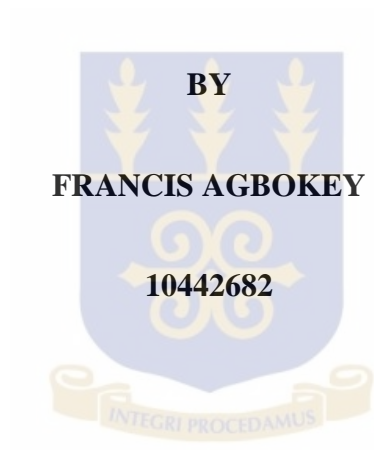


**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**

**HEALTH SEEKING BEHAVIOURS FOR BREAST CANCER AMONG BREAST
CANCER PATIENTS AT THE KOMFO ANOKYE TEACHING HOSPITAL,
KUMASI, GHANA**

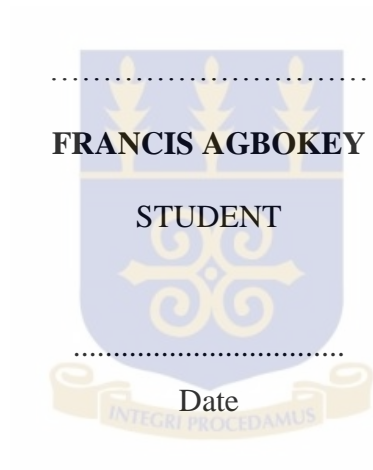


**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE
AWARD OF MASTER OF SCIENCE IN APPLIED HEALTH SOCIAL SCIENCE
DEGREE**

JULY, 2014

DECLARATION

I hereby declare that apart from references to other people's work which have been duly acknowledged, this dissertation is as a result of my own independent research work under the supervision of Dr. Mawuli Dzodzomenyo. I further declare that this dissertation has not been submitted in part or in whole for the award of any degree in this institution and other universities elsewhere.



.....
DR. MAWULI DZODZOMENYO

ACADEMIC SUPERVISOR

.....
Date

DEDICATION

I dedicate this dissertation to the love of my life, Emily Eva Beebe Agbokey (Mrs.) and my daughters and titans, Jessica Elorm Agbokey and Melissa Eyrarn Agbokey.



ACKNOWLEDGEMENTS

My utmost thanks go to the Lord Almighty, for seeing me through this project and for supplying me the strength to carry it through. Many times I was held back from giving up by God's strength and well-timed interventions.

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I would also like to thank my able supervisor, Mawuli Dzodzomenyo, PhD. His timely corrections and priceless input have elevated this project from being merely a book with many words, to a dissertation worthy of space in a Medical Science library.

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Last but not least, I would like to thank everyone else who, through one contribution or another, provided help for the execution and completion of this project. Without your inestimable input this project would be nonexistent today.

May the good Lord, bless you.



ABSTRACT

Background: Globally, breast cancer is a major public health problem in terms of morbidity and mortality. In Ghana, breast cancer constitutes 15% of all cancers and 40% of female cancers and is reported to be the second commonest cancer among women in Ghana. Over 60% of breast cancer patients present late with advanced stages of breast cancer despite the many awareness campaigns to promote early reporting and detection. This study therefore sought to find out and document reasons for these phenomena.

Methods: The study was a qualitative exploratory study using in-depth interviews to elicit information from patients, care givers, health workers and traditional healers. The study was conducted at the Komfo Anokye Teaching Hospital (KATH). All participants were purposively selected from breast cancer patients, health workers and caregivers at the Oncology Directorate at KATH. Ethical approval was sought from the GHS Ethics review committee. Interviews were audio-taped, transcribed verbatim, imported into NVIVO 7 and coded. Results were analysed and presented under themes as narratives and supported with quotes.

Results: This study found that breast cancer patients prior to their diagnosis, had poor knowledge of breast cancer. However, following their attendance to the oncology clinic at KATH, their knowledge improved tremendously. Screening methods such as breast-self examination (BSE) were not used frequently. Some participants had delayed going to the hospital because of lack of knowledge, fear of the diagnosis and fear of death, misinterpretation of the signs, economic or financial difficulties, the influence of lay beliefs and advice from the community coupled with health worker's disinterest in breast cancer. In some cases, however, suggestions from relatives and close associates led to a timely medical consultation. Poor clinical practices by some health workers coupled with a rare involvement

of decision makers and significant others regarding issues having to do with the creation of awareness about breast cancer, discouraged patients from seeking and adhering to appropriate therapy. It was also found that a good number of the patients though resorted to the hospital as the first point of call in seeking healthcare for breast cancer they did so at an advanced stage.

Conclusions: Awareness and knowledge of breast cancer was found to be poor among patients prior to their diagnosis, and although this has generally improved after the diagnosis, knowledge on the risk factors for developing breast cancer is still very poor. There was limited use of screening methods and a generally delay in seeking of medical attention. The need for increased awareness and use of screening practices was identified to be critical for early diagnosis of the disease and for improved outcomes of breast cancer management in Kumasi.

Key words: Breast cancer, health seeking behaviour, late presentation, Komfo-Anokye Teaching Hospital, Kumasi, Ghana.

TABLE OF CONTENTS

Content	Page
DECLARATION	i
DEDICATION	ii
ACKNOWLEDGEMENTS	iii
ABSTRACT.....	v
TABLE OF CONTENTS.....	vii
LIST OF TABLES	xii
LIST OF FIGURES	xiii
LIST OF ACRONYMS	xii
OPERATIONAL DEFINITION OF TERMS	xiii
CHAPTER ONE.....	1
INTRODUCTION	1
1.0 Background	1
1.1 Problem Statement	3
1.2 Justification	4
1.3 Objectives.....	5
1.3.1 General Objectives	5
1.3.2 Specific Objectives	5
1.4 Research Questions	5

CHAPTER TWO	9
LITERATURE REVIEW	9
2.1 Breast cancer knowledge – causes and risk factors.....	9
2.2.1 Definition of breast cancer	9
2.2 Health seeking behaviours - pathways to seeking care for Breast Cancer.....	14
2.3 Factors accounting for late presentation of Breast Cancer.....	15
2.4 Sources for obtaining information about breast cancer care	16
CHAPTER THREE	18
METHODS	18
3.1 Study design	18
3.2 Study location.....	18
3.3 Study Population	20
3.4 Sampling Procedures and Respondent numbers	21
3.5 Data Collection Procedure	22
3.6 Data Management and Analysis of results	23
3.7 Training of Research Assistants	24
3.8 Ethics of the Study	24
3.9 Inclusion Criteria.....	25
3.10 Exclusion Criteria.....	25
3.11 Piloting / Pretesting	25
3.12 Dissemination.....	26

CHAPTER FOUR.....	27
RESULTS	27
4.1 Demographic Characteristics of Respondents.....	27
4.1.1 Age range of respondents:	27
4.1.2 Sex of respondents:.....	27
4.1.3 Educational status of respondents:	27
4.1.4 Ethnicity of respondents:	28
4.1.5 Marital status of respondents:.....	28
4.1.6 Occupation of respondents:	28
4.1.7 Religion of respondents:.....	28
4.2 Knowledge about breast cancer.....	29
4.2.1 Perceptions of breast cancer	29
4.2.2 Perceptions about causes of breast cancer:.....	31
Perception of caregivers about the causes of breast cancer:.....	33
4.3 Risk factors for developing breast cancer	34
4.4 Signs and symptoms of breast cancer	36
4.4.1 Patients' view on signs and symptoms of BC:	36
4.4.2 Perceptions of HWs about the signs and symptoms of breast cancer:	36
4.4.3 Perceptions of herbalists about signs and symptoms of breast cancer:	37
4.4.4 Caregivers' perceptions about the signs and symptoms of breast cancer:	37
4.5 Perceptions about Treatment and Management of Breast Cancer	37
4.5.1 Patients perceptions about whether BC was curable:	37
4.5.2 Perceptions of health worker about breast cancer cure:	38

4.5.3 Perceptions of caregivers about BC cure:.....	39
4.5.4 Perceptions of herbalists about BC cure:.....	39
4.6 Prior knowledge about breast cancer	40
4.7 Sources of seeking health care for breast cancer.....	41
4.8 Description of type of care provided / received at the various sources of care.....	42
4.8.1 Description of Nature and type of care given at the hospital	42
4.9 Duration between onset of breast cancer and health seeking.....	44
4.10 Reasons for late reporting for breast cancer treatment.....	44
4.10.1 Lack of knowledge about breast cancer:	44
4.10.2 Fear of diagnosis and death:	45
4.10.3 Infrequent screening for breast cancer for early detection and treatment:	45
4.10.4 Practitioners lack of seriousness about breast cancer:.....	46
4.10.5 Influence of traditional healers and faith healers on delayed medical treatment: .	47
4.10.6 Financial constraint.....	48
4.10.7 Perceptions of competing priorities	48
4.11 Sources of information on breast cancer management.....	49
CHAPTER FIVE	51
DISCUSSION.....	51
5.1 Main findings of the Study	51
5.2 Knowledge and Beliefs of Breast Cancer Patients	51
5.3 Health-seeking behaviours for breast cancer among breast cancer patients:.....	52
5.4 Decision makers of health seeking behaviour:	54

5.5 Sources of information about treatment options for breast cancer	54
5.6 Reasons for late reporting for Breast Cancer treatment	55
5.7 Key findings in relation to the constructs of the Theory of Planned Behaviour:.....	58
5.8 Limitations of the Study	59
CHAPTER SIX.....	61
CONCLUSIONS AND RECOMMENDATION	61
6.1 Conclusion.....	61
6.2 Recommendation.....	61
REFERENCES	64
APPENDICES	71
APPENDIX A: Ethical Clearance	71
APPENDIX B: Patient In-Depth Interview Guide	72
APPENDIX C: Health Worker Interview Guide	74
APPENDIX D: Questionnaires.....	75
APPENDIX E: Interview Guide for Alternative Health Providers	76

LIST OF TABLES

Table1: Breakdown of qualitative interviews conducted..... 22

LIST OF FIGURES

Figure1: Conceptual Framework: The Theory of Planned Behaviour.....	6
Figure 2: Map of Ghana showing the location of KATH in the Ashanti Region.....	20

LIST OF ACRONYMS

ASIR	Age Standardised Incidence Ratio
BCP	Breast cancer patient
BRCA 1	Breast Cancer gene 1
BRCA 2	Breast Cancer gene 2
BSE	Breast Self-Examination
CBE	Clinical Breast Examination
CG	Caregiver
GPs	General Practitioners
HB	Herbalist
HW	Health worker
IDIs	In-depth Interviews
KATH	Komfo Anokye Teaching Hospital
KNUST	Kwame Nkrumah University of Science and Technology
MoH	Ministry of Health
OPD	Out-Patient Department
TPB	Theory of Planned Behaviour
WHO	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Breast cancer: A tumour that starts from the breast tissues.

BRCA 1 and BRCA 2: These are two abnormal genes associated with inherited cases of breast cancer such that women who inherit either of these genes have a much higher-than-average lifetime risk of developing breast cancer.

Late presentation: A time lapse of three months between the onset of symptoms and the presentation to a hospital.

Health seeking behaviour: Health-seeking behaviour is described as a sequence of remedial actions that individuals undertake to cure perceived ill health.

Stage 3 of breast cancer: This means the breast cancer has extended to beyond the immediate region of the tumour and may have invaded nearby lymph nodes and muscles, but has not spread to distant organs.

Health Worker: A trained health provider of health care in the orthodox setting.

Healthcare Provider: Any provider of healthcare using unorthodox means.

CHAPTER ONE

INTRODUCTION

1.0 Background

Globally, breast cancer is a major public health problem in terms of morbidity and mortality (Benson & Jatoi, 2012; Ferlay, Soerjomataram, & Ervik, 2012). It is the most frequently diagnosed cancer and the leading cause of cancer-related deaths among women throughout the world. In 2012 for instance, an estimated 1.7 million women were diagnosed with breast cancer with a total of 522,000 of them dying as a result of the disease (J Ferlay et al., 2012).

Breast Cancer incidence and mortality has increased by over 20% and 14% respectively between 2008 and 2012. A study published by the Lancet in 2011, showed that whereas breast cancer diagnosis occurred more frequently in developed countries in the 1980s, incidence rates have been higher in developing countries since 2010 (Forouzanfar et al., 2011). Also, it is reported that about half the breast cancer cases and 60% of the deaths are estimated to occur in economically developing countries. Incidence rates in general, are reportedly high in Western and Northern Europe, Australia, New Zealand, and North America; intermediate in South America, the Caribbean, and Northern Africa; and low in sub-Saharan Africa and Asia (Jemal et al., 2011).

In Africa, 100,000 cases of breast cancer are diagnosed annually with 49,000 (42%) dying (Ferlay et al., 2012). Black African women are reported to have a lower incidence but higher mortality rates from breast cancer compared to their Caucasian counterparts for example, approximately 713,220 women were estimated to have been diagnosed and 269,800 deaths occurring from cancer in the United States of America in Western Europe, breast cancer incidence has reached over 90 new cases per 100,000 women annually, as against 30 per

100,000 in Eastern Africa (Asiago et al., 2010). This paradox of lower-incidence-high-mortality has been attributed to the fact that African women tend to have more aggressive breast cancer and do not have access to the best treatment (Jacques Ferlay et al., 2010; Siegel, Naishadham, & Jemal, 2013; Tfayli, Temraz, Abou Mrad, & Shamseddine, 2010).

Projections for the year 2020 shows that the incidence and mortality rates of breast cancer in developing countries will increase significantly compared to developed countries. (Cazap et al., 2010) Awareness and understanding of breast cancer is particularly low in the general population of Africa. For example, among Western African women, supernatural aetiology was the most commonly cited cause of breast cancer (Grunfeld, Ramirez, Hunter, & Richards, 2002; Ohaeri, Campbell, Ilesanmi, & Ohaeri, 1999).

In Ghana, breast cancer constitutes 15% of all cancers and 40% of female cancers; and is reported to be the second commonest cancer among women in Ghana. Though there is no national cancer registry in Ghana, estimates from the World Health Organisation (WHO) puts the Age Standardised Incidence Ratio (ASIR) at 37/100,000 of the population and an incidence-mortality ratio of 0.68 as against 0.2 in the USA (Mathers, Fat, & Boerma, 2008). According to the GLOBOCAN 2012 report, 2,260 new cases of breast cancer are diagnosed annually with 1,021 deaths occurring; therefore 45.2 % of women diagnosed with breast cancer are likely to die.

Most breast cancer patients in Ghana (50-70%) present with advanced (stage III and stage IV) disease, 8-10 months after first noticing a change in their breasts. (Clegg-Lampsey & Hodasi, 2007) Possible reasons for the late presentation of breast cancer to the hospital for treatment may be attributed to socio-demographic, economic and cultural factors and lack of the right information about breast cancer. other reasons include fear of mastectomy 20 (57.1%), herbal

treatment 13(37.1%), financial incapability 11(31.4%) and the frequent use of prayers or prayer camps 10(28.6%) (Clegg-Lamptey, Dakubo, & Attobra, 2009).

There has been a remarkable rise in the diversity of non-biomedical healing services worldwide. Health care options different from biomedicine have recently increased both in numbers and variety, modifying in turn the composition of medical pluralism in the country. The non biomedical system is however characterised by the relatively uninformed healthcare demands of the Ghanaian population, the lack of professionalization of non biomedical practitioners, the widespread use of self-medication among the population, the distribution of medical benefits according to the person's socio-economic status, and the permanent availability and accessibility in both rural and urban areas.

1.1 Problem Statement

Available statistics indicate that a woman dies every 69 seconds from breast cancer globally (Jemal et al., 2011). In Ghana, 2,260 new cases of breast cancer are diagnosed annually with 1,021 deaths occurring; a figure showing that 45.2 percent of women diagnosed with breast cancer die. In addition, Ghanaian women are at risk of developing breast cancer 10 – 15 years earlier than their Caucasian counterparts. With a prevalence rate of 0.41 – 1.11 percent, the most affected age group for breast cancer in Ghana is said to be between the ages of 35 – 45. The situation at KATH indicates that breast cancer constitutes the leading cancer cases reported in 2012 representing 24% as contained by extracts from the Kumasi cancer registry. Seeking early biomedical health care for breast cancer is a major step toward the identification and management of the disease. However, though there has been many Breast Cancer awareness campaigns aimed at promoting early detection and reporting for treatment (K. Sharma, Costas, Shulman, & Meara, 2012), about 60% of patients with breast cancer in Ghana still report with advanced stages of breast cancer, which has been estimated to be

between 8 months – 5 years from the onset of symptoms (Clegg-Lampsey & Hodasi, 2007; Kazaura, Kombe, Yuma, Mtiro, & Mlawa, 2007). Anecdotal reports suggest that this could be attributed to such factors as: self-medication, patronage of faith-based healers, herbalists, misinformation or lack of information about breast cancer. The role of the non-biomedical medicine is considered as very important in improving awareness and management of breast cancer (Asobayire & Barley, 2014).

Despite these reports, it is still not very clear why patients would come late to the hospital. Therefore, what this study sought to do was to understand the factors that inform health seeking behaviours for breast cancer through the exploration of patients' treatment history for breast cancer as well as explore the determinants of the behaviour.

1.2 Justification

This qualitative study was important and needed for several reasons. First, a gap exists in the literature on health seeking behaviours for breast cancer among breast cancer patients where the treatment history has not been explored to identify why breast cancer patients resort to other sources as first points of call for health care for breast cancer other than the hospital and thereby end up presenting late to the hospital with advanced stages of the condition. Most studies on breast cancer are quantitative. This study is qualitative in order to gain in-depth understanding of alternative health-seeking options for breast cancer aside from medical care and explanations for these choices, from the patient's own perspective. Third, this study would add new knowledge to this neglected but important area, as well as provide information to social scientists, health care providers, programmes officers and policy makers to plan more effective and humane approaches for preventing and controlling breast cancer in low resource settings in developing countries as a way of treating breast cancer patients.

1.3 Objectives

1.3.1 General Objectives

The main aim of the study was to examine the health-seeking behaviours for breast cancer among breast cancer patients.

1.3.2 Specific Objectives

1. To explore breast cancer patients' beliefs about causes of breast cancer.
2. To document the various sources of care that breast cancer patients resort to in seeking health care for breast cancer.
3. To document reasons for delayed medical care for breast cancer.
4. To explore the sources of information about treatment options for breast cancer.

1.4 Research Questions

1. What are the beliefs about causes of breast cancer?
2. What are the various sources of care that breast cancer patients resort to in seeking health care for breast cancer?
3. Where do patients access information about treatment options for breast cancer?
4. What factors contribute to delay in presenting with breast cancer to the hospital?

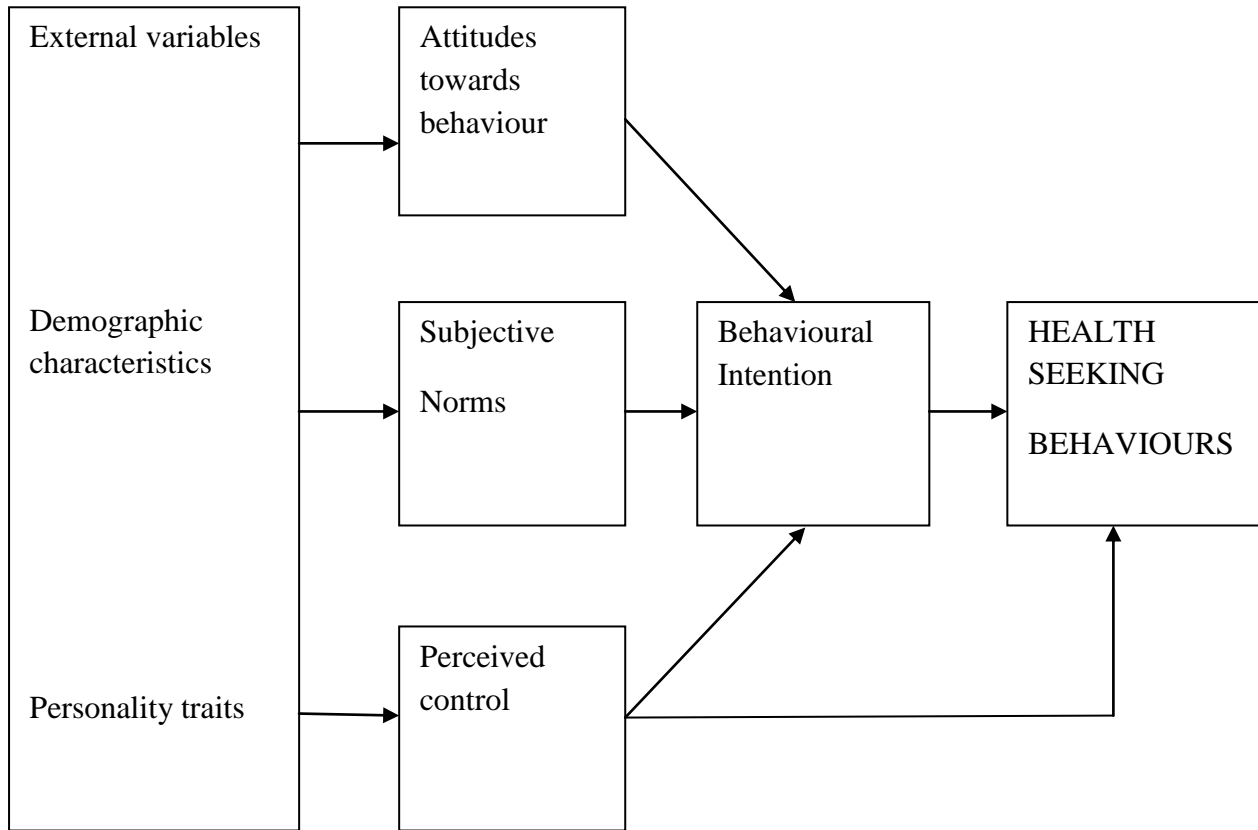


Figure 1: Conceptual Framework: The Theory of Planned Behaviour

Theory of Planned Behaviour, adapted from Conner & Sparks, 1995

Health-seeking behaviour can be explained using many theories. The theory used in this study and aimed at explaining the predictors of health-seeking behaviour for breast cancer is the Theory of Planned Behaviour (TPB) by Conner and Sparks (1995). The TPB is usually used to shape behaviour and therefore also provides determinants for behavioural change (Armitage & Conner, 2001).

The TPB assumes that people usually make rational choices that determine their behaviour (Armitage & Conner, 2001). The focus of the TPB is on the intention to act in a certain way of whether or not to seek health care or not. This intention is the determinant of the behaviour

(Norman & Conner, 2006). As illustrated in figure1, is the intention itself which in turn is predicted by three other determinants namely: the attitude towards the behaviour, subjective norm regarding the behaviour, and perceived control over the behaviour.

1. Attitude is defined as a general evaluation of an object that is based on cognitive, emotional and behavioural information (Maio & Haddock, 2009). It therefore relies on beliefs and the personal opinion over the consequences of certain behaviour. The attitude is shaped by previous experiences and environmental factors of the individual involved. (Armitage & Christian. 2003)

2. The subjective norm is a social component in the TPB which is defined as a perceived social pressure of group conformity from people that have a considerably high influence on the individual or the belief in whether significant others will approve of one's behaviour, coupled with the personal motivation to fulfil the expectations of others (Armitage & Conner, 2001). One's behaviour and by extension, health-seeking behaviour can be influenced significantly by people popularly referred to as "significant others" such as the family and friends of the individual. (Maio & Haddock, 2009).

Perceived behaviour control is the third determinant and describes how people estimate the extent to which they are free to make their own decisions (Armitage & Conner, 2001). In order to be able to perform a certain action, people have to feel self-efficient to undertake that action. They also need to think that they are capable of behaving autonomously and intentionally. In seeking healthcare, this could be understood as the feeling to be able to control the decisions regarding one's own health-seeking behaviour as to when, where and how to seek this healthcare; as well as the belief about access to the resources needed in order to act successfully, and the success of these resources (information, abilities, skills, dependence or otherwise from others, barriers, and opportunities) then, the socio-

demographic variables and personality traits which condition attitudes, subjective norms and perceived behavioural control.

CHAPTER TWO

LITERATURE REVIEW

This chapter is divided into four themes. The first theme describes breast cancer – its definition, causes, risk factors and types. The second theme focuses on the health seeking behaviours or the pathways to seeking health care for breast cancer. The third theme emphasizes on the factors accounting for late presentation of breast cancer for treatment at the hospital. Finally, the fourth theme focused on the area of sources of obtaining information about breast cancer.

2.1 Breast cancer knowledge – causes and risk factors

2.2.1 Definition of breast cancer

Breast cancer is a tumour that starts from cells of the breast tissue, either in cells that line the ducts that carry milk to the nipples (ductile cancer) and or in cells that line the lobules, which are glands involved in milk production (Ali & Coombes, 2002; Zimmerman, 2004). Breast tumours can be benign or malignant, the former are not life-threatening, can usually be removed, do not invade adjacent tissues or spread to other parts of the body and can include fibrocystic tissue, fibro adenomas and benign breast disease (Bertrand et al., 1992; Peepliwal & Tandale, 2013). Malignant breast tumours are cancerous and can invade surrounding tissues or metastasize to other parts of the body via the lymphatic system (lymphatic vessels and lymph nodes), such as the liver and bone. If cancer cells have spread to the surrounding lymph nodes, there is a much higher probability that the tumour has entered the bloodstream and metastasize to other parts of the body (McPherson, Steel, & Dixon, 2000; Sauter et al., 1997; Virgo & Re, 2012).

It has been reported that a women's knowledge and beliefs about breast cancer as well as its management, may contribute significantly to medical health seeking behaviours (Hadi, Hassali, Shafie, & Awaisu, 2010; O. Odusanya, 2001; Okobia, Bunker, Okonofua, & Osime, 2006). A strong relationship has also been established between the practice of preventive procedures and knowledge.(Haji-Mahmoodi et al., 2002)

Awareness and understanding of breast cancer is particularly low within the general population of Africa. In some previous studies, supernatural aetiology was the most commonly cited reason by Western African women for the cause of breast cancer. (Grunfeld et al., 2002; Kazaura et al., 2007; Ohaeri et al., 1999; Okobia et al., 2006) In Kumasi, as in other parts of Ghana, breast cancer affects mostly the young pre-menopausal who present with advanced stages of the disease. (Ohene-Yeboah & Adjei, 2012)

The implications of causal beliefs on health outcomes are vast. The beliefs that women hold about the causes of breast Cancer have been shown to influence the preventive actions they undertake to reduce their risk. (Ferrucci et al., 2011; Friedman et al., 2007; Rabin & Pinto, 2006) This relationship may partially be due to the role of causal beliefs and attributions on influencing subsequent beliefs about disease controllability as well as the effectiveness of medical interventions. (Parrott, Silk, & Condit, 2003)

Both genetic and environmental factors are reportedly to be responsible for causing breast cancer. For example, findings of a study conducted in the United States of America (USA), among women in the general population on their beliefs about the causes of breast cancer indicated that majority of them identified heredity, changes in immune system, pollution in the environment, aging, smoking, obesity (reflected in diet and exercise) as well as alcohol

use as risk or predisposing factors of breast cancer. (Wang, Miller, Egleston, Hay, & Weinberg, 2010) Additionally, fate, bad luck, not breastfeeding one's baby, as well as a punishment by God were some of the responses women gave as reasons why people get breast cancer. (Donnelly et al., 2013)

One's socio-demographic status such as level of formal education, race / or ethnicity, religion and occupation are major determinants in deciding what course of action to take in seeking health care for breast cancer. Numerous social theoretical frameworks have been advanced to explain and predict health related behaviours (Bandura, 1986; Glanz & Bishop, 2010). Although such health-behaviour theories may differ with respect to their fundamental constructs, most include consideration of beliefs regarding one's susceptibility to disease, knowledge of potential risk factors, and understanding of the associations between health-related behaviours and health outcomes. Such theories hold that engaging in a healthy lifestyle is partially predicated on an accurate assessment of risk factors and understanding the relation between such risks and one's behaviours. Applied to breast cancer, limited awareness of proven breast cancer risk factors represents an obstacle to positive health outcomes. (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003; Davis, Williams, Marin, Parker, & Glass, 2002; Kindig, Panzer, & Nielsen-Bohlman, 2004; Nielsen-Bohlman, Panzer, & Kindig, 2013)

The awareness of the signs and symptoms of breast cancer has been identified as key to several factors determining the stage at which breast cancer patients present to the hospital to seek healthcare. (Azubuike & Okwuokei, 2013)

Some of the possible early signs and symptoms of breast cancer include: a lump in a breast; a pain in the armpits or breast that does not seem to be related to the woman's

menstrual period; pitting or redness of the skin of the breast; like the skin of an orange; a rash around (or on) one of the nipples; a swelling (lump) in one of the armpits; an area of thickened tissue in a breast; One of the nipples having a discharge; sometimes it may contain blood; the nipple changes in appearance; it may become sunken or inverted; the size or the shape of the breast changes; the nipple-skin or breast-skin may have started to peel, scale or flake. (Anderson et al., 2003; Norman et al., 2009; P. Sharma et al., 2005; Smith et al., 2006)

Moreover, knowledge of risk factors is said to be motivational to practice, perhaps because it helps people to estimate to what extent they are vulnerable. (Azubuike & Okwuokei, 2013). A risk factor is explained as something that affects one's chances of getting a disease. For breast cancer, the risk factors are categorised under any of the following 3 main categories: (1) risk factors related to personal choice such as lifestyle, and which can be changed, (2) those that are not related to personal choice and which cannot be changed because one has no control over them for example, gender, aging, genetics, race and ethnicity, menarche has been outlined below.

Gender has been linked strongly to developing breast cancer. Being a woman is the main risk factor for developing breast cancer. Though men can develop breast cancer, it is about 100 times more common among women than men. This is probably because men have less of the female hormones estrogens and progesterone, which can promote breast cancer cell growth (Shen, et al, 2008). Aging is yet another risk factor of developing breast cancer such that the older one gets, the higher likely she is to developing breast cancer. For instance, it is reported that about 1 out of 8 invasive cancers are found in women younger than 45 years, while about 2 of 3 invasive breast cancers are found in women age 55 or older (Colditz & Rosner, 2000).

Genetic factors have also been identified as predisposing factors for developing breast cancer. About 5% to 10% of breast cancer cases are said to be hereditary resulting from gene defects or mutations. The most common cause of hereditary breast cancer is an inherited mutation in the BRCA1 and BRCA2 genes. Although in normal cells these genes help prevent cancer by making proteins that keep the cells from growing abnormally, persons who inherit a mutated copy of either gene from a parent have a high risk of developing breast cancer during their lifetime. (Shen et al., 2008) Also, persons with a family history of breast cancer stood a higher risk of developing the breast cancer disease. Again, a woman with a personal history of breast cancer of having the disease in one breast has 3-to 4-fold increased risk of developing a new cancer in the other breast or in another part of the same breast. (Bernstein, et al. 2002) Also related to genetics is one's race and ethnicity. White women are found to be slightly more likely to develop breast cancer than are African-American women over 45 years of age. (Chlebowski, et al. 2005; Smigal, et al. 2006)

For the lifestyle-related risk factors for developing breast cancer risk, some studies indicate that women who have not had any children or who had their first child after age 30 have a slightly higher breast cancer risk overall. It has been found that women using oral contraceptives (birth control pills) have a slightly greater risk of breast cancer compared to women who have never used them. This risk however seems to go back to normal over time once the pills are stopped because studies have shown that women who stopped using oral contraceptives more than 10 years ago do not appear to have any increased breast cancer risk. (Kumle, et al. 2002) In addition it has been found that not breastfeeding, excessive drinking of alcohol, being overweight or obese particularly after menopause

coupled with the lack of physical activity all increased one's risk of developing the breast cancer disease. (Holmes, Chen, Feskanich, Kroenke & Colditz, 2005)

Several studies have also found that women who work at night such as nurses on a night shift may be more prone to developing the breast cancer disease than those women who did not work at night. (Hansen, 2001; Lie, Roessink & Kjærheim, 2006; Megdal, Kroenke Laden, Pukkala & Schernhammer, 2005).

2.2 Health seeking behaviours - pathways to seeking care for Breast Cancer

Medical pluralism may be explained to mean the co-existence of multiple systems of medicine, including what are referred to as folk systems, popular systems, or traditional professionalised systems which present multiple choices to individuals. Medical pluralism further addresses the way people choose between competing therapies. The concept or idea of pluralism may be found in people's conceptions of disease and illness, in their resort to medical practices belonging to different systems, and in their responses to other medical dimensions. The layman's perspective on medicine has component from various systems of medicine (Nigenda, Lockett, Manca & Mora, 2001).

Health-seeking behaviour refers to a chain of corrective measures adopted by individuals to cure perceived ill health (Ahmed, Tomson, Petzold, & Kabir, 2005). The value of care that women place on themselves goes a long way in determining their health seeking behaviour (Chamberlain et al., 2007). A study conducted in Ontario, Canada between 1998 and 2005 revealed that the proportion of breast cancer patients using other forms of sources other than the biomedical source to seek cure for breast cancer varied from 67% to 83% (Boon, Olatunde, & Zick, 2007). In Ghana, as in many societies where serious health

problems are also religious experiences, breast cancer patients – depending on the definition of their condition - may ‘shop around’ consulting allopathic practitioners, faith healers and traditional medical practitioners in their quest for therapy. This plural health-seeking behaviour may pose serious problems for therapy management in the long term.

(Jansen et al., 2001), in a study examining patient preferences in women with early-stage breast cancer, suggested that many patients feel that doing something is better than doing nothing, even if it means enduring the toxic side effects associated with chemotherapy. In this case, patients are trading one aspect of their quality of life, the physical well-being that will be compromised by the side effects of chemotherapy, for another aspect they consider to be more important, the emotional well-being they derive from taking charge of their own bodies (Koedoot et al., 2003; Stockler, Duric, & Coates, 2006).

2.3 Factors accounting for late presentation of Breast Cancer

Patient delay is defined as the period from recognition of the first symptom by the patient to initial medical consultation, usually spanning a period of more than three months (Burgess et al., 2006; Nosarti et al., 2000). A study conducted in Kumasi between 2004 and 2009 shows that two hundred and eighty –one patients (85.2%) presented late with Stages III and IV of breast cancer (Ohene-Yeboah and Adjei, 2012). One of the reasons for delaying healthcare seeking is the low socioeconomic status of women particularly in Africa. In view of this, they are unwilling to or unable to spend money on their own health without feeling guilty (Bairati, Jobin, Fillion, Larochelle, & Vincent, 2007; Harirchi, Ghaemmaghami, Karbakhsh, Moghimi, & Mazaherie, 2005; Rogers et al., 2007; Tromp, Brouha, De Leeuw, Hordijk, & Winnubst, 2004). Cultural and religious practices that limit a woman’s social and financial freedom from men, ensures women’s subordinate position in society. This position may influence women’s health seeking behaviour and lead to

women not perceiving their ill health as important enough to warrant treatment (Ahmed et al., 2005; Robertson et al., 2004).

Many African cultures still believe that cancer is limited to the white population and consider advanced cancer as the only form of real cancer (Ross & Deverell, 2004). In a study conducted to determine the general health care practices of urban black women, it was found that weakness of the body was considered by most women (36%) as an indication of a serious health problem. Anorexia, pyrexia, dizziness and pain were also regarded to be serious. With respect to cancer, waiting until these signs are present would not be beneficial to early detection and lead to late presentation as weakness and pain are symptoms of advanced cancer (Wright, 2008).

2.4 Sources for obtaining information about breast cancer care

Information is a necessary prerequisite to informed decision-making. Women with breast cancer must be abreast with information regarding the disease. Sources of information include a range of interpersonal providers, including hospital consultants, breast care nurses, general practitioners (GPs), ward and clinic nurses, family and friends (Luker, Beaver, Lemster, & Owens, 1996). Others also use the mass media such as the internet, newspapers, books, the radio and television. Varied findings regarding the use of the internet by breast cancer patients for information have been reported, for example, fewer than 10% of breast cancer patients use the internet to seek information about their cancer (Mills & Davidson, 2002). However, other findings reported a much higher number of internet use of between 40% – 45%. These findings further indicate that breast cancer internet users tend to be younger with a higher education level than non-users (Fogel,

Albert, Schnabel, Ditkoff, & Neugut, 2002; Pereira, Koski, Hanson, Bruera, & Mackey, 2000).

The media (television, radio and newspaper) was reported as a major source of information for nearly three-fifth of the study participants. Two hundred (29.6%) of the respondents who reported to have had information on breast cancer mentioned colleagues /friends/neighbors as their major information source. The contribution of health professionals as a source of breast cancer-related information was however found to be very minimal 10. (1.5%) (Legesse & Gedif, 2014)

CHAPTER THREE

METHODS

3.1 Study design

The study is a qualitative exploratory study. The reason for this approach is to afford the researcher an opportunity to get a deeper understanding of the participants' experiences. The qualitative approach was used because of the following reasons: it includes context as an essential component of the research; it addresses the researcher's process of self-awareness and self-reflection; it is uniquely able to capture the meanings made by participants of their experiences; this method provided the platform for voices that would have been silenced to be heard (Morales, 2006).

3.2 Study location

The study was conducted at the Komfo Anokye Teaching Hospital (KATH), located in Kumasi 250 kilometres north of the national capital Accra. The hospital started as a regional hospital in 1955 with less than 500 beds but became a teaching hospital in 1975 and currently has over 1200 beds. KATH provides training for medical and allied health students from Kwame Nkrumah University of Science and Technology (KNUST) in Kumasi and other Nurses and Midwives from training colleges in the country. In addition, it is a training centre for the Ghana Post Graduate College of Physicians and Surgeons and the West African College of Physicians and Surgeons.

The hospital which is a referral point has a catchment population of more than 10 million. In 2008, the hospital recorded an out-patient department (OPD) attendance of 483,462 and 58,000 in-patients admissions. The KATH has staff strength of 2,700 employees. The Komfo Anokye Teaching Hospital was selected for this study because it runs an autonomous clinic

devoted solely to breast diseases everyday (Ohene-Yeboah & Adjei, 2012). In addition, statistics for 2012 which was extracted from the Kumasi population-based cancer registry started in 2004 by the hospital indicates that breast cancer is the leading cancer case affecting the population as it constitutes twenty four percent (24%) of all cancer cases. The Oncology Directorate is one of the Clinical Directorates in the hospital. It administers Radiotherapy, Brach therapy and Chemotherapy services to patients. Outpatient service outlets provided 5,854 consultations in 2008. The Oncology directorate specializes in the provision of comprehensive cancer care to patients and the general public in the area of primary, secondary and tertiary prevention of cancer. Services delivered include haematology, medical oncology and radiation oncology. The Radiotherapy Centre of the Oncology Directorate which began operations in January 2004 currently provides treatments for all kinds of cancers through radiotherapy and chemotherapy (Accessed at: www.kathhsp.org on 6th February, 2014).



Figure 2: Map of Ghana showing the location of KATH in the Ashanti region.

3.3 Study Population

The study was conducted among breast cancer patients attending the Out Patient Department (OPD) of Oncology and Radiotherapy of the Komfo Anokye Teaching Hospital (KATH), Kumasi and their caregivers as well as clinician specialists and other health workers working at the Oncology Directorate of KATH.

3.4 Sampling Procedures and Respondent numbers

All participants were purposively selected for the study. Purposive sampling according to Kerlinger (1986) is a non-probability based sampling technique which is characterised by a deliberate attempt at getting representative samples through the inclusion of groups or typical areas in a sample.

Purposive sampling was used for this study because it focuses on specific characteristics of the population that are of interest to the research and which best enables the researcher answer questions about health seeking behaviour for breast cancer. In this study for convenience sake, the study units that happen to be available at the time of data collection are selected in the sample. Thus, breast cancer patients, caregivers, herbalists and specialist breast cancer health workers were recruited to provide the necessary information needed to adequately answer the research questions. At the end of it all a total of 35 respondents were interviewed. After review of patients records with the clinician attendant, patients were identified from the breast cancer register of the Oncology Unit and interviewed until the point of theoretical saturation was reached where the 19th and 20th patient-participants interviewed failed to yield any additional information to the ones provided early on by other respondents before them thereby ending the interviews of patients and bringing the number of patients interviewed to 20. 7, 6 and 7 patients were selected and interviewed on days 1, 2 and 3 respectively. Caregivers who accompanied breast cancer patients to the KATH for healthcare were also interviewed one after the other until the point of saturation was reached when the responses given by the 7th and 8th respondents did not bring any new insight to the research questions thus bringing the number of caregivers interviewed to 8. Furthermore, health professionals working at the oncology directorate of the KATH were identified, interviewed until the point of saturation was attained following the interviews of the 4th and 5th respondents thus bringing the total number of health professionals interviewed for this study

to 5. Additionally, 2 traditional healers who were identified by respondents in the course of the interviews as providers of alternative treatment for breast cancer and who resided in the study area were also followed and interviewed for this study. Therefore the total number of participants interviewed for the study was 35.

3.5 Data Collection Procedure

Data was collected through the conduct of In-depth Interviews (IDIs), to explore issues that related to health seeking behaviours for breast cancer (BC) among breast cancer patients (BCPs) with focus on the following key themes: knowledge on BC, screening for BC, sources of health seeking for breast cancer, the treatment options for breast cancer, sources of information on breast cancer. For detailed individual accounts, IDIs were held with key informants. 35 interview sessions were held among the participants as follows: (20 with BCPs, 8 with caregivers of BCPs, 5 with health workers and 2 with herbalists) as shown in table 1.

Table 1 : Breakdown of qualitative interviews conducted

Category	Interview Type	Number of interviews
Breast Cancer patients	In-depth interview	20
Health workers	In-depth interview	5
Caregivers	In-depth interview	8
Herbalists	In-depth interview	2
Total		35

The data was analysed along the following key themes in the IDI which formed the basis for the analysis plan.

1. Knowledge about breast cancer (in relation to such areas as perception and beliefs about breast cancer, causes, signs and symptoms, age group that is more susceptible to breast cancer, and whether the disease is curable).
2. Screening methods – (BSE, CBE, and Mammogram) adopted by patients as well as the frequency of engaging in the method to check and screen for breast cancer.
3. Sources of seeking healthcare for breast cancer
4. Causes of delay healthcare seeking and presentation to the hospital.
5. Sources of seeking information about breast cancer

3.6 Data Management and Analysis of results

The recorded interviews were transcribed verbatim and field notes typed, expanded and saved as word documents on the day of the interview or shortly after. A duplicate copy of the field notes were created to serve as a backup and to allow for concurrent data analysis. Each data file was labelled with the following: date, time and duration of interview; name of interviewer, identification code of interviewee. The data was stored in a locked desk drawer in the researcher's residence for the duration of the study until the results were analysed, written up and presented. Transcripts were read through and the emerging themes namely: knowledge about breast cancer, perceptions about causes of breast cancer, treatment and management of breast cancer, reasons for late reporting, and sources of information on breast cancer were developed. The transcripts were imported into Nvivo 7 and coded according to the themes. Sub-themes were also developed to capture related responses during the coding process. The results were finally analysed, presented as narratives and supported with quotes.

3.7 Training of Research Assistants

The field studies involved the principal researcher and one part-time research assistant with some experience in conducting qualitative research. The field assistant was given further training with emphasis on both the theoretical foundations and the application of relevant qualitative techniques. The assistant was exposed to participatory skills, facilitation, note-taking and practical hands-on-sessions in observation and the systematic gathering of data. The interview guides were developed in English and translated into the local Twi language, translated back from the local language into English for comparability of the instruments in English and Twi. The instruments were then reviewed to determine how easy they were to understand, ease of use, and language level. This was done through piloting of the guides among 5 respondents: (2 BCPs, 1 health worker and 2 caregivers) at the Peace and Love Breast Cancer Treatment Centre in Kumasi.

3.8 Ethics of the Study

Ethical approval and clearance was sought from the Ghana Health Service Ethics Review Committee of the Ministry of Health (MOH) for the study. Permission was also sought from the Committee on Human Research, Publications and Ethics, Kwame Nkrumah University of Science And Technology, School of Medical Sciences & Komfo Anokye Teaching Hospital in Kumasi, Ghana; as well as from the Oncology Directorate of KATH. A written informed consent was sought from all study participants. They were informed that those who do not wish to participate have the right to do so and will continue to have treatment like other patients. The respondents were required to endorse (by either thumb printing or signing) an informed consent form once its contents have been read out in the local language and their questions adequately addressed by the research team. Anonymity and confidentiality was properly taken care of and any potential personal identifier was replaced by unique reference codes appropriately. Interviews were tape-recorded with permission of the participants. All

study documents were kept under lock and key. All the electronic data are to be kept for 2 years until all publications have been produced.

3.9 Inclusion Criteria

- i. Women (over 18 years old) diagnosed with breast cancer who access specialist palliative care services at the Oncology unit of the Komfo-Anokye Teaching Hospital (KATH).
- ii. Caregivers of female adults diagnosed with breast cancer who access healthcare services at the oncology unit of the Komfo-Anokye Teaching Hospital (KATH).
- iii. Healthcare professionals who work within the oncology unit of the Komfo-Anokye Teaching Hospital.
- iv. Traditional healers / herbalists, faith-based healers identified by participants as providing alternative healthcare for breast cancer and who are within the study area.

3.10 Exclusion Criteria

- i. Women above 18 years old who report with other forms of ailments other than breast cancer and their caregivers.
- ii. Health workers in other units other than the Oncology unit.

3.11 Piloting / Pretesting

The guides for the IDIs were pre-tested at the Peace and Love Breast Cancer Treatment Centre located at Oduom in the Oforikrom sub-metropolitan area of the Kumasi Metropolitan Assembly (KMA) among 5 people made up of: (2 breast cancer patients, 2 caregivers, and 1 health worker) with the view of fine-tuning the guide to ensure its validity and reliability before it was used for the final study.

3.12 Dissemination

The results will be presented to the KATH authorities, study participants and the written report and recommendations presented to the relevant stakeholders as well as to the scientific community through publications.

CHAPTER FOUR

RESULTS

4.1 Demographic Characteristics of Respondents

4.1.1 Age range of respondents:

The ages of the breast cancer patients who participated in the study ranged from 29 to 80 years with a mean age of 52 years. The ages of the caregivers that participated in the study ranged from 19 to 48 with a mean age of 36, whilst the ages of herbalists participating in the study ranged from 31 to 49 with a mean age of 40 years. Lastly, with a mean age of 32 years for health workers who participated in this study, their ages ranged from 30 – 35 years.

4.1.2 Sex of respondents:

All the 20 breast cancer patients who participated in this study were females. Also, most of the 8 caregivers who participated in the study were females. This affirms the dominance of women when it comes to discharging the responsibility of care-giving towards other members of the family in times of sickness or ill-health. There were no female herbalist respondents interviewed in this study and the sex of the 5 health professionals interviewed for this study was male dominated with only one being a female.

4.1.3 Educational status of respondents:

The level of education attained by the breast cancer patients ranged from no formal education to tertiary with most being basic (Junior High School) level which is low with one of them attaining secondary level of education. For the health professionals, their level of education was high considering the fact that all of them had attained tertiary education. The level of education of the care-givers ranged from basic to tertiary with most of them attaining basic education. For the two herbalists interviewed for this study, their level of education was basic.

4.1.4 Ethnicity of respondents:

The patients interviewed in this study were mainly from the Asante tribe located in Kumasi in the Ashanti region. However, there were respondents from some tribes from Northern Ghana and Ga-Adangbe.

4.1.5 Marital status of respondents:

The marital status of the breast cancer patients who participated in the study ranged from married and widowed with most of them being married. For the health professionals most of them were single with the rest married. All the two herbalists that participated in the study were married whilst most of the care-givers were married and the rest being single.

4.1.6 Occupation of respondents:

Most of the patients in this study were engaged in either peasant farming or petty trading with the rest of them being professionals in the fields of education and health. It is significant to note that most of the women with breast cancer who participated in this study were in their productive age except two patients who were both 80 years old. Also, most of the care-givers interviewed for this study were either as peasant farmers or petty traders with the rest of them being students. For the health professionals that participated in this study, some of them were nurses with the rest being medical Physicists. All the two herbalists practiced were traditional healers.

4.1.7 Religion of respondents:

Most of the patients who participated in this study belonged to the Christian faith by way of religious affiliation with only one of them being a Muslim. For the health professionals, care-givers and herbalists were all Christians.

4.2 Knowledge about breast cancer

4.2.1 Perceptions of breast cancer

Some of the breast cancer patients who participated in the study perceived breast cancer to be a very dangerous, terrible and fatal disease which spreads very fast and kills instantly and which should not be taken lightly at all. These patient-participants were of the opinion that anyone who chooses to ignore the devastating effects of breast cancer which could either maim or kill its victim, does so at their own peril. This view is illustrated by a patient's response below.

"It is a killer disease. This is because when it affects you and you do not send it to the hospital, it can lead to your breast being amputated and when that is done, some lose their lives through that. Not many people survive from Breast Cancer." (IDI with BCP No. 12)

There were yet some of the patients who described breast cancer as a '*disturbing disease*' that in the past affected mostly persons who have not given birth before: a situation which they described as a punishment from the ancestors and the gods on such persons for their refusal to give birth and continue the human race. They however added that this definition seem to have changed lately considering the fact that even those of them who have given birth to children have also developed the disease and thus were at a loss as to what exactly the disease is. This is illustrated by the response below.

"I can't tell. I can't tell what it really is, because at first they said it's for people who haven't given birth before as a punishment from the gods and ancestors for their refusal to give birth but as it stands now even those of us with children also have the disease...I really can't tell." (IDI with BCP No. 13)

Some other patients responding to what breast cancer in their opinion was, explained breast cancer to mean a cancerous disease of the breast which starts as a sore inside the breast as captured by the response below.

“Breast cancer is the sickness of the breast.” (IDI with BCP No. 10)

There some patients who said that they had no idea whatsoever about what breast cancer is hence were not in a position to explain what it is. The quote below amply illustrates this expressed by these patients.

“I do not have an idea concerning it” (IDI with BCP No.03)

Meaning of breast cancer from the health workers’ perspective:

From the Health Workers’ perspective of what breast cancer is, they explained breast cancer to mean a malignant tumour in the breast or any lump in the breast which has been pathologically confirmed as malignant and that it is where the malignancy is found that gives the name. This view is illustrated by the response of a health worker below.

“Breast cancer generally is a cancer that appears in the breast. It can be a lump and if pathologically it’s confirmed to be malignant then it means it’s cancer of the breast. So it is where the malignancy is found that gives it the name. ” (IDI with HW No. 05)

Meaning of breast cancer from the perspective of Caregivers:

For their part, caregivers who participated in this study explained breast cancer to mean a disease in the breast or any abnormal growth that may occur around the breast or on the breast. The response below illustrates the view expressed above.

“It could be an abnormal growth that may occur around the breast or on the breast.” (IDI with CG 01)

Meaning of breast cancer from the perspective of herbalists:

In explaining what breast cancer is in their opinion, the herbalists who participated in this study were of the view that breast cancer is anything such as a growth which was previously not present in the breast but has now found its way into the breast. They likened it to fibroid which they said formed slowly then gradually occupies the entire region of the breast. This view by the herbalists is illustrated with the quote below.

“Breast Cancer is something which before, was not present in the breast but is present in the breast now. It is just like fibroid; it forms slowly and then occupies the entire region of the breast. As it grows, it is referred to as cancer” (IDI with HB 01)

4.2.2 Perceptions about causes of breast cancer:

Perceptions of patients about causes of developing breast cancer:

Patients held varied perceptions about what the causes of breast cancer are. Some were of the view that the disease was a punishment from the gods and ancestors who expressed their anger and displeasure particularly towards women who have out of their own volition decided not to give birth to ensure the continuity of the human race by giving them spiritual babies who suckle their breast spiritually thereby causing the disease.

This opinion is illustrated amply by the quote below.

“... it is a punishment from the gods and ancestors to those [women] who have decided not to give birth... they are given spiritual babies to suckle their breast...” (IDI with BCP No. 13)

There was one patient who attributed the cause of her breast cancer condition to an insect bite. The particular insect mentioned here was the spider which she said found its way into her cloth and bit her on her nipple resulting in itching of the nipple and subsequent discharge from the nipple. This view is captured by the quote below.

“As for me I don’t know oh. No one in my family has ever gotten it. If that insect had not bitten me I would not have even known about it. It was a spider; very small spider. It came to hide in my dress and when I hit it through the dress it bit me...” (IDI with BCP No. 07)

Some of the breast cancer patients were of the view that they did not know what the cause of breast cancer is. This view is illustrated by the following response.

“I don’t know. I have no idea too and I have never heard of any cause” (IDI with BCP No.12)

Perceptions of health workers about causes of breast cancer:

The health workers who participated in this study were of the opinion that there are no known causes of breast cancer though there are risk factors that predispose one to getting the disease. Their opinion is captured in the quote below.

“...there are no known causes of breast cancer though there is predisposing or risk factors for developing the disease.” (IDI with HW No. 02)

Perceptions of HBs about the causes of breast cancer:

Causes of breast cancer from the perspective of herbalists who participated in the study were attributed to three main things which are practiced by some women. These practices include such things as smearing of oils and other substances on the breast by women in their bid to making the breast look more attractive, keeping of money in the brassieres and also the

emission of radiation particularly from mobile phones which some women prefer keeping by their breast in their brassieres. This opinion is amply illustrated by the response below.

“First of all, there are some women who are fond of applying oil or other substances to their breast just so they can make it look more attractive but what they do not know is that, when you apply the oil to the breast and expose it, ... a lot of dust and other unwanted substances can penetrate into the breast, making it very likely for you to get the disease. Also, some women prefer keeping their phones in their brassieres and whenever the phone vibrates, it causes harm to the breast and this is one factor that generates breast cancer rapidly. So in all, the oil women apply to the breast, the monies kept by the breast as well as keeping phones on the breast are all pathways to or causes of getting breast cancer.” (IDI with herbalist No. 01)

Also mentioned by another herbalist aside those stated above on the perceptions of herbalists about the cause for breast cancer, from the herbalists was what the respondents termed as immoral practice such as the frequent sucking of women’s breasts by men. This is illustrated in response below.

“...Breast Cancer was not a known disease in Ghana and women, who had the disease, acquired it from the age of thirty and above but the sad thing now is that women as young as twenty can get the disease due to some immoral practices such as allowing a man to suck the breast repeatedly.” (IDI with an herbalist No. 02)

Perception of caregivers about the causes of breast cancer:

The caregivers’ opinion on the causes of breast cancer was similar to those expressed earlier by the health workers and reported above. Their view was that they were no known cause of breast cancer. The quote below illustrates this view.

“...we don't know the actual cause.” (IDI with CG 02)

4.3 Risk factors for developing breast cancer

Patients' perceptions about risk factors for BC:

On what their perceptions about the risk factors for developing BC are, some (only 2) of the patients cited such factors as heredity and lifestyles such as eating of fatty foods as some predisposing factors for the BC disease. Their view is captured by the following by the quote below.

“It's about your health and your diet. The things we make our food with sometimes come with a lot of sickness. So watch your diet. Cut down oily food, and you will be less susceptible to breast cancer. It can also be inherited...” (IDI with BCP No. 18)

Most of the patients said that they had no idea about what the risk factors for developing BC are. Their position is illustrated by the response below.

“I honestly don't know what the risk factors for developing breast cancer are.” (IDI with BCP No. 08)

Perceptions of HWs on the risk factors for developing BC:

On what the risk factors for developing BC are, health workers mentioned such factors as heredity, age, which they explained to mean that the older one grows the more likely they are to getting BC, lifestyle such as lack of exercise, diet, gender or the fact that one is a female, then never breastfeeding and or never given birth before. It is worth noting that of all the participants that participated in the study, only the health worker category mentioned early menarche which they pegged at ages nine and ten as a risk factor or predisposing factor for developing BC. The view of the health workers is illustrated by the following response.

“...with BC, some of the pre-disposing factors include being a female. Once you are a female you are more pre-disposed to BC than male, though males also do get BC it’s on a low side. Another one too will be age. The more you grow the more you become susceptible to other diseases including BC; Lack of exercise, sometimes too the BRCA genes the BRCA 1 and the BRCA 2 if they can be traced in the first-degree relatives that is hereditary. We also have early menarche, late menopause, diet, then giving birth to your first child or full-term pregnancy after 30 years of age...”(IDI with H W No. 05)

Perceptions of Herbalists on risk factors for developing BC:

Views expressed by HBs on what they perceive to be the risk factors for developing breast cancer were same as those that they stated earlier on under their perceptions about the causes of the breast cancer disease were. This view of the herbalist is illustrated with the response below.

“...the oil women apply to the breast, the monies kept by the breast as well as keeping phones on the breast are all pathways to or causes of getting breast cancer.” (IDI with HB No. 01)

Caregivers’ perceptions about the risk factors for BC:

Caregivers were of the perception that the risk factors for breast cancer could as well be the same as the causes of the disease. They mentioned such things as the type of food that one eats for example excessive intake of fatty foods as well as smoking to be the risk factors for developing breast cancer. The response below further illustrates this view.

“It’s the same as the cause and I think, it has to do with some of the foods that we eat. Fatty of so much foods can make you get breast cancer”(IDI with CG No. 02)

4.4 Signs and symptoms of breast cancer

4.4.1 Patients' view on signs and symptoms of BC:

The most common signs and symptoms that were identified by the BCPs that participated in this study relation to the BC disease include: lump in the breast, sharp pain in the breast, itches of the breast as well as discharges from the breast. This view is illustrated by the responses below:

“Your nipples begin to ache, bleeding from the nipple and swelling of the breast, heaviness and hardening of the breast” (IDI with BCP No. 12)

Another patient reports that in sharing her personal experience mentioned blackening of the face and palms as some of the signs and symptoms associated with the breast cancer disease. This experience by the patient is captured below.

“I for one, when I discovered I had breast cancer, I went through a lot of pains- my face became very black, as well as my palms.”(IDI with BCP No. 19)

4.4.2 Perceptions of HWs about the signs and symptoms of breast cancer:

The health workers' perceptions about what the signs and symptoms of the BC disease is, mentioned such things as: pain in the breast, swollen nipples, reddening of breast, discharge from the breast as well as painless lumps in the breast as some of the most common signs and symptoms associated with BC thus corroborating the perceptions of patients. This is summed up in the response below.

“...pain in the breast, swollen nipples, reddening of breast, discharge from the breast as well as painless lumps in the breast.” (IDI with HW No. 04)

4.4.3 Perceptions of herbalists about signs and symptoms of breast cancer:

On the part of the herbalists regarding what the signs and symptoms of breast cancer were, an herbalist participant said that the breast cancer disease is characterised by intermittent sharp pains, strange lumps in the breast as well as excruciating pains that become very unbearable with the passage of time. This view is amply illustrated by the response below.

“One of the symptoms is that, some women feel intermittent sharp pains in the breast and after rubbing their hands on it, they notice a strange lump in the breast and as time goes on, the pain generated from the lump becomes increasingly unbearable.” (IDI with HB No. 02)

4.4.4 Caregivers’ perceptions about the signs and symptoms of breast cancer:

The views held and expressed by the caregivers on what they perceived to be the signs and symptoms of BC were consistent with those mentioned earlier respondents in the other 3 categories of respondents except to add that they indicated that the pain felt in the breast was preceded by the action of lifting of hands by the patient. This view is indicated by the response below.

“...when you’re just lifting up your hands you’ll feel pain in your breast.” (IDI with CG No. 02).

4.5 Perceptions about Treatment and Management of Breast Cancer

4.5.1 Patients perceptions about whether BC was curable:

Patients held varied opinions about whether or not breast cancer was curable. These opinions ranged from not being sure to a yes. Whereas some of the respondents were of the view that the disease was not curable or could not be treated, there were some who were not so sure hence were unable to tell with certainty whether it could be cured or treated. There were also those who opined that the breast cancer disease is curable on condition that it was detected early enough whilst some of them though believed it could be cured could not tell if that cure

would be permanent or whether there was the possibility of the disease recurring at some point in the future. These varied responses by the patients are illustrated below.

“As for that one I don’t know if it is curable or not.” (IDI with BCP No. 15)

“Yes, breast cancer can be cured but only when it is detected early. I was told if you seek early treatment, you can be cured. I think when the lump found in the breast is not as big as to cause severe damage to the breast, one can be cured.” (IDI with BCP No. 14)

There was however a respondent who was of the view that the disease could be managed if physician’s instructions about medication are religiously adhered to by the patient, she was however not sure if breast cancer could be completely cured. This view is illustrated by the response below.

“I know that if you follow all the instructions the doctors give you the cancer’s effects will reduce. But whether it can go away completely I don’t think so.” (IDI with BCP No.18)

4.5.2 Perceptions of health worker about breast cancer cure:

The views of HWs as to whether the breast cancer disease could be cured were of the view that the breast cancer disease was indeed curable but on condition that the disease was detected early at its initial stage I & II and the appropriate care sought from the appropriate source which is the hospital. These views are summed by the responses below.

“Yeah, it’s curable! First of all I said it’s curable but it is not 100%. It’s not 100% because, depending on the stage that the breast cancer is diagnosed or depending on the stage that the person comes to seek medical attention, if it is at the early stage, it is curable but if it’s advanced stage, then we can’t cure it.” (IDI with H W 01)

4.5.3 Perceptions of caregivers about BC cure:

Caregivers were of the view that breast cancer was curable and that once it is detected early and treatment commences to cure it. These views are summed in the response below.

“At the early stage, it can be cured because they say that they have four stages in breast cancer. The first and the second stage, if we see it early, maybe, yeah it can be cured but if you wait till third and fourth stage, that one it can’t be cured and you have limited time. By limited time I mean, you will not live that long. It can kill you at any time.”(IDI with CG NO. 02)

4.5.4 Perceptions of herbalists about BC cure:

On whether the breast cancer disease could be cured or not, the opinion expressed by the herbalists that participated in this study was that the disease is curable because they were of the view that much as there are many ailments in the world, God has made provision for the cure all of them by making herbs available to man for the purpose. As intimated by an herbalist respondent who cited the case of a client in her 40’s who saw an almost instant positive results after seeking health care at his herbal facility. This response is illustrated below.

“It is highly curable by God’s grace. Although a lot of diseases abound, God has made available several herbs to cure the diseases. We herbalists have been treating several diseases with these herbs. I recall one woman in her 40’s who had breast cancer came to me for assistance. Her condition was very severe and I could tell that she had spent a lot of money on medication. I applied some herbs on her breast and just a day after, she called to tell me that the breast had bust. She was amazed at the efficacy of the herb. So the herbs are very powerful and when rightly identified for its purpose, can cure the breast cancer disease.” (IDI with an herbalist No. 01)

4.6 Prior knowledge about breast cancer

Asked whether patients have had any prior knowledge about breast cancer before being diagnosed of the disease, their responses were varied. Whilst some said that that they have had some prior knowledge on the disease before getting diagnosed of it, others responded in the negative to indicate their ignorance about the disease before their diagnosis. This prior knowledge they suggested spurred them on into taking prompt action to seek treatment as early as possible to save them from dying prematurely. The responses of those who reported as having had some prior knowledge about the breast cancer disease are indicated by the quote below.

“Yes my older sister had it. But she did not get a good doctor so she died. She has been dead for fifteen years. At the time we were all afraid. We had heard that if they use a knife on your breast you will die. For her when she was going for surgery she found that her breast would be removed so she was scared. She died and she had not even had the mastectomy. So I reasoned that, if my sister had not had her breast removed and yet she died, why not have the surgery and save my life? I knew a woman who had had hers removed and was still alive twenty years later. I advised myself and decided to undergo surgery.” (IDI with BCP No. 13)

Those patients who said they had no prior knowledge alluded to the fact that this apparent lack of prior knowledge about the disease contributed partly to them not taking it serious when the symptoms started setting in because they did not think it could develop into something as dangerous and painful as they later found it to be. The view of those who said they knew nothing about disease prior to their diagnosis is illustrated below.

“No not at all. I had no prior knowledge about breast cancer. As a result, I didn’t know it could be so serious.” (IDI with BCP No. 09)

4.7 Sources of seeking health care for breast cancer

Participants in all categories in this study were of the view that patients employed more than one medical system – both conventional and complementary and alternative medicine for health and illness. Breast cancer patients in this study resorted to the use of a variety of health services and practices in seeking healthcare for their breast cancer condition. These sources include traditional healers or herbalists, home-made remedies concoctions, across the counter pills, prayers, health centres, clinics and hospital.

Some participants resorted to non-biomedical sources for seeking health care for their condition. Unorthodox sources such as prayer camps, home-made remedies concoctions were employed in their attempt to find cure for the disease. The response below indicates a patient's action in seeking healthcare for her cancer condition by resorting to the practising of self-medication as well as patronage of drugs from over counter and from the open market.

“I had Breast Cancer for close to 15 years before getting treated. It used to emit some dirty blood, which I tried to manage by myself through the buying of ointments and other drugs from the market and the drug store” (IDI with BCP No. 04)

There were some respondents who said that their health seeking journey for their breast cancer condition started first at the prayer camps where they were made to undergo prayers and fasting. However, they had to stop attending the camp to seek healthcare elsewhere following so many months of no improvement in their condition. This health-seeking behaviour is illustrated by a patient's response below.

“... I didn't know it was breast cancer, so I first went to a prayer camp upon the advice of my sister-in-law who said she suspected the lumps in my breast were caused by witches. I was only made to fast and pray from 6 am to 6 pm after which I was given anointing oil which was blessed by the pastor to be smearing on the breast to ward off the witches who have been

using my breast as football in the night thereby causing the lumps in my breast. But after three months of going there and not seeing any improvement, my husband advised that I went to the hospital and I did.”(IDI with BCP No. 06)

There was yet another respondent who shared the experience of how she had to first seek care at the KATH but later had to stop and go to the herbal centre for 6 months due to financial difficulties in meeting treatment cost there at the hospital. She is however back to the KATH after her children had been able to raise some money for her to be paying the medical bills. Her experience is indicated by the response below.

“I used to come for treatment here but I stopped for awhile because I could not afford the high cost of medicines so I was advised by my children to go to seek herbal treatment elsewhere at the Dr. ‘XX’. Herbal Centre and then it deteriorated after almost six months of going there so I stopped and came back here [KATH] after my children had promised to help foot the cost of medication.”(IDI with patient No. 07)

4.8 Description of type of care provided / received at the various sources of care

4.8.1 Description of Nature and type of care given at the hospital

Some of the patients, who sought treatment for their breast cancer condition through the biomedical system, described their experiences in relation to the type and nature of treatment that they have to undergo in the curative process. A patient who resorted to the Komfo-Anokye teaching hospital for care outlined how she had to endure great pain to undergo two separate operations to have lumps in her breast and armpit removed and was now awaiting to undergo chemotherapy and radiation as captured below:

“When they saw it and I brought it to my doctor, he also educated me on that and said it’s the initial stage. He made me go through all tests to see whether it has affected any other parts of my organs or other parts of my body. He saw that I had a lump and that I had another lump under my armpit. So he brought me to the tumour board and they asked him to do the surgery for me to remove the lumps before I start because he educated me. He said I may go through three steps. After the operation I need to go through either radiation or chemotherapy. So right now, the first step has been done. I went through the operation twice. The first one they removed was...the lump in my breast, and then the second one the one under my armpit. So today I’m coming here...I came to meet the tumour board again and the doctors said I should start the radiation on maybe Friday but I should come today for them to assess the area.”(IDI with BCP No. 01)

Another patient in describing the nature of care obtained at KATH and how she had one of her breasts cut off as well as how some parts of her body such as arms, legs and face became dark following what she described as a very painful injection she was given as part of the treatment. This is illustrated in the quote below.

“They treated me for about seven months, after which they cut my breast off. ... I have been injected but I have not undergone a chemo therapy. It’s very painful too; my arms, legs and face became very dark. I also threw up.”(IDI with BCP No. 20)

There were some who though chose the biomedical system of health care in seeking health care for their breast cancer conditions; they went to the private hospital and other clinics at the district level where the nature of care obtained was different from what pertained at the KATH which is a well resourced referral hospital. The experience of a patient is illustrated below.

“I went and had surgery to remove it. It started as a lump. Over there, there was no X-ray, no

lab test, just straight forward surgery. If they had done X-rays and lab tests, they would have known exactly what was wrong with me. Instead they referred me to KATH to come and get tested.”(IDI with BCP No. 05)

4.9 Duration between onset of breast cancer and health seeking

The period of time that it took patients from the onset of sign and symptoms of their breast cancer condition and the time of seeking healthcare from either the orthodox and unorthodox medical sources for their breast cancer condition ranged from 3 days to 15 years. This is illustrated by the following response from a patient participant below.

“Oh, it took me about three days after noticing the lump in my breast to go to the hospital for healthcare.” (IDI with patient No. 13)

Another patient responding to the length of time before seeking healthcare said she waited for 15 years to do that. This is captured by the response below.

“Well, it took me 15 years before going to the hospital for treatment.” (IDI with patient No. 04)

4.10 Reasons for late reporting for breast cancer treatment

4.10.1 Lack of knowledge about breast cancer:

Some of the breast cancer patients reported late to the hospital for treatment of the disease because of ignorance or inadequate knowledge particularly about the signs and symptoms of breast cancer. As a result they were not in the position to suspect it could be breast cancer when they started seeing the symptoms to enable them to take appropriate steps to seek care at the hospital for treatment. This view is indicated by the response below.

“I didn’t even know it was breast cancer. I thought it was just an itch because of an insect bite. It was when I went to the doctor that he referred me to KATH and it was confirmed.” (IDI with patient No. 07)

4.10.2 Fear of diagnosis and death:

Some of the patients who participated in the study said that they delayed seeking early treatment for their breast cancer condition at the hospital because of fear of being diagnosed as having breast cancer and also dying. These fears had often been influenced by past experiences of breast cancer in relatives or friends. The response below illustrates this view.

“For mine, when I was first diagnosed, I did not want to go for treatment for fear that I may die or end up coming home with no breasts. It actually took me about 3 years before finally making up mind to go for treatment through the advice from friends. I managed to go treat it.” (IDI with patient No. 20)

4.10.3 Infrequent screening for breast cancer for early detection and treatment:

Another reason for the delayed presentation for treatment for breast cancer at the hospital was the infrequent screening for breast cancer which would have ensured that the condition was detected early enough for treatment. Patients who participated in this study reported not to be practicing such screening methods as self breast examination (BSE) and clinical breast examination (CBE) and mammogram which are all ways of detecting breast cancer. This view is illustrated by the following quote.

“They [the nurses] checked the breast and they said you we always be checking for lump. So I kept on doing that but not that frequently.” (IDI with BCP No. 16)

Health workers' perceptions about uptake of screening practices by patients:

Health workers were of the view that uptake of screening activities such as breast self examination (SBE), clinical breast examination (CBE), and mammogram to enable early detection and diagnosis of the breast cancer disease was irregular and poor among women despite the advice given them during health talks at the various departments of the hospital and in the community by health workers to encourage them to do so. This is illustrated by the quote below.

“The delay usually is related to the patients. The patients they don't usually see the cancer at early stage or they don't self-examine with respect to breast cancer, they don't self-examine to detect the cancer at early stage.” (IDI with H W No. 01)

4.10.4 Practitioners lack of seriousness about breast cancer:

Participants cited the apparent lack of seriousness and apathy shown by some practitioners both in both the orthodox and unorthodox medical systems towards breast cancer coupled with the bureaucratic nature of the referral system. Some of these practitioners namely the health centres, prayer camps, herbal centres and sometimes even the district and some private hospitals were accused of failing to refer patients who present with symptoms of breast cancer to their facilities to specialists although they know very well that they were not in the position to treat them but would continue to hold them there until the condition worsens or gets to an advanced stage. A respondent who held this view had this to say:

“...the bureaucracy level with the treatment, delay the treatment as in sometimes the private hospitals would also hold the treatment till an advanced stage and when it's getting worse before they refer to the specialist for care, ... sometimes these private hospitals that they go to

are not experts, they are not experts since they don't even know that that is cancer and that is why.” (IDI with a health worker No.01)

A patient, who expressed disappointment and annoyance at lack of seriousness and disinterest exhibited by some health professionals towards breast cancer, shared her experience stating that though she reported very early to the hospital to seek healthcare for her breast cancer condition, it was the attitude of the health worker at the health facility that delayed her treatment. This experience is illustrated below.

*“Oh, it took me about three days [to report at the hospital to seek health care]. It was even the hospital that delayed me...the doctor always joked and told me it [the lump] was nothing serious but fat...even the lab report which was supposed to take one week took twelve weeks and there I was told by another doctor who re-examined me that I have breast cancer, ...in fact, before God and man I got very furious and walked to the doctor who has been downplaying the severity of my condition and said loudly to him: **“Oh doctor, you have killed me!!!”...**” (IDI with patient No.06)*

4.10.5 Influence of traditional healers and faith healers on delayed medical treatment:

Delay in reporting early for treatment at the hospital has been attributed in part to traditional healers and faith healers whose activities some participants said were instrumental in influencing the decision of patients in seeking appropriate treatment late at the hospital with advanced stages of the disease. Some of these activities which according to the participants include the huge claims made on radio and television about their ability to cure breast cancer at a faster time and cheaper cost without surgery succeed in swaying some patients who hear these things on radio to go to them instead of the hospital for cure but only go to the hospital

after failure to get the expected treatment promised them by these people [traditional and faith healers]. This view is illustrated by the response below.

“Some herbalists and pastors would come on radio and make huge claims about their ability to cure all manner of diseases including breast cancer and people go to them in search of treatment but end up worsening their condition. I heard of a woman who neglected proper treatment. Her brother gave her money to go to hospital, but she went to an herbal doctor for medicine worth fifteen million old Cedis (□ 15,000,000), [the equivalence of GH□ 1,500.00] and she died” (IDI with patient No. 13)

4.10.6 Financial constraint

Some of the respondent delayed in seeking healthcare for their breast cancer condition at the hospital due to financial constraints. Further explaining, some said that they were not staying outside the Ashanti region which is the home region of the KATH and therefore needed lots of money to travel to Kumasi as well as for their upkeep as well as meet hospital bills. In view of this they had to go seeking healthcare from other sources like the prayer camp till they got money to enable them travel to Kumasi for treatment. This is illustrated by the response below.

“I was at Tema, which is where I work, so when I saw it I had to wait awhile, because to travel involved a lot of money which I did not have at that time.” (IDI with patient No. 06)

4.10.7 Perceptions of competing priorities

One significant sub-theme that emerged from this study on why patients delay in seeking healthcare for breast cancer had to do with the issue of competing effects such as childbearing which were prioritised over and above their personal health. For instance, the situation whereby a respondents has been diagnosed diagnosis of having breast cancer

delayed seeking treatment at the clinic because she would rather prefer to buy time and be managing it on her own until she had finished giving birth to all the number of children she intended having, breastfeeding and raising them up to some age where they can fend for themselves before going to seek appropriate treatment for the condition. This is supported by the quote below.

“By then I had just given birth to my first child. It was after I had my third child that I had surgery to remove the breast because I wanted to be able to breast feed them when they were born and see them grow up a bit. It was when it started to grow bigger that, about two years ago, I decided to get treatment at the hospital and had the surgery done.” (IDI with patient No. 04)

4.11 Sources of information on breast cancer management

The patients’ main sources of health information on breast cancer management and treatment points to an exposure to a variety of sources such as the media (both print and electronic), family members and friends, the internet (for those literate) and health professionals.

Some of the respondents said that they resort to the electronic media – the radio and the television in gathering the needed information about the breast cancer disease. A patient who participated in this study had this to say on what her source of information is about for breast cancer.

“I’ve been listening when people are being interviewed on television, so I found out that if you notice a lump in your breast rush to the hospital. And I had a lump in my breast, and it was itching, as if there was an insect there. So I went to the hospital. I also hear a lot about the disease on radio.” (IDI with patient No. 18)

Some of the participants also reported that they relied extensively on the health professionals at the health facilities that they visited to seek healthcare in obtaining their information on breast cancer which they said was usually given through the health talks given at the start of each clinic day. This view is illustrated by the quote below.

“When we go to the breast care, the nurses here give us information on breast cancer every day before actual consultations start for the day.” (IDI with patient No. 01)

Some of the participants also reported that they obtained information on breast cancer by reading from books and the internet. It is significant to note that those participants belonging to this group of internet users had attained a high level of tertiary education. Their view is captured by the response of a caregiver below.

“I sometimes read about breast cancer on the internet and from text books or sometimes seek help from some health workers.” (IDI with caregiver No. 02)

Decision-makers in health seeking behaviour:

The role of husbands as the decision-makers in determining where and when to seek health care for breast cancer cannot be over-emphasised as most of the patients who participated in this study mentioned their husbands as the final decision-makers when it came to seeking healthcare for their breast cancer condition. The response below illustrates this.

“...it was my husband’s to go and seek health care from the hospital. I did not challenge him on that because he was going to pay the bill.” (IDI with BCP No. 16)

Some of the patients also mentioned other members of the family such as their children and sister-in-laws as the final decision-makers for healthcare seeking for their breast cancer. This position is illustrated by the quote below.

“...my sister-in-law was the one who decided that I went to the prayer camp to seek care for my condition.” (IDI with BCP No. 09).

CHAPTER FIVE

DISCUSSION

5.1 Main findings of the Study

The main findings of this study are the following: knowledge and awareness about breast cancer (BC) was generally very low among patients who were diagnosed with breast cancer. Secondly, the biomedical system of healthcare coexists with the non-biomedical systems with breast cancer patients resorting to both systems for health seeking. Thirdly, the decision making on where and when to seek healthcare involved many members of the family with husbands being the final decision makers in most cases. Fourthly, screening practices among patients was irregular and poor. Fifthly, radio was the main source of information about breast cancer. Lastly, most of the breast cancer patients presented late to the health facility for care and management of the breast cancer disease.

5.2 Knowledge and Beliefs of Breast Cancer Patients

Knowledge about breast cancer as shown in this study was generally low among patients diagnosed with the disease and managed at the KATH in Kumasi. After the diagnosis however, their knowledge improved remarkably though knowledge on the risk factors for developing BC was still poor for some of these patients. This improved knowledge could be attributed to health and health education they received from health workers at the hospital about the disease during visits to the hospital for health care for the BC condition as well as the quest to satisfy the curiosity that might have aroused in them in wanting to learn more, following the awareness created by these health talks.

This finding compares with findings of other studies reported in Nigeria and South Africa which indicated that just a few participants were knowledgeable about the role of early menarche as well as the risk factors for the development of breast cancer (De Vos, 2014;

Mbuka-Ongona & Tumbo, 2013; Oluwatosin & Oladepo, 2006). In addition, this finding on the awareness of predisposing factors for breast cancer among the participants, compares with a similar study conducted among women in the general population on their beliefs about the causes of breast cancer which reported that majority of participants identified heredity, aging, smoking, obesity as well as alcohol use as risk factors for breast cancer (Wang et al., 2010).

However, the findings of this study do not compare with previous studies conducted in Accra and Sunyani – two urban towns in Ghana and reported by (Opoku, Benwell & Yarney, 2012) as well as those reported from Egor local government area, a semi-urban community in Edo State of Nigerian by (Okobia, Bunker, Okonofua & Osime, 2006) which suggested that knowledge on breast cancer generally was lacking among the groups of women that participated. This disagreement may stem from the fact that the participants in this current study unlike those participants in the other one by (Oluwatosin & Oladepo, 2006), were purposively selected after they were diagnosed with breast cancer and given so much information about the condition.

5.3 Health-seeking behaviours for breast cancer among breast cancer patients:

In Ghana, as in many societies where serious health problems are interpreted based on the socio-cultural beliefs of what the aetiology of sickness is and what practices are to be undertaken to restore a person to good health, breast cancer patients – depending on the definition of their condition - may ‘shop around’ consulting allopathic practitioners, faith healers and traditional medical practitioners in their quest for therapy. This study demonstrated that breast cancer patients sought help for their condition from different health providers. This health-seeking behaviour may pose serious problems for therapy management

in the long run particularly when situated in the context of the unwillingness on the part of some practitioners to refer cases that they are unable to manage and especially on time for specialist care. Findings by this study compares favourably with a study conducted in Ontario, Canada between the period 1998 and 2005 which revealed that the proportion of breast cancer patients using sources other than biomedical to seek cure for breast cancer varied from 67% to 83% (Boon et al., 2007). This means breast cancer patients uses both the orthodox and unorthodox means for seeking health care for their condition.

Although these diverse sources were unanimously endorsed as sources of care resorted to in the pursuit of treatment for breast cancer and reported by this study, there was no consensus when it came to which of these sources patients resorted to as first point of call in seeking health care for breast cancer. Whereas the health workers indicated that breast cancer patients present to the health facilities with advanced stages of the disease, some of the breast cancer patients and their caregivers held a different view, reporting that their first point of call for health care was the health facility. The breast cancer patients may be seeking to suggest that the use of the hospital was their first point of call for health care for their condition because perhaps they were not really sure what the consequences of opening up and admitting to resorting to the use of herbalists as first points of call might possibly turn out to be, especially considering the fact that this study was facility-based. It would therefore be better for future studies on this area to focus on community-based rather than facility-based participants since the former is less intimidating for participants to speak up and express concerns freely (Leonard, 2004).

5.4 Decision makers of health seeking behaviour:

The decision on where and when a breast cancer patient should seek health was ultimately made by the husband. This view was held by patients. Husbands took the ultimate decision based on their positions as head of household, but also because they were the ones who provided funds for seeking health care. This finding compared with earlier studies (Asobayire & Barley, 2014; Mwangome, et al., 2010). It is therefore important to emphasise that in intervention and educational programmes, husbands' voices should be taken into account in the decision making process.

5.5 Sources of information about treatment options for breast cancer

The participants relied on various sources of information such as health workers, the media: both electronic (radio and television) and print (newspapers, posters), as well as friends and relatives in gathering and acquiring the requisite knowledge on breast cancer. The study did not set out to determine at what point in time relative to the date of diagnosis the participants gained their knowledge as information about breast cancer is readily available in Ghana.

The study also found that patients obtained information on breast cancer from a wide range of interpersonal providers including hospital consultants, general practitioners, ward and clinic nurses, family and friends. This finding is very consistent with a similar finding reported by (Luker et al., 1996).

It was also found that very few of the patients reported ever using the internet as a source of information on breast cancer and its management thus comparing favourably with a similar one reported by (Mills & Davidson, 2002) that fewer than 10% of breast cancer patients use the internet to seek information about their cancer. This finding further indicates that breast cancer internet users tended to be younger with a higher education level than non-users (Fogel et al., 2002; Pereira et al., 2000).

5.6 Reasons for late reporting for Breast Cancer treatment

Findings of this study also show that patients report late for treatment at the hospital with advanced stages of breast cancer with some presenting after fifteen years following the onset of symptoms. These findings compare favourably with an earlier study conducted in Kumasi between 2004 and 2009 which shows that 281 patients (85.2%) presented late with advanced stages of breast cancer (Ohene-Yeboah & Adjei, 2012), as well as a similar study conducted at the Korle-Bu Teaching Hospital in Accra, Ghana which indicated that over 60% percent of the patients present at advanced stages of breast cancer (Clegg-Lampsey & Hodasi, 2007). Another study conducted in Kenya reported that about 77% of black women presented at stages three and four of the disease, according to the Kenyan national cancer registry covering the period of 1986 to 1996 (Otieno, Micheni, Kimende, & Mutai, 2010). In this study, factors responsible for delay in presenting to the hospital for healthcare included the negative influence of traditional healers, miscommunication on the part of some health professionals and lack of interest in breast cancer, fear, poor advice, and limited access to care in rural and deprived communities.

The results from this study also show the important role the views of community members such as friends and relatives commonly referred to as “significant others” play in shaping the health-seeking behaviours of people. Spouses of some patients for example were reported in this study as playing their gate-keeping role as heads in deciding when and where healthcare for breast cancer was to be sought. It was also evident from the findings that husbands played a role in delayed medical care. This finding compares favourably with the findings of a study carried out in Canada amongst Asian women that found that religion, culture and the views of the community determined members health-seeking behaviour (Bottorff et al., 1998; Mbuka-Ongona & Tumbo, 2013).

Late presentation of breast cancer has been a major problem globally as far as the management and therapy of the disease condition is concerned, and it has been described, for example, in the sub-Saharan region studies from the University of Benin, Nigeria as well as from the Korle-Bu Teaching Hospital in Accra, Ghana that a high proportion of women (78%) who presented at stages three and four of breast cancer (Opoku, Benwell, & Yarney, 2012). There are some similarities and differences in the reasons for late presentation of the disease between countries with different levels of development. In the United States of America reasons include a lack of education and knowledge about symptoms, risk factors and the benefits of early detection of breast cancer (Gullatte, Phillips, & Gibson, 2006). In Africa ignorance, the use of alternative medicine and a fear of surgery were common reasons given for late presentation (Ekanem & Aligbe, 2006); The disease explanatory model based on cultural beliefs was an important determinant of the health-seeking behaviour in Africa. In many societies, witchcraft is perceived as a cause of cancer and this leads to delayed presentation at hospitals (Yip & Taib, 2012). Usually, in some parts of Africa a painless lump is not associated with breast cancer due to the high knowledge-gap that exist about breast cancer among women in most deprived and rural areas on the continent (Okobia et al., 2006). In the United Arab Emirates it was found that advancing age, low socioeconomic status, fear of the diagnosis, fear of the consequences of cancer treatment, misconceptions about the aetiology, denial and spirituality, including faith, were responsible for late presentation (Macleod, Mitchell, Burgess, Macdonald, & Ramirez, 2009).

It was also evident that screening methods for breast cancer were infrequently used.

Early detection of breast cancer is dependent on awareness and knowledge of screening techniques. Women have been reported to lack appropriate information about breast cancer and consequently also about early detection measures. (Oluwatosin & Oladepo, 2006) In a

study undertaken in Nigeria, women living in rural areas were found to have an extremely low level of awareness of breast cancer with minimal skills regarding breast self-examination and clinical breast examination (Okobia et al., 2006)

In developed countries increased awareness and knowledge do not necessarily result in enhanced use of screening procedures. In a survey performed in Austria, only 31% of the participants undertook breast self-examination (BSE), although 92% of them were aware of the practice. (Montazeri et al.) Similar gaps between knowledge and practice were shown amongst women in the United Arab Emirates, Iran and Australia and amongst Japanese American women. (Robins Sadler & Takahashi, 2003)

Majority of the participants in this study were employed albeit in what could be said to be low-income generating activities, had not participated in screening activities. This is in contrast with the findings of a study amongst United Arab Emirates women which indicated that being employed proved to be an independent predictor for participation in three screenings examinations: breast self-examination (BSE), clinical breast examination (CBE) and mammography (Jumah, 2013).

Another reason for delaying healthcare seeking is the low socioeconomic status of women particularly in Africa coupled with the high cost of treatment for breast cancer. Although the cost of treatment for breast cancer is supposed to be borne by the National health insurance scheme (NHIS), the study found that the supply of drugs has been very irregular thus compelling patients to part with very huge sums of money on these drugs from private pharmacy shops. This development coupled with their low socio-economic status results in preferring to seek alternative health care which comes at a relatively cheaper cost hence the delay. This finding compares favourably with the one reported by (Bairati et al., 2007) that in

view of this high cost of treatment coupled with the low socio-economic status of patients, they are usually neither willing nor able to spend money on their own health without feeling guilty of spending money that could have been used in providing some of the needs of the family on their personal health.

It has also been found by this study that much as some patients do delay in presenting to the hospital for treatment, there were others that presented very early but faced with the problem of system delay which they blamed on health workers. For instance, a patient who reported just three days to the hospital after detecting a lump in her breast was delayed treatment for close to six months just because the health professional did not attach much seriousness to the complaints of the poor woman but rather kept jokingly saying it was nothing but an accumulation of fat. It was not until another health professional examined her that it was realised that it was cancer by which time it was too late because it had spread so rapidly that she had to lose one of her breasts through surgery.

5.7 Key findings in relation to the constructs of the Theory of Planned Behaviour:

It was possible to ascertain influences which provoked eventual health seeking in the accounts of women with breast cancer vis-à-vis the main constructs of the theory of planned behaviour on which this study was anchored. The low level of knowledge and awareness of breast cancer demonstrated by the patients was as a result of their low socio-economic status coupled with other environmental factors such as their past experiences that informed their attitude towards breast cancer.

This attitude together with their subjective norms regarding breast cancer - that is whether they will yield to societal pressures especially from their 'significant others' such as spouses regarding breast cancer care and its management; in addition to their perceived behaviour

control as regards the extent to which they are free and able to perform such actions as BSE for early detection of the disease as well as deciding where and when to seek care led to behavioural intention of whether or not to seek healthcare and which eventually serve as triggers to action of seeking healthcare – which was found by this study as being pluralistic in nature.

For some of the patients who participated in this study, the influence of significant others, a change in life circumstances or information received through the media either prompted or supported the decision to seek healthcare. For example, the patient who reported the presence of lumps in her breast but thought it was just something that was normal with every lactating mother lacked the knowledge which will have spurred her on into action to seek healthcare. Realizing how susceptible she was, she moved further to confide in her sister-in-law who in this case was her ‘significant other’ with the hope of getting more information about the condition. She was told that the lumps were caused by witches and advised to go to the prayer camp for assistance which she did before abandoning it for the hospital. From the framework, one’s socio-economic background, external factors determine the amount of information at her disposal and which invariably influence her attitude (Edwards, 2009).

5.8 Limitations of the Study

Limitations of the study include the following: The use of a qualitative design dictates that these findings cannot be generalised. The purposive sampling provided information unique to the participants who had experienced the disease and failed to depict the experiences of those who have no breast cancer. Insight into the practice and knowledge of those not suffering from breast cancer would be critical in the design of prevention and therapeutic strategies. Nonetheless, caregivers with no history of breast cancer had their views captured. As

purposive sampling was used in this qualitative study, the findings are unique to the setting and cannot be generalised. Also, this study was facility-based, views of breast cancer patients who never visited the health facility were not captured but which could have been very informative in enriching the findings of the study. Despite the few limitations, this study highlighted very important issues about health seeking behaviours for breast cancer care and management.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATION

6.1 Conclusion

The findings of this study showed that patients had poor knowledge on the risk factors for developing breast cancer. Screening for breast cancer was infrequently performed. Patients with breast cancer generally delayed in seeking health care at the hospital because of their fears, misinformation, and misinterpretation of signs, cultural influences and system delay as well as health workers disinterest in breast cancer.

6.2 Recommendation

As shown from this study, breast cancer patients employ both orthodox and unorthodox methods in seeking healthcare for their breast cancer conditions. In view of the inadequate access to orthodox healthcare in most communities in Ghana and with traditional medicine constituting the first source of healthcare for most people of the population due to the prevalence of the services of traditional healers or herbalists, there is the urgent need for policy makers to learn from traditional healers and include traditional medicine in the treatment of breast cancer. The ministry of health and the Ghana health service must enact a policy that will foster the integration of the traditional medicine into the modern medicine because they constitute a very important outlet in meeting the health needs of a large spectrum of society so like it or not, they are going to them anyway to seek healthcare.

There is a need for a systematic national breast cancer screening programme. Findings from this study further suggest that there was a problem identifying and diagnosing the breast cancer condition early enough for prompt management and treatment thus resulting in late presentation. This was due to the absence of a systematic national screening programme in Ghana involving mammography to screen and identify women who may be at risk of breast

cancer or already have breast cancer and need further examination. The ministry of health should therefore consider introducing a national breast cancer screening day.

In view of the obvious lack of knowledge demonstrated by the breast cancer patients and caregivers who participated in this study about the risk factors for developing breast cancer, there is the need for an urgent intervention by way of education on awareness creation about breast cancer in general and the risk factors for developing breast cancer in particular to be put in place by the Ministry of Health (MoH) and the Ghana Health Service (GHS) to ensure that information about the breast cancer disease features prominently in the daily health talks that are given at the various Out-Patient Departments (OPD) in health centres at all levels of the health care provision across the country in order to address this knowledge gap and misconceptions about breast cancer and adopt preventive lifestyles that will in the long run reduce people's risks of getting the disease.

Fourthly, the MoH should provide all districts and municipal hospitals with mammograms to make it easier for people to have access to prompt screening service right in their districts of residence without necessarily having to travel to the cities with these things to access to get screened. In addition to this, the MOH should put in place a policy that will ensure that all health professionals from the community level to the regional hospitals are given refresher courses on in equipping them with the skill of performing clinical breast examination for as this will lead to early detection of the disease and ensure that the appropriate action is taken to manage and treat it at the early stage so that does not get to the advanced stage and thus become almost impossible to treat. The general populace should also be thought the basic skill of breast-self examining themselves to enable them report any symptoms as early as possible to the appropriate place for attention and management of breast cancer.

Given the evidence from this study that patients rely not only on the bio-medical in seeking health care but on the non-biomedical source as well such as traditional and faith healers for treatment for their breast cancer conditions, the MoH should as a matter of urgency consider forging stronger collaborations with practitioners in the non-biomedical field so as to win them over in getting them to refer as quickly as possible people who attend their facilities with suspected cases of breast cancer. This when done will contribute greatly in the quest for early detection and treatment to save lives, because their services will continue to be needed and patronised by the populace.

Findings from the study also indicated the problem relating to high cost involved in breast cancer treatment, which as per the National Health Insurance Scheme, the insurance policy by the MoH and the National Health Insurance Authority, is to be borne jointly by both patient and the NHIA, should be reviewed to make the treatment for breast cancer free-of-charge to the client. Measures must also be instituted to ensure that medication is always in stock for the clients to access since this when done will go a long way in encouraging people to continue with treatment to the end without having to skip treatment due to the current situation of irregular supply of chemo drugs and the attendant high cost of treatment.

Finally, further studies should be conducted on what the first point of call in seeking health care for breast cancer is. In doing so however, it suggested that any such future studies should to interview patients who are selected to participate in an environment that would be less 'intimidating' preferably their homes as a way of getting them more relaxed to volunteer information freely instead of engaging in a facility-based as this current study has done.

REFERENCES

- Ahmed, S. M., Tomson, G., Petzold, M., & Kabir, Z. N. (2005). Socioeconomic status overrides age and gender in determining health-seeking behaviour in rural Bangladesh. *Bulletin of the World Health Organization*, 83(2), 109-117.
- Ali, S., & Coombes, R. C. (2002). Endocrine-responsive breast cancer and strategies for combating resistance. *Nature Reviews Cancer*, 2(2), 101-112.
- Anderson, B. O., Braun, S., Lim, S., Smith, R. A., Taplin, S., & Thomas, D. B. (2003). Early detection of breast cancer in countries with limited resources. *The breast journal*, 9(s2), S51-S59.
- Asiago, V. M., Alvarado, L. Z., Shanaiah, N., Gowda, G. N., Owusu-Sarfo, K., Ballas, R. A., & Raftery, D. (2010). Early detection of recurrent breast cancer using metabolite profiling. *Cancer research*, 70(21), 8309-8318.
- Azubuikwe, S., & Okwuokei, S. (2013). Knowledge, attitude and practices of women towards breast cancer in Benin City, Nigeria. *Annals of medical and health sciences research*, 3(2), 155-160.
- Bairati, I., Jobin, E., Fillion, L., Larochelle, M., & Vincent, L. (2007). Determinants of delay for breast cancer diagnosis. *Cancer detection and prevention*, 31(4), 323-331.
- Bandura, A. (1986). *Social foundations of thought and action*: Englewood Cliffs, NJ Prentice Hall.
- Benson, J. R., & Jatoi, I. (2012). The global breast cancer burden. *Future Oncology*, 8(6), 697-702.
- Bertrand, P., Girard, N., Delpech, B., Duval, C., d'Anjou, J., & Dauce, J. (1992). Hyaluronan (hyaluronic acid) and hyaluronectin in the extracellular matrix of human breast carcinomas: Comparison between invasive and non-invasive areas. *International journal of cancer*, 52(1), 1-6.
- Boon, H. S., Olatunde, F., & Zick, S. M. (2007). Trends in complementary/alternative medicine use by breast cancer survivors: comparing survey data from 1998 and 2005. *BMC women's health*, 7(1), 4.
- Bottorff, J. L., Johnson, J. L., Bhagat, R., Grewal, S., Balneaves, L. G., Clarke, H., & Hilton, B. (1998). Beliefs related to breast health practices: the perceptions of South Asian women living in Canada. *Social Science & Medicine*, 47(12), 2075-2085.

- Boulware, L. E., Cooper, L. A., Ratner, L. E., LaVeist, T. A., & Powe, N. R. (2003). Race and trust in the health care system. *Public health reports, 118*(4), 358.
- Burgess, C., Potts, H., Hamed, H., Bish, A., Hunter, M., Richards, M., & Ramirez, A. (2006). Why do older women delay presentation with breast cancer symptoms? *Psycho-Oncology, 15*(11), 962-968.
- Cazap, E., Buzaid, A., Garbino, C., de la Garza, J., Orlandi, F., Schwartzmann, G., . . . Breitbart, G. (2010). Breast cancer in Latin America: experts perceptions compared with medical care standards. *The Breast, 19*(1), 50-54.
- Chamberlain, J., Watt, S., Mohide, P., Muggah, H., Trim, K., & Bantebya Kyomuhendo, G. (2007). Women's perception of self-worth and access to health care. *International Journal of Gynecology & Obstetrics, 98*(1), 75-79.
- Clegg-Lamprey, J., Dakubo, J., & Attobra, Y. (2009). During treatment in Ghana? A pilot study. *Ghana Med J, 43*(3).
- Clegg-Lamprey, J., & Hodasi, W. (2007). A study of breast cancer in Korle Bu Teaching Hospital: Assessing the impact of health education. *Ghana Med J, 41*(2).
- Davis, T. C., Williams, M. V., Marin, E., Parker, R. M., & Glass, J. (2002). Health literacy and cancer communication. *CA: a cancer journal for clinicians, 52*(3), 134-149.
- De Vos, C. L. (2014). *Breast cancer in the Ashkenazi Jewish population of South Africa: some psychosocial issues*.
- Donnelly, T. T., Al Khater, A.-H., Al-Bader, S. B., Al Kuwari, M. G., Al-Meer, N., Malik, M., . . . Fung, T. (2013). Beliefs and attitudes about breast cancer and screening practices among Arab women living in Qatar: a cross-sectional study. *BMC women's health, 13*(1), 49.
- Ekanem, V. J., & Aligbe, J. (2006). Histopathological types of breast cancer in Nigerian women: a 12-year review (1993-2004). *African journal of reproductive health, 71-75*.
- Ferlay, J., Shin, H. R., Bray, F., Forman, D., Mathers, C., & Parkin, D. M. (2010). Estimates of worldwide burden of cancer in 2008: GLOBOCAN 2008. *International journal of cancer, 127*(12), 2893-2917.
- Ferlay, J., Soerjomataram, I., & Ervik, M. (2012). GLOBOCAN 2012 v1. 0, Cancer Incidence and Mortality Worldwide: IARC Cancer Base No. 10 [Internet], International Agency for Research on Cancer, 2013.

- Ferrucci, L. M., Cartmel, B., Turkman, Y. E., Murphy, M. E., Smith, T., Stein, K. D., & McCorkle, R. (2011). Causal attribution among cancer survivors of the 10 most common cancers. *Journal of psychosocial oncology*, 29(2), 121-140.
- Fogel, J., Albert, S. M., Schnabel, F., Ditkoff, B. A., & Neugut, A. I. (2002). Use of the Internet by women with breast cancer. *Journal of medical Internet research*, 4(2).
- Forouzanfar, M. H., Foreman, K. J., Delossantos, A. M., Lozano, R., Lopez, A. D., Murray, C. J., & Naghavi, M. (2011). Breast and cervical cancer in 187 countries between 1980 and 2010: a systematic analysis. *The Lancet*, 378(9801), 1461-1484.
- Friedman, L. C., Romero, C., Elledge, R., Chang, J., Kalidas, M., Dulay, M. F., . . . Osborne, C. K. (2007). Attribution of blame, self-forgiving attitude and psychological adjustment in women with breast cancer. *Journal of behavioral medicine*, 30(4), 351-357.
- Ganle, J. K., Parker, M., Fitzpatrick, R., & Otupiri, E. (2014). A qualitative study of health system barriers to accessibility and utilization of maternal and newborn healthcare services in Ghana after user-fee abolition. *BMC pregnancy and childbirth*, 14(1), 425.
- Glanz, K., & Bishop, D. B. (2010). The role of behavioral science theory in development and implementation of public health interventions. *Annual review of public health*, 31, 399-418.
- Grunfeld, E., Ramirez, A., Hunter, M., & Richards, M. (2002). Women's knowledge and beliefs regarding breast cancer. *British Journal of Cancer*, 86(9), 1373-1378.
- Gullatte, M., Phillips, J., & Gibson, L. (2006). Factors associated with delays in screening of self-detected breast changes in African-American women. *Journal of National Black Nurses' Association: JNBNA*, 17(1), 45-50.
- Hadi, M. A., Hassali, M. A., Shafie, A. A., & Awaisu, A. (2010). Evaluation of breast cancer awareness among female university students in Malaysia. *Pharmacy Practice*, 8(1), 29-34.
- Haji-Mahmoodi, M., Montazeri, A., Jarvandi, S., Ebrahimi, M., Haghighat, S., & Harirchi, I. (2002). Breast Self-Examination: Knowledge, Attitudes, and Practices Among Female Health Care Workers in Tehran, Iran. *The breast journal*, 8(4), 222-225.
- Harirchi, I., Ghaemmaghani, F., Karbakhsh, M., Moghimi, R., & Mazaherie, H. (2005). Patient delay in women presenting with advanced breast cancer: an Iranian study. *Public Health*, 119(10), 885-891.

- Jansen, S., Kievit, J., Nooij, M., Haes, J. d., Overpelt, I., Slooten, H. v., . . . Stiggelbout, A. (2001). Patients' preferences for adjuvant chemotherapy in early-stage breast cancer: is treatment worthwhile? *British Journal of Cancer*, *84*(12), 1577-1585.
- Jemal, A., Bray, F., Center, M. M., Ferlay, J., Ward, E., & Forman, D. (2011). Global cancer statistics. *CA: a cancer journal for clinicians*, *61*(2), 69-90.
- Jumah, J. A. B. (2013). Knowledge & Practice of Saudi Women about the Prevention of Breast Cancer. *International Journal of Applied*, *3*(2).
- Kazaura, M., Kombe, D., Yuma, S., Mtiro, H., & Mlawa, G. (2007). Health seeking behavior among cancer patients attending ocean road cancer institute, Tanzania. *East African Journal of Public Health*, *4*(1), 19-22.
- Kindig, D. A., Panzer, A. M., & Nielsen-Bohlman, L. (2004). *Health Literacy:: A Prescription to End Confusion*: National Academies Press.
- Koedoot, C., De Haan, R., Stiggelbout, A., Stalmeier, P., De Graeff, A., Bakker, P., & de Haes, J. (2003). Palliative chemotherapy or best supportive care? A prospective study explaining patients' treatment preference and choice. *British Journal of Cancer*, *89*(12), 2219-2226.
- Legesse, B., & Gedif, T. (2014). Knowledge on breast cancer and its prevention among women household heads in Northern Ethiopia. *Open Journal of Preventive Medicine*, *2014*.
- Luker, K. A., Beaver, K., Lemster, S. J., & Owens, R. G. (1996). Information needs and sources of information for women with breast cancer: a follow-up study. *Journal of advanced nursing*, *23*(3), 487-495.
- Macleod, U., Mitchell, E., Burgess, C., Macdonald, S., & Ramirez, A. (2009). Risk factors for delayed presentation and referral of symptomatic cancer: evidence for common cancers. *British Journal of Cancer*, *101*, S92-S101.
- Mathers, C., Fat, D. M., & Boerma, J. (2008). *The global burden of disease: 2004 update*: World Health Organization.
- Mbuka-Ongona, D., & Tumbo, J. M. (2013). Knowledge about breast cancer and reasons for late presentation by cancer patients seen at Princess Marina Hospital, Gaborone, Botswana: original research. *African Primary Health Care and Family Medicine*, *5*(1), 1-7.

- McPherson, K., Steel, C., & Dixon, J. (2000). ABC of breast diseases: breast cancer—epidemiology, risk factors, and genetics. *BMJ: British Medical Journal*, *321*(7261), 624.
- Mills, M. E., & Davidson, R. (2002). Cancer patients' sources of information: use and quality issues. *Psycho-Oncology*, *11*(5), 371-378.
- Montazeri, A., Vahdaninia, M., Harirchi, I., Harirchi, A. M., Sajadian, A., Khaleghi, F., . . . Jarvandi, S. Asia Pacific family medicine Volume: 7 ISSN: 1447-056X ISO Abbreviation: Asia Pac Fam Med Publication Date: 2008. *Detail*.
- Morales, A. (2006). A Sample Qualitative Dissertation Proposal.
- Nielsen-Bohlman, L., Panzer, A., & Kindig, D. (2013). Health Literacy: A prescription to end confusion. 2004. *National Academy of Sciences: Washington, DC*.
- Norman, S. A., Localio, A. R., Potashnik, S. L., Torpey, H. A. S., Kallan, M. J., Weber, A. L., . . . Solin, L. J. (2009). Lymphedema in breast cancer survivors: incidence, degree, time course, treatment, and symptoms. *Journal of Clinical Oncology*, *27*(3), 390-397.
- Nosarti, C., Crayford, T., Roberts, J., Elias, E., McKenzie, K., & David, A. (2000). Delay in presentation of symptomatic referrals to a breast clinic: patient and system factors. *British Journal of Cancer*, *82*(3), 742.
- Odusanya, O., & Olumuyiwa, O. O. T. (2001). Breast cancer knowledge, attitudes and practice among nurses in Lagos, Nigeria. *Acta Oncologica*, *40*(7), 844-848.
- Ohaeri, J., Campbell, O., Ilesanmi, A., & Ohaeri, B. (1999). The opinion of caregivers of some women with breast and cervical cancer on aspects of the disease. *West African journal of medicine*, *18*(1), 6.
- Ohene-Yeboah, M., & Adjei, E. (2012). Breast cancer in Kumasi, Ghana. *Ghana Med J*, *46*(1), 8-13.
- Okobia, M. N., Bunker, C. H., Okonofua, F. E., & Osime, U. (2006). Knowledge, attitude and practice of Nigerian women towards breast cancer: a cross-sectional study. *World Journal of Surgical Oncology*, *4*(1), 11.
- Oluwatosin, O. A., & Oladepo, O. (2006). Knowledge of breast cancer and its early detection measures among rural women in Akinyele Local Government Area, Ibadan, Nigeria. *BMC cancer*, *6*(1), 271.

- Opoku, S. Y., Benwell, M., & Yarney, J. (2012). Knowledge, attitudes, beliefs, behaviour and breast cancer screening practices in Ghana, West Africa. *Pan African Medical Journal*, 11(1).
- Otieno, E., Micheni, J., Kimende, S., & Mutai, K. (2010). Delayed presentation of breast cancer patients. *East African medical journal*, 87(4), 147-150.
- Parrott, R. L., Silk, K. J., & Condit, C. (2003). Diversity in lay perceptions of the sources of human traits: genes, environments, and personal behaviors. *Social Science & Medicine*, 56(5), 1099-1109.
- Peepliwal, A. K., & Tandale, P. (2013). Breast Cancer in India: Etiology, Diagnosis and Therapy. *RESEARCH & REVIEWS: JOURNAL OF MEDICAL AND HEALTH SCIENCES*, 2(2), 31-42.
- Pereira, J. L., Koski, S., Hanson, J., Bruera, E. D., & Mackey, J. R. (2000). Internet usage among women with breast cancer: an exploratory study. *Clinical breast cancer*, 1(2), 148-153.
- Rabin, C., & Pinto, B. (2006). Cancer-related beliefs and health behavior change among breast cancer survivors and their first-degree relatives. *Psycho-Oncology*, 15(8), 701-712.
- Robertson, R., Campbell, N., Smith, S., Donnan, P., Sullivan, F., Duffy, R., . . . Munro, A. (2004). Factors influencing time from presentation to treatment of colorectal and breast cancer in urban and rural areas. *British Journal of Cancer*, 90(8), 1479-1485.
- Robins Sadler, G., & Takahashi, M. (2003). Japanese American women: behaviors and attitudes toward breast cancer education and screening. *Health Care for Women International*, 24(1), 18-26.
- Rogers, S., Pabla, R., McSorley, A., Lowe, D., Brown, J., & Vaughan, E. (2007). An assessment of deprivation as a factor in the delays in presentation, diagnosis and treatment in patients with oral and oropharyngeal squamous cell carcinoma. *Oral oncology*, 43(7), 648-655.
- Ross, E., & Deverell, A. (2004). *Psychosocial approaches to health, illness and disability: A reader for health care professionals*: Van Schaik Publishers.
- Sauter, E., Ross, E., Daly, M., Klein-Szanto, A., Engstrom, P., Sorling, A., . . . Ehya, H. (1997). Nipple aspirate fluid: a promising non-invasive method to identify cellular markers of breast cancer risk. *British Journal of Cancer*, 76(4), 494.

- Sharma, K., Costas, A., Shulman, L. N., & Meara, J. G. (2012). A systematic review of barriers to breast cancer care in developing countries resulting in delayed patient presentation. *Journal of oncology*, 2012.
- Sharma, P., Sahni, N. S., Tibshirani, R., Skaane, P., Urdal, P., Berghagen, H., . . . Sharma, P. (2005). Early detection of breast cancer based on gene-expression patterns in peripheral blood cells. *Breast Cancer Research*, 7(5), R634.
- Siegel, R., Naishadham, D., & Jemal, A. (2013). Cancer statistics, 2013. *CA: a cancer journal for clinicians*, 63(1), 11-30.
- Smith, R. A., Caleffi, M., Albert, U. S., Chen, T. H., Duffy, S. W., Franceschi, D., & Nyström, L. (2006). Breast Cancer in Limited-Resource Countries: Early Detection and Access to Care. *The breast journal*, 12(s1), S16-S26.
- Stockler, M., Duric, V., & Coates, A. S. (2006). Patients' Preferences: What Makes Treatments Worthwhile? *Breast Cancer and Molecular Medicine* (pp. 925-944): Springer.
- Tfayli, A., Temraz, S., Abou Mrad, R., & Shamseddine, A. (2010). Breast cancer in low-and middle-income countries: an emerging and challenging epidemic. *Journal of oncology*, 2010.
- Tromp, D., Brouha, X., De Leeuw, J., Hordijk, G., & Winnubst, J. (2004). Psychological factors and patient delay in patients with head and neck cancer. *European journal of cancer*, 40(10), 1509-1516.
- Virgo, N., & Re, R. BENIGN BREAST DISORDERS. *EXPERIENCING THESE SYMPTOMS?*, 1, 52.
- Wang, C., Miller, S. M., Egleston, B. L., Hay, J. L., & Weinberg, D. S. (2010). Beliefs about the causes of breast and colorectal cancer among women in the general population. *Cancer causes & control*, 21(1), 99-107.
- Wright, S. (2008). Health care practices influencing health promotion in urban black women in Tshwane. *Curationis*, 31(3), 36-43.
- Yip, C.-H., & Taib, N. A. (2012). Challenges in the management of breast cancer in low-and middle-income countries. *Future Oncology*, 8(12), 1575-1583.
- Zimmerman, B. T. (2004). *Understanding breast cancer genetics*: Univ. Press of Mississippi.

APPENDICES

APPENDIX A: Ethical Clearance

APPENDIX B: Patient In-Depth Interview Guide**SCHOOL OF PUBLIC HEALTH, COLLEGE OF HEALTH SCIENCES,
UNIVERSITY OF GHANA**

**Title: “Health Seeking Behaviours for Breast Cancer among Breast Cancer Patients at
Komfo Anokye Teaching Hospital”**

PATIENT INDEPTH INTERVIEW GUIDE**THEME 1: Knowledge about Breast Cancer**

1. In your opinion, what would you say Breast Cancer is?
2. What do you think causes Breast Cancer?
3. What are some of the signs and symptoms of Breast Cancer?
4. Which age group of people would you say are more susceptible to Breast Cancer?
(probe for reasons)
5. In your opinion, would you say that Breast Cancer is curable or not? Give reasons for
your answer.
6. How did you get to know that you have Breast Cancer?
7. When did you notice you had Breast Cancer?
8. How did you respond when you found out that you had Breast Cancer?
9. Screening methods (self-breast examination, clinical breast examination,
mammogram) used and the frequency it is used.

THEME 2: Sources of Obtaining Care for Breast Cancer

10. Where did you first seek care when you got to know that you have Breast Cancer?
11. Could you please describe the nature of care obtained there (probe for type of medication given; attitude of provider, etc.) – *if more than one source, let interviewee describe each one.*
12. How is it, dealing with the treatments? What do you think helps (physically, spiritually, emotionally)? What has been difficult to deal with?
13. Could you kindly give reasons for movement from one treatment source to another?

THEME 3: Sources Of Information For Treatment Options

14. Where did you seek information about treatment options for Breast Cancer?

THEME 4: Factors For The Delay Presentation To The Hospital

15. How long after you first realized you have Breast Cancer did it take you to come to the hospital?
16. Why did it take you that much time to do so?

End interview and thank participant

APPENDIX C: Health Worker Interview Guide

SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA

TITLE: “Health seeking behaviours for Breast Cancer among Breast Cancer patients at the Komfo Anokye teaching hospital”

Health Workers’ Interview Guide

1. What is Breast Cancer?
2. What causes Breast Cancer?
3. Is Breast Cancer curable?
4. What treatment options are available to Breast Cancer patients who come to the hospital?
5. Which of these options do patients prefer most? Why?
6. At what stage of Breast Cancer do patients usually present to the hospital for treatment? (Probe for implications for treatment).
7. What are some of the causes for delay in seeking biomedical health care for Breast Cancer?
8. Are there instances where patients who initially chose the hospital as first point of call for treatment, left to seek care from other sources before coming back again to KATH to continue? (Probe for reasons).
9. How long does it take for Breast Cancer to be fully treated? (Early/late stage).
10. How much does it cost in monetary terms to fully treat Breast Cancer? (Early/late stag)
11. Is the treatment of Breast Cancer covered under the NHIS?
12. Recently, there have been many stories about increasing cases of Breast Cancer in Ghana. What do you say about that?
13. How do you manage Breast Cancer at the terminal stage as well as in the early stage?
14. What are the cultural challenges of educating the community about Breast Cancer?

APPENDIX D: Questionnaires

SCHOOL OF PUBLIC HEALTH,
COLLEGE OF HEALTH SCIENCES,

UNIVERSITY OF GHANA

**Title: “Health Seeking Behaviours for Breast Cancer among Breast Cancer Patients at
Komfo Anokye Teaching Hospital”**

Care Giver’s In-depth Interview Guide**A. KNOWLEDGE ON Breast Cancer, CARE FOR Breast Cancer:**

1. In your opinion, what would you say Breast Cancer is?
2. What do you think causes Breast Cancer?
3. What are some of the signs and symptoms of Breast Cancer?
4. Which age group would you say are more prone to getting Breast Cancer?
5. Why do you say so? (In reference to response given to ‘5’ above).
6. In your opinion, would you say that Breast Cancer is curable or not? Give reasons for your answer.

B. CHOICE OF CARE

7. Where did you first seek care for your relative’s Breast Cancer? (Probe for reasons for choice given)
8. What informed this choice????
9. Why did you now decide to bring the patient to the hospital??
10. What do people in your community do when they get Breast Cancer?
11. Where are the common areas the patient seek care?
12. What role do you play as a caregiver in deciding where to seek care?
13. Briefly describe what you do in discharging your role as a caregiver.
14. How do you go about discharging these roles?
15. What are the challenges you face in discharging your role as a caregiver?
16. What sources do you rely on in obtaining information about Breast Cancer as a caregiver

End the interview and thank the respondent

APPENDIX E: Interview Guide for Alternative Health Providers

1. What is Breast Cancer?
2. What are the risk factors or causes Breast Cancer?
3. Is Breast Cancer curable?
4. Please describe the treatment process that patients go through when they come here.
5. How long does it take for Breast Cancer to be fully treated?
6. How much does it cost to fully treat Breast Cancer here?
7. What age group of women suffering from usually come here for treatment?

SCHOOL OF PUBLIC HEALTH

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UNIVERSITY OF GHANA

**Title: Health Seeking Behaviours for Breast Cancer among Breast Cancer Patients at
Komfo Anokye Teaching Hospital**

Socio-Demographic Characteristics of Respondent

Date of interview: Interview Code / Number:

Name (Optional):

Age:

Sex:

Level of Education:

Religious Affiliation:

Occupation:

Marital Status:

Ethnicity:

Contact Address/ Phone number

SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA

**Title: Health Seeking Behaviours for Breast Cancer among Breast Cancer Patients at
Komfo Anokye Teaching Hospital**

Socio-Demographic Characteristics of Respondent (BCPs)

Date of interview: Interview Code / Number:

Name (Optional):

Age:

Sex:

Level of Education:

Religious Affiliation:

Occupation:

Marital Status:

Number of Children:

Ethnicity:

Contact Address/ Phone number.....