancer are television, radio, newspaper, colleagues killed by breast cancer and of course the internet etc”.
(R1).

“...aamm..As we are an NGO trying to help address breast cancer myths, misconception and perceptions, our outfit is able to educate and sensitize people through Education, counselling, sensitization and Awareness creation.” (R8)

“intensified public education has assumed higher burden in the country compared to the past due to the setting up of health-focused NGOs and the readiness of most of the houses to provide a platform for breast cancer discussions ... As a result of this, the preventive measures for cancer are now known. Now young women between the ages of 20 and 24 are presenting themselves in the difficult stages of the disease, which is very alarming but first those who used to be diagnosed were between 40 and 49 years”. (R3)

Few participants also identified advocacy as a major role played by the various stakeholders to ensure that breast cancer patients receive the needed services from care providers. An official of the Ghana Health Service exclaimed that

“...There have been several advocacy groups such as Sister Support Network (SSN), Enidaso Initiative, Astra Zeneca etc. These groups have done tremendously well by helping patients get the needed care from service and care providers...” (R2)

“...we advocate more for patients and work towards making sure quality care is provided for them...”(R8).

From the responses of the respondents it is clear that the roles they play provided the actors the opportunity to respond appropriately to breast cancer in Ghana. These findings concur with Azenha et al. (2011) who found direct and indirect services and support provision as the major roles played by cancer civil societies. Grey and McMikel (2012) also found that NGOs play a critical role in addressing issues that are overlooked or ignored by government. They further found that NGOs help raise knowledge and awareness; they advocate for policy change and enforcement; and they instill moral urgency to neglected issues such as breast cancer. Azenha et al (2011) also found the availability of civil society organizations and participative approaches as very vital in ensuring that actors play their roles effectively geared towards addressing a public health challenge. For instance costs, effects and cost effectiveness is one of the policy interventions used by Enidaso Initiative in that there is Bi-annual screening by clinically examining the breast of women between the ages of 40-69` years, in combination with treatment of all stages. This seems to be the most cost-effective intervention. The mass media awareness raising is also another cost-effective intervention; here education goes on towards the awareness of breast cancer and its effects on the

individual and the society. Mammography screening of women is also another cost-effective intervention.

Their implementation is meaningful if the capacity of cancer diagnostic, referral, treatment and palliative services is improved. They further found that these boulevards help the actors to play their roles effectively, discover and share their common interests (Azenha et al, 2011).

The findings of the study more over showed that the actors have policy interventions which include policy development, program development and advocacy. These interventions are found to be the major pillar of all efforts geared towards addressing breast cancer nationally in Ghana. This is supported by Grey and McMikel's (2012) findings that advocate for policy change and enforcement; and they instill moral urgency to neglected issues such as breast cancer.

Also NGO's try to also address breast cancer myths, misconception and perceptions. Also they also try to use their outfit to educate and sensitize people through counselling, sensitization and Awareness creation. Intensified public education has assumed higher burden in the country compared to the past due to the setting up of health-focused NGOs and the readiness of most of them to provide a platform for breast cancer discussions. As a result of this, the preventive measures for cancer are now known by some women.

However, now young women between the ages of 20 and 24 are presenting themselves in the difficult stages of the disease, which is very alarming but at first those who used to be diagnosed were between 40 and 49 years.

NGO,s are doing our best to provide resources to boost the capacity of providers of breast cancer care and also offer support to help patients of breast cancer with financial support,

free treatment for patients, assurance that the disease is curable, and decreasing the cost of treatment/ medicines for patients.

Some respondents pointed out that the education of the general public on breast cancer is a major role for both the state and non-state actors. They are saying that because if education is intensified then they would solve 90% of the problem. The actors also try to educate the community members about the risk factors and the essence of early detection. They go to the extent of teaching women how they can detect breast cancer themselves. Their staffs feature on talk shows on radios to the extent that they tell people where they can locate specialist and breast care clinic.

The Media also partners other stakeholders such as the health professionals and other institutions in expanding knowledge and education on the dangers of the disease.

Individuals also hear of breast cancer on television, radio, newspaper, colleagues killed by breast cancer and of course the internet.

Advocacy groups also play a major role with various stakeholders to ensure that breast cancer patients receive the needed services from care providers.

The critical role of Enidaso Initiative which is an NGO of breast cancer is into addressing breast issues through advocacy, coalition, information, community awareness, early detective campaigns, direct medical services, emotional support research, basic material provisions, financial support and legal support. With community awareness, its organization engages in breast cancer education and awareness activities is engaged in, in specific communities including presentations, lectures, meeting and public awareness.

The organization provides prints or web-based information materials to patients and general public on breast cancer issues. It also provides cancer screening and diagnostic services, treatment as in surgery, radiotherapy, chemotherapy and medication.

It also empowers woman by leveraging survivors and providing information to enable patients to have a voice in their health care. Its organization engages in organizing campaigns to promote breast cancer awareness, early detection which targets a broad public through mass media channel. For instance through television, radio, magazines, newspapers, online media and the billboard.

The Organisation also provides non-financial material support such as brassieres, wigs and prosthesis and lymphedema sleeves to address or ameliorate the effects of breast cancer treatment. It also provides professional counselling services, organises group therapy, coordinates informal emotional support from survivors and other volunteers.

With financial support the organisation provides to support and cover direct treatment costs or cost incurred as a result of structural barriers of treatments that is housing, travelling expenses and food cost. Through its advocacy activities the organisation engages in organised legislative, executive or judicial advocacy targeting decisions makers who will aim for system-wide policy change, effective and equitable implementation of existing policies.

Its legal right activities provide information or counselling on legal rights and represents patients in legal procedure. However most government institutions do not offer these services as compared with the NGO's.

There are advocacy groups such as Sister Support Network (SSN), Enidaso Initiative and Astra Zeneca. They help patients get the needed care from services and care providers. They also advocate more for patients and work towards making sure quality care is provided for them.

4.6 Policy Interventions of Non-state and state actors

Policy interventions have been put in place in responding to breast cancer. Respondents disclosed that the actors have interventions that have helped to address breast cancer issues in Ghana. The respondents identified policy interventions which are likened to a three-legged stool. The types of policy interventions as revealed by respondents are mass media, policy and programme services. All the three, support behavioural change and without any one of the interventions, the policy will not stand. These three types of policy interventions were captured by an officer of Mammocare Ghana who indicated that

“...the interventions being put in place to aid patients’ breast cancer are financial support from government and NGOs, advocating medical support, raising awareness of the disease through education, government intensifying education to increase awareness and knowledge among patients so as to inform them of current issues of the disease...” (R8)

The Respondents indicated that the provision of leadership for policy development is a core function of the state actors. It was evident that most of the policies regarding breast cancer in Ghana originates from both state and non-state actors. For instance, a respondent from Ministry of Health stated that;

“...National policies come from our outfit. We design the policies in consultations with other stakeholders for the parliament to pass into law. The other agencies may have their own policies regarding issues of breast cancer ...” (R2)

“...the policy interventions being put in place to aid patients breast cancer are financial support from government and...eehh...NGOs, advocating Medical Support,

raising awareness of the disease through education, intensifying education to increase awareness and knowledge among patients so as to inform them of current issues of the disease...” (R6)

“...The Ministry of Health and the Ghana Health Service led the NHIS policy, the National breast care programme, (GSGDA) Ghana Shared Growth for Development Agenda- 2012-2016 and Health Sector Medium Term Development (HSM TDP) plan which seek to intensify prevention and control of non-communicable diseases and improvement on institutional care service delivery. The two agencies outlined programs and services geared towards intensifying action against cancer and reinforcing cancer projects... the Ministry enacting legislation for cancer research and control programs, establish budgetary priorities, train and pay research and health care personnel, provide health care equipment, constructing and managing oversight programs, and enable evaluation of programs and outcomes...” (R7)

Furthermore, the result shows that both the state and non-state actors develop programs to help in the treatment and prevention of breast cancer. The program activities of the actors as found from the study included providing information, community awareness, early detection campaigns, direct medical services, emotional support, research, basic material provision, and financial support. The respondent from Breast Care International indicated that

“...Breast Care International (BCI) Ghana is spearheading an initiative dubbed ...aamm... ‘Peer-Nurse Navigation Program’ to use breast cancer survivors and nurses to help freshly diagnosed patients to accomplish quality health outcomes. This project is based on the principle of HOPE – Helping Others through Personal Experiences (HOPE)...” (R8)

“...the two major programs championed by the Ministry of Health to intensify prevention and control breast cancer as well as other non-communicable diseases are the National breast care programme and the Health Sector Medium Term Development (HSMTDP) plan ...” (R6)

“...GHS has received budget approval for funds to support its Cancer Chart Programme...” (R.1)

Moreover, the state and non-state actors help shape community norms about breast cancer and build support for public and private policies through the mass media and social networks. Some of the responses that indicated that are quoted below:

“...Our outfit has during the past 12 months rolled-out several programs and projects, all with the intent to create, increase and sustain awareness about breast cancer. The organization is further planning to initiate similar programs to boost efforts aimed at curbing the rise in breast cancer incidence in Ghana...” (R5)

“..NGOs like ‘Run For a Cure’ and Breast Care International have tried to dispel societal myths, increase the awareness of timely screenings, and provide financial support to less privileged women...”. (R6)

Furthermore, the non-state actors use a policy advocacy approach to prevent breast cancer. This is a major public health approach to breast cancer prevention and control adopted by the non-state actors as revealed by the study. Media advocacy helps bring about public and private policy changes, which in turn increase the demand for and use of program services. This was captured in an interview with a respondent from the Ministry of Health in an interview who exclaimed that

“...I can remember well one NGO, Quality Health Africa (QHA) which have had some meetings with successive ministers of this Ministry on the extent of the cancer problem and reform for access and financial support for cancer. QHA has been making efforts towards impacting health policies and resource provision to the needs of cancer patients in Ghana...”(R2)

From the respondents point of view the study further found the major roles played by the state and non-state actors towards awareness creation and early detection, equipping and resuscitation of breast cancer care providers, drafting and implementation of policy interventions have helped the actors to try to dispel societal myths, increasing the awareness of timely screenings, and provide financial support to less privilege ones and help in formulating programmes to boost efforts aimed at curbing the rise in breast cancer incidence in Ghana. Efforts are also being put in place to help treat and prevent any sickness from affecting the total being of the individual. Azenha et al (2011) also found the need to create awareness and create a viable network towards participatory approaches and instituting vital platforms in ensuring that actors play their roles effectively.

The interventions being put in place to aid patients with breast cancer are financial support from government and NGOS, advocating for medical support, raising awareness of the disease through education. Government also intensifying education to increase awareness and knowledge among patients so as to inform them of current issues of the disease. The respondents said this because he thinks that right from the onset cancer issues and for that matter breast cancer should be added to the school’s curriculum so that right from day one the child would already know what cancer entails or have an idea about breast cancer. Through that they would be able to take care of themselves.

Also some respondents said that National policies came from their outfit. That is from Ghana Health Service. But however it is designed in consultations with other stakeholders from parliament to be passed into law. Here the respondent is trying to say that their institution do not work in a vacuum.

Other agencies also said they have their own policies regarding issues of breast cancer. The policy interventions is put in place to aid patients with breast cancer includes financial support from government and Non Governmental Organization advocating for medical support, raising awareness of the disease through education, intensifying education to increase awareness and getting a platform among patients so as to inform them of current issues of the disease. This I think can be than through mobile alerts and text messages educating individuals on about breast cancer.

The discussions on the table are that The Ministry of Health and Ghana health services initiated the NHIS policy and the national breast care programme. Ghana shared growth for development agenda. It started from 2012-2016, and it has been put in place to aid in cancer care. The health sector medium term development plan which seeks to intensify prevention and control of non-communicable diseases and improve on institutional care service delivery, but looking at the way forward, its implementation has not seen the light of day. It is still experiencing a lot of challenges.

From the discussions it is seen that some agencies have outlined programmes and services geared towards intensifying action against cancer and also to reinforce cancer projects but one would realise that the programmes and services are just on paper and that the ministry

enacting legislation for cancer research and control programs and establishing budgetary priorities do not even train and pay for researches being done.

The health care personnel are sometimes provided with health care equipment to help in constructing and managing oversight programmes and helping to enable the evaluation of programmes and outcomes on breast care.

However, with international agencies Ghana is spearheading an initiative dubbed Peer-Nurse Navigation programmes it is aimed at using breast cancer survivors and nurses to help freshly diagnosed patients with breast cancer to be able accomplish quality health outcomes. This project is based on the principle of hope – helping others through personal experiences (HOPE) which I think is a laudable idea. Also major programmes championed by the Ministry of Health helps to intensify, control and prevent breast cancer as well as other non-communicable diseases.

The national breast care programme and the health sector medium term development (HSMTDP) plan spearheaded by GHS has received budget approval for funds to support its cancer chart programme. Also GHS has during the past months rolled-out several programmes and projects, all with the intent to create, increase and sustain awareness about breast cancer which I think it is just on paper because looking at our health care system all these measures is not being practicable.

Although organizations are further planning to initiate similar programmes to boost efforts aimed at curbing the rise of breast cancer in Ghana, NGOS like ‘Run for a Cure’ and breast care international have tried to dispel societal myths, increase the awareness of timely screenings, and provide financial support to less privileged women.

Some NGO’s have had some meetings with successive ministers of the health sectors on the extent of the cancer problem and have tried to adapt some reforms for access and financial

support for cancer. QHA which is also an NGO has been making efforts towards impacting health policies and resource provision to the needs of cancer patients in Ghana

4.7 Challenges facing Stakeholders in addressing Breast Cancer issues

Actors face several challenges which often affect their ability to perform their roles effectively. It includes resource challenges; perceptions, beliefs and cultural practices; ignorance and lack of knowledge; apathetic attitude of men and stigmatization.

One major challenge identified by the study is men's apathetic attitude towards breast cancer and its associated issues. Men seem not to be bothered by it because it does not affect majority of them. This was said by respondents who indicated that

"...The vast majority of breast cancer cases occur in females hence most men do not give reverence to it and do not care about the pain and anguish the women go through ..." (R4)

Here it is clear that respondents want to point out that men do not care about the disease because they are simply men and the breast cancer does not affect men more than it affects the women and most of the time the women go through a lot of pain which in the long run affects the family. This is so because most decisions taken stems up from the men. Most of the time decision taken favours men more than women.

Another challenge that came up is cultural beliefs and practices. A respondent from affirmed this by stating that:

"...Most Ghanaians in the villages associate breast cancer with curses from the gods, others find it difficult going through metastasis and society also stigmatizes people with breast cancer ... these pose a great challenge to our work. Some individuals also reject education on breast cancer, some would not have time to listen and some would listen but practicing its preventive measures is a problem..." (R7)

The respondent also supported this by indicating that the increase in disease burdens is due to

“...poor knowledge, late detection and diagnosis delay in treatment procedures, negative social cultural beliefs and lack of funds for treatment...” (R4)

A respondent also threw more light on stigmatisation, late report of the disease and cultural beliefs as a major challenge by reiterating that

“...the challenges of breast cancer are financial burdens on the individual and family, stigmatization, curses from the gods, fear of going through metastasis and depression...” (R5)

“patients report late for treatment according to the official because they work so they do not get time, clinics and hospitals are far from rural areas, they do not have money for treatment (poverty) and some individual also do not report because of fear.” (R1)

Moreover, it was evident from the interviews that poverty or financial hardship constitutes a major challenge to patients' ability to continue with treatment. Thus, several patients fail to complete treatment processes due to poverty. This makes it difficult for treatment processes to achieve their set targets, or in some worse case scenarios, being abandoned in mid-stream. A respondent stated that

“...Lack of political will on the part of government to fund the prevention and treatment of breast cancer is a major challenge patients report late for treatment ... they do not have money for treatment (poverty) and some individual also do not report because of fear....” R.2

A respondent supported this by stating that

“Patients face financial difficulty, eehh...they have different perception and cultural beliefs on breast cancer. Also the challenges that institutions face are financial burdens, over-spending by government, miss appropriation of funds by individuals, not enough pathologists in all regions, not enough breast cancer personnel and no budget allocated for breast cancer”. R.7

The challenges were summed up by a respondent (R6) in an interview who stated;

“With challenges, hmmm..... financial constraints; that is some operations on breast care are not borne by NHIS which was a big problem to them because most victims cannot afford to pay for instance, part of the operation is borne by NHIS but was very minimal and on the low side, for instance if you are supposed to pay GH¢400.00-500.00, NHIS pays GH¢60.00. For instance chemotherapy, hormonal therapy, part was borne by NHIS but with radiotherapy, histology/biopsy (the examination of cells taken from a living body to find out about disease it might have) it not covered with NHIS. Also there is delay in lab results and the numbers that come to the clinics are on the increase. Superstition is also a major challenge (taken something from the bag) she went on to say that individuals think it’s a curse and some say it’s a spirit that has entered them and to their minds from that misconception was really a problem.

Here it is clear that the vast majority of breast cancer cases occur in females hence most men simply do not care about the pain and anguish the women go through. Most Ghanaians in the villages associate breast cancer with curses from the gods, others find it difficult going through metastasis and society also stigmatizes people with breast cancer. This poses a great challenge to women work.

The causes for individuals to reject education on breast cancer is really a challenge, some women would simply not have time to listen to breast cancer and some would listen because somehow they care, but practicing its preventive measures is really a problem.

Poor knowledge, late detection and diagnosis delay in treatment procedures and at the same time negative social cultural beliefs and lack of funds for treatment poses a lot of challenges toward breast cancer care. It really poses a challenge because the illiteracy rate is very high and to how the individual will understand the danger of the disease is something that must be grasped.

Delay in treatment procedures and at the same time negative social cultural beliefs is really a challenge. The respondent is saying this because a lot of patients abandon the treatment midstream in that they think they are waiting their time because whether they like it or not they will eventually die, which I think is not through.

Negative social cultural beliefs also re-echoed in the respondent responses. Here according to the respondents patients attribute the disease to being a curse from the gods. Also they think it is punishment from the gods for doing something bad. I think that notion should be from the minds of the patients so that they would be able to cure the disease on time. In so doing the disease would not get worse.

Financial burdens on the individual and family, stigmatization, curses from the gods, fear of going through metastasis and depression were all challenges said by the respondents. Patients report late for treatment according to the official because they work so they do not get time, clinics and hospitals are far from rural areas, they do not have money for treatment (poverty) and some individual also do not report because of fear challenge to patients' ability to continue with treatment. Thus, several patients fail to complete the treatment because they

think they would eventually die anyway so why should they worry themselves over the disease.

Lack of political will on the part of government to fund the prevention and treatment of breast cancer is a major challenge for patients hence they report late for treatment. Some patient says they do not have money for treatment all due to poverty. (Poverty) Some individuals also do not report because of fear that people might be aware that she has acquired the disease. Patients face financial difficulty; they have different perception and cultural beliefs on breast cancer.

Over-spending by government, miss appropriation of funds by individuals, not enough pathologists in all regions, not enough breast cancer personnel and no budget allocated for breast cancer.

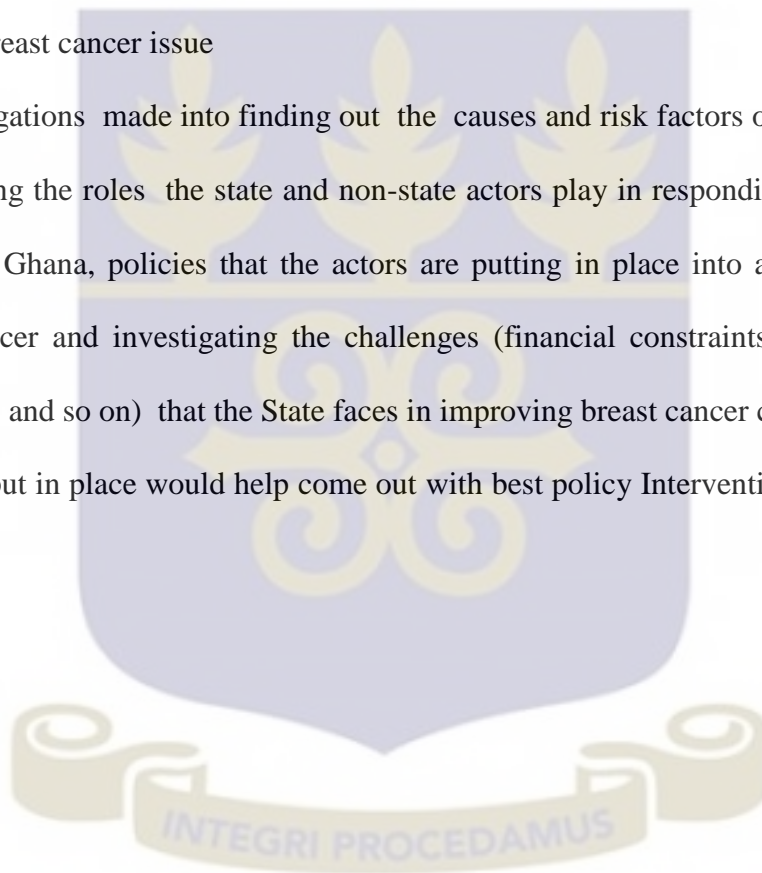
Also the challenges that institutions face includes financial burdens, With challenges on financial constraints is that with the operations on breast care most are not borne by NHIS which is a big problem to the individual because most victims cannot afford to pay. For instance, part of the operation is borne by NHIS but was very minimal and on the low side which I think is violates the right of the individual. Every pesewa must be borne by the NHIS since payments for high cost of treatment is the fault of the patient. For instance in Ghana with chemotherapy, hormonal therapy, part is borne by NHIS but with radiotherapy, histology/biopsy (the examination of cancer cells taken from a living body to find out about more about the disease or what might have triggered the disease to that stage. All these are not covered with NHIS and you can just imagine the patient waited for the disease to escalate before reporting at the hospital. Some use local herbs for treatment of cancer it can be cured but it does not work.

There is delay in lab results and the numbers that come to the clinics are on the increase. It is so because our resources are scarce and our facilities are overstretched. There is not enough laboratory Technicians to handle the situation.

Respondents reiterated the fact that superstition is really a major challenge and that individuals think it is a curse or a spirit that has entered them. In the victims minds that misconception has already been printed and this is posing a problem for stakeholders in addressing the breast cancer issue

However investigations made into finding out the causes and risk factors of breast cancer in Ghana, identifying the roles the state and non-state actors play in responding to the issue of breast cancer in Ghana, policies that the actors are putting in place into aiding individuals with Breast Cancer and investigating the challenges (financial constraints, misconceptions about the disease and so on) that the State faces in improving breast cancer care.

All these being put in place would help come out with best policy Interventions for Non-state and state actor



CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter is made up of three sections; the first presents the summary of the study. The second section is devoted to conclusions arrived at based on the responses elicited from the respondents while the final section deals with the recommendations made based on the findings of the study.

5.2 Summary of the Study

With the current rate of breast cancer in Ghana and the interest in breast cancer by both state and non-state actors, the need to understand more about the role of the key actors in responding to breast cancer in Ghana is unquestionable. Until the roles of the state and non-state actors are being supported by evidence, attempts to address their challenges may be fruitless. This study therefore sought to investigate the roles of state and non-state actors in responding to breast cancer in Ghana. It specifically seeks to identify the risk factors of breast cancer in Ghana; highlight the roles played by the key actors; explore the policy interventions of these actors and unearth the challenges confronting these actors in their quest to respond to breast cancer in Ghana. A total sample size of twelve (8) respondents was used for the study. Interview guides were used to collect data for the study. This study adopted a qualitative research method which used purposive sampling techniques to select respondents.

The findings from this study indicate that both environmental (individuals' lifestyle) and genetic factors predispose most women to breast cancer in Ghana. It was again revealed from the study that the state and non-state actors perform several roles which include awareness

creation and early detection, equipping and resuscitation of breast cancer care providers, drafting and implementation of policy interventions.

Moreover, the study revealed that the actors have three types of policy interventions which include policy development, program development and advocacy. The program activities of the actors as found from the study included providing information, community awareness, early detection campaigns, direct medical services, emotional support, research, basic material provision, and financial support.

Finally, the study revealed that several challenges confront the actors in performing their roles. These challenges include resource challenges (Financial constraints); perceptions, beliefs and cultural practices; ignorance and lack of knowledge; apathetic attitude of men and stigmatization.

In general, the findings from this study provide an overall picture of the role of state and non-state actors in addressing the issue of breast cancer in Ghana. From the study, it was clear that actors are indispensable aspect of efforts towards reducing the incidence of breast cancer in Ghana. This implies that strengthening these actors, establishing a strong cooperation and partnership relationship among these actors will have a significant impact on the countries goal of reducing breast cancer rate in Ghana. The study is however limited in the following ways: first, the findings of the study are limited in their level of reliability since they were based on self-report from the respondents. Self-reports can have social desirability effects which may limit their level of reliability.

5.3 Conclusion

This study is a step toward bringing to the fore the importance of state and non-state actors in providing care for people with breast cancer. From the analysis of the data, the following conclusions can be drawn.

Firstly, the state and non-state actors are major stakeholders in dealing with breast cancer. They play important roles in policy development, program service development, the provision of quality breast cancer care and the provision of emotional and financial support for breast cancer patients. It must be established that the relationships among them and the roles they play are very essential in any nation's quest to help in the provision of quality care for breast cancer patients. Again, this study conveys a contribution to the empirical literature in breast cancer in that most literature reviewed all

Secondly, despite the essence of these actors and their roles, they are faced with several challenges. For Ghana to be able to fully benefit from the efforts of these actors, all stakeholders have the responsibility to help address these challenges. It must however be mentioned that there is no magic bullet for breast cancer. Given the multiple levels of predisposing factors of breast cancer, single intervention strategies by single sectors will not solve these problems. What is required is a comprehensive approach that incorporates the home, the school, the community, the healthcare setting as well as change at the structural level.

5.4 Recommendations

Based on the findings of this study the following recommendations are made: First, from the study it was found that perceptions, cultural beliefs and practices constitute a major challenge for the state and non-state actors. It is therefore recommended that Government and NGOs should intensify education to increase the awareness and knowledge among women so as to inform them on current issues of the disease. This could be done through intensive community educational programmes using multimedia approaches such as radiobroadcast, mobile cinema vans to remote rural areas, television broadcast films shows and the use of the various Ghanaian languages.

Second, the focus on education should concentrate mainly on preventive measures; preventive measures where women live wellness of life by engaging in regular exercise and reducing or avoiding the intake of alcohol, highly fatty foods and other unhealthy activities which have potential of increasing their risk of developing the disease.

It is also recommended that the Ghana Education Service (GES) adds the issues of breast cancer – risk factors, treatment and preventive measures – to their syllabus. Teaching of breast cancer issues in schools will have the potential of enlightening most Ghanaians about breast cancer and boost governments' efforts towards addressing it.

Again, it is recommended that the State and Non-State Actors help support patients financially, advocate for medical and emotional support for breast cancer patients.

It is further recommended that the actors use research as a tool to improve breast cancer care outcomes. Government needs to establish a national research program and basic research laboratories in existing institutions. These laboratories should be equipped to provide clinical

research that will help test and adopt interventions suitable to the target population (breast cancer patients in Ghana).

Furthermore, the study found that breast cancer testing and treatment are not covered by the National health Insurance Scheme (NHIS) of Ghana. There is therefore the need for a legislative Instrument (LI) which will seek to include the testing (check-ups) and treatment of breast cancer in the National Health Insurance Policy. This is likely to prevent people abandoning treatment in mid-stream due to financial problems.

Moreover, it was evident that non-state actors play an important role in initiating and supporting improvements in breast cancer care in Ghana. It there therefore recommended that such actors initiate programs that afford the best existing substantiation to enlighten the public, keep cancer control on the public agenda, and pressure governments and decision makers on issues related to breast cancer control, either directly or indirectly. The non-state actors need to serve as the spur for exchange of ideas and collective action within national and local breast cancer organizations, both state and non-state. Eventually, well-coordinated public-private partnerships can greatly enhance national breast cancer care.

Finally, it is recommended that the government institutes a long term national strategy for cancer control. This can be broadened to incorporate free breast examination and public education. This should be community-based or community-focused to ensure that the services are brought to the doorsteps of the local people. The government should further create or establish more specialist hospitals for breast cancer with less cost of treatment

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APPENDICES

APPENDIX I

BREAST CANCER INTERVIEWS GUIDES FOR STATE AND NON-STATE ACTORS

This interview guide relates to an academic study being conducted in relation to an M.A. programme in SOCIAL POLICY STUDIES being undertaken at University of Ghana, Legon. It aims at finding views and responses of Breast cancer menace in Ghana and policies that go with it. It would be very much appreciated if you could answer the following questions as frankly as you can. Your responses are confidential and your anonymity is assured

DEMOGRAPHIC BACKGROUND

1. Age:
2. Gender: Male [] Female: []
3. What is your Marital Status
Single
Divorced
Married
Widow
4. Level of Education of Respondent.
5. Position occupied at institution.

BACKGROUND OF RESPONDENT WORK AND EXPERTISE RELATED TO BREASTCANCER.

6. Do you organise educational campaign for individuals or workers on the causes of Breast Cancer?
7. Do you do research on Breast Cancer?

RESPONDENTS (PERSONAL AND PROFESSIONAL)KNOWLEDGE AND PERSPECTIVES ON BREAST CANCER.

8. What causes Breast Cancer?
9. What are the symptoms of Breast Cancer?
10. What are some of the challenges that individuals face when they are confronted with the disease?
11. Do you have any idea as to why Breast cancer patients report late for treatment or abscond from treatment?

RESPONDENT INSTITUTIONAL RELATION TO BREAST CANCER

12. What challenges do your institution face when confronted in tackling with the disease
13. What kind of financial support or assistance do you get from institution(state ,banks ,organizations ,individuals etc)
14. Which advocacy groups or cancer NGOs are helping to curb the disease?
15. What solution have your outfit outlined towards Breast Cancer?

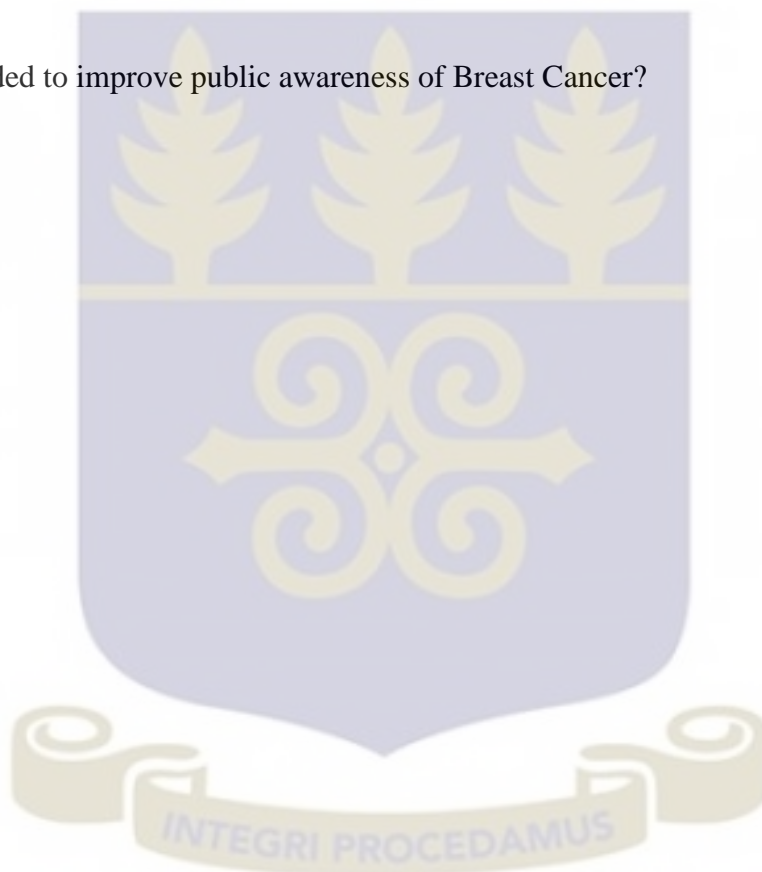
WHAT THE PUBLIC KNOW ABOUT BREAST CANCER AND THEIR SOURCE OF INFORMATION

15. From what source does the public hear of Breast cancer?

EDUCATION TO IMPROVE PUBLIC AWARENESS ON BREAST CANCER

17. What are the preventive measures towards Breast Cancer?

18. What is needed to improve public awareness of Breast Cancer?

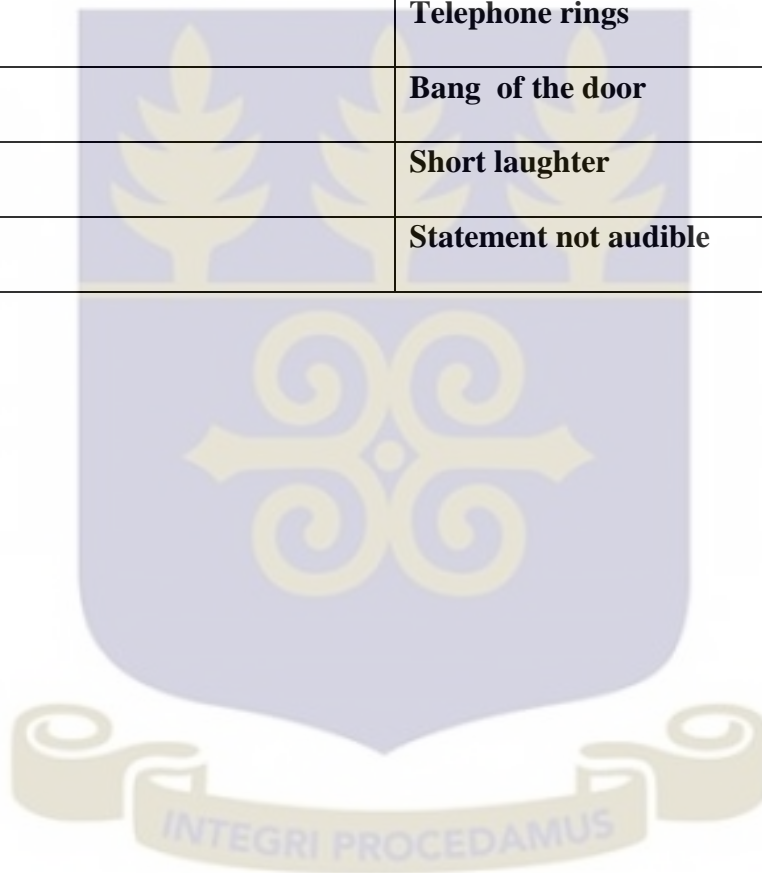


APPENDIX 2

BREAST CANCER INTERVIEWS GUIDES FOR STATE AND NON-STATE ACTORS

Key of symbol used in transcription.

^^^	Pause
<u>Underlined statement</u>	Stressed statement
...	Incomplete statement
=====	Telephone rings
----	Bang of the door
~~~~~	Short laughter
&&&&	Statement not audible



**APPENDIX 3**

**PROFILE OF RESPONDENTS....New Profile**

<b>Respondent</b>	<b>Sex</b>	<b>Age</b>	<b>Marital Status</b>	<b>Type of institution</b>	<b>Position held in institution</b>	<b>Name of institution</b>	<b>Educational Background</b>	<b>Number of years in institution</b>	<b>Number of Children</b>
1	M	46	Married	State Actors	Senior co-ordinator	GHS	Tertiary	8 years	3
2	F	35	Married	State Actors	Public Relation Officer	MOH	Tertiary	4 years	3
3	M	50	Married	Non-State Actors	Frontline Administrator	Mammocare	Tertiary	12 years	4
4	M	43	Married	State Actors	Senior Co-ordinator	MoH-Tema General	Tertiary	6 years	2
5	M	48	Married	State Actors	Senior Co-ordinator	MoH	Tertiary	6 years	3
6	F	47	Married	State Actors	Public relation officer	GHS	Tertiary	10 years	
7	F	42	Married	State Actors	Senior Nursing Officer	Korle Bu Teaching Hospital.	Tertiary	8 years	3
8	M	39	Married	Non-State Actor	Quality care administrator	Breast Care International	Tertiary	5 years	None

## APPENDIX 4

Table 1 General Profiling

<b>Variable</b>	<b>Number of Respondents</b>
<b>Male</b>	<b>5</b>
<b>Female</b>	<b>3</b>
<b>Age</b>	<b>Number of Respondents</b>
<b>35-45</b>	<b>4</b>
<b>&gt; 45</b>	<b>4</b>
<b>Type of Institution</b>	<b>Number of Respondents</b>
<b>State Organization</b>	<b>6</b>
<b>Non State organization</b>	<b>2</b>
<b>Educational Background</b>	<b>Number of respondents</b>
<b>Tertiary</b>	<b>8</b>
<b>Position of Respondent</b>	<b>Number Respondents</b>
<b>Coordinator</b>	<b>3</b>
<b>Public Relations</b>	<b>2</b>
<b>Administrator</b>	<b>2</b>
<b>Health professional</b>	<b>1</b>
<b>Number of years in Institution</b>	<b>Number of Respondents</b>
<b>1to 5 years</b>	<b>2</b>
<b>6to 10 years</b>	<b>5</b>
<b>&gt; 10 years</b>	<b>1</b>

