

**SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES
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**EXPLORING THE WELLBEING OF UNMARRIED MEN WITH PROSTATE
CANCER IN THE ACCRA METROPOLIS**

BY

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DECLARATION

I hereby declare that this thesis was the result of my own research work conducted under supervision. This thesis has not been submitted in any form to another university for any degree or diploma. The references to other works and literature used in this research have been duly acknowledged in the text and list of references.

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DEDICATION

This thesis is dedicated to the Almighty God for his grace. I also dedicate it to my family without whom I could not have come this far; especially my mother Madam Theodora Kutsienyo, my wife Juliet Naa Aku Annan and my daughter Angelyn Naa Anowah Annan for their support and strength throughout this work.

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LIST OF ABBREVIATIONS

ADT:	Androgen Deprivation Therapy
ED:	Erectile Dysfunction
GHS	Ghana Health Service
MOH	Ministry of Health
NGO	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
OPD:	Out-Patient Department
PCa:	Prostate Cancer
PSA:	Prostate Specific Antigen
QOL-ATCS:	Quality of Life model applied to cancer survivors
WHO:	World Health Organisation

ABSTRACT

Prostate Cancer (PCa) is a serious public health problem, with high rates of incidence and mortality in the male population across the world. Globally, the burden on the cost of survival and living with cancer diseases is on a higher rate in recent times, with PCa being commonest cancer among men. In the Ghanaian context, there are limited studies on unmarried men with PCa, hence, this study sought to explore the wellbeing of unmarried men with PCa in the Accra Metropolis using the Quality of Life Model applied to cancer survivors (QOL-ATCS) as a guiding framework. With an exploratory descriptive study design, purposive sampling technique was used to recruit ten (10) unmarried men as participants. A semi-structured interview guide was used to conduct in-depth face-to-face interviews. Data collection and analysis were done concurrently using thematic content analysis technique. Five (5) major themes were identified; physical, psychological, social, and spiritual wellbeing, and coping strategies. The findings revealed that participants experienced physical effects such as fatigue, poor rest and sleep, pain, erectile dysfunction, reduced urge for sex, and having to deal with a urethral catheter in situ. These physical experiences had a worrying effect on the psychological, social and spiritual wellbeing which includes anxiety, depression, suicidal ideation, isolation and financial burden. Participants therefore employed varied coping strategies to help them deal with these effects. The psycho-social and religious effect of PCa largely depend on physical symptoms, which are more visible with unmarried men. Therefore, counselling and psychological management of unmarried men with PCa should be a priority in all oncology (urology) units.

CHAPTER ONE

INTRODUCTION

1.1 Background

Prostate Cancer (PCa) is a serious public health problem, with an increased level of incidence and deaths in the male population across the world. It is the fourth most common cancer of all cancers and the second most occurring cancer in men (Ferlay et al., 2015). Most men with PCa exhibit localised symptoms or extend to regional lymph nodes (Heckel, Fennell, Mohebbi, Byrnes, & Livingston, 2017), and mostly one out of five experience metastasis (Luo, Yu, Smith, & O'Connell, 2015). Even though majority of tumours affecting the prostate gland progress slowly and may not affect the life span of men, some spread rapidly due to their aggressive nature, which is noted among dark-skinned men than other races (Percy-Laurry et al., 2017). This accounts for the increased rate of deaths among African men (McGinley, Tay, & Moul, 2016).

Globally, 1.1 million men were estimated to be diagnosed with PCa per annum, which accounts for 15% of cancers in men. Seventy percent (70%) of these occur in high-income countries with an estimated mortality rate of 6.6% accounting for 307,000 deaths (Ferlay et al., 2015). The incidence of PCa varies geographically, with higher rates recorded in high-income countries. Australia/New Zealand and Northern America have the highest incidence of 111.6 and 97.2 per 100,000, respectively (Chambers et al., 2018). The American Cancer Society (2018) noted that PCa is the commonest non-skin cancer among men in the United States of America and that 164,690 (19%) new cases were recorded out of which 29,430 (9%) deaths were recorded in 2018. A High incidence of PCa has also been reported in Western and Northern Europe in recent times. This trend is largely due to majority of men availing

themselves for testing for Prostate Specific Antigen (PSA) and then subsequent biopsy among high-income countries; leading to early detection and diagnosis which could be left undetected in low-income countries where there is less or no practice of PSA testing (Ferlay et al., 2015).

Among African men, the occurrence of PCa was reported to be 23.2 per 100,000, with Southern Africa recording the highest incidence rate of 61.7 per 100,000 (Bray, Jemal, Grey, Ferlay, & Forman, 2012). Recent reports indicate a lower incidence rate of PCa in Northern Africans at 10.6 per 100,000, compared to Sub Saharan Africans with an average rate of 34.3 per 100,000 (Adeloye et al., 2016). While the trend shows a relatively lower incidence in Africa than other regions of the world, some authors argue that black men of African descent often suffer from PCa compared to other races. It was noted there is increased deaths among men with PCa among African men compared to men of others (Rebbeck et al., 2013).

Generally, these inequalities in PCa infection have been associated with differences in socioeconomic status, in which the high-income countries have access to quality healthcare than those in low-income countries (Singh & Jemal, 2017; Thakare & Chinegwundoh, 2015). Genetic factors, deficient knowledge, and cultural beliefs have also been cited as reasons for disparities in health outcomes among PCa patients (McGinley et al., 2016).

The issue of PCa in Ghana is becoming alarming, with lots of men at different stages in life battling with this dreadful disease. As indicated by Ego and Nana (2012), a survey at the Korle-Bu Teaching Hospital showed that the country had surpassed the global average of 170 men out of every 100,000, indicating a prevalence of 200 men out of every 100,000 as at 2007. More recently, out of 1,037 men included in a study in Ghana, 352 men were positive to PSA screening or digital rectal examination and 73 had PCa by biopsy, amounting to a 7.0% screen

detection with PCa occurrence (Yeboah et al., 2016). This condition has become part of the challenging disease of men in Ghana where there are inadequate prostate cancer screening centres for early detection, diagnosis, and management.

Finally, dealing with the treatment after the diagnosis of PCa is quite demanding and stressful. Most men are faced with a myriad of issues ranging from emotional, psychological and physical distress and ill-health (Gray, Fitch, Phillips, Labrecque, & Fergus, 2000). In a recent study by Kamen et al. (2015), men with PCa who were married and reported high support from their partners were significantly less distressed than men who were not married. The study is designed to explore the wellbeing of unmarried men with PCa in the Accra Metropolis. The framework used to guide this study was the Quality of Life Model Applied to Cancer Survivors (QOL-ATCS) by Ferrell, Grant, Padilla, Vemuri, and Rhiner (1991).

1.2 Problem Statement

Globally, the burden and cost of surviving with chronic cancer diseases in the last two decades have increased, with PCa as the most common cancer among men (Aizer et al., 2014). African men are faced with an increased disease burden with early-onset and more aggressive PCa (Aizer et al., 2014; Shenoy, Packianathan, Chen, & Vijayakumar, 2016).

Despite the paucity of literature in Africa, the research based on the wellbeing of men with PCa is advancing progressively and a substantial research of clinical significance exists presently in other jurisdictions. Unfortunately, studies that seek to address the wellbeing of men with PCa is still limited, especially in low-income countries. In the Ghanaian context, limited studies on PCa led to over-dependence on research findings from elsewhere in the world, and a search of the literature did not find any published study on the wellbeing of unmarried men

with PCa in Ghana. Again, studies in Canada and Scotland emphasized the persisting limited services that support men with advanced PCa (Paterson, Kata, Nandwani, Chaudhury, & Nabi, 2017). This implies that a more qualitative inquiry is imperative to elucidate men's wellbeing to develop effective supportive care interventions. Surprisingly, few studies have sought to explore the wellbeing of unmarried men who are diagnosed with PCa worldwide (Huang et al., 2017; Kazer et al., 2011).

After five years of professional observation and experiences with urology patients at the male surgical ward, the researcher observed the challenging experiences that patients with urology problems go through especially the physical, psychological, and socioeconomic wellbeing. Through such prolonged observation and experiences, it was discovered that some become withdrawn and attempt to commit suicide. These observations and experiences motivated the researcher to explore the wellbeing of unmarried men with prostate cancer in the Accra Metropolis in Ghana.

1.3 The Purpose of the Study

This study purposed to explore the wellbeing of unmarried men with PCa in the Accra Metropolis.

1.4 Specific Objectives

The specific objectives of the study are to describe:

1. The physical wellbeing of unmarried men with PCa.
2. The psychological wellbeing of unmarried men with PCa.
3. The social wellbeing of unmarried men with PCa.

4. The spiritual wellbeing of unmarried men with PCa.

1.5 Research Questions

1. What is the physical wellbeing of unmarried men with PCa?
2. What is the psychological wellbeing of unmarried men with PCa?
3. What is the social wellbeing of unmarried men with PCa?
4. How do unmarried men manage PCa disease and treatment spiritually?

1.6 Significance of the Study

This study offered the participants the opportunity to make their voices heard, by sharing experiences of their wellbeing as unmarried men with PCa. The utilization of the findings will expand healthcare professionals' understanding of the impact of the disease on the patients, as well as the responses and coping mechanisms. The knowledge shared from the wellbeing of unmarried men with diagnosis and treatment for PCa can also support discussions among those involved in their care and motivate health professionals to create strategies and actions aimed at improving the quality of life of patients with PCa. Again, the findings from this study will add relevant information to the existing literature in Ghana. This will broaden the horizon of knowledge on the wellbeing of unmarried men with PCa among the nursing fraternity and other healthcare professionals.

Lastly, it will provide a resource and opportunity for future research in other areas of PCa and make recommendations for further research in these areas.

1.7 Operational Definitions

Unmarried men: Men who have never been married in their entire lives and those who are divorced or widowers and un-partnered.

Wellbeing: This is the state of being healthy, comfortable, happy and prosperous with a sound mind to life.

Erectile dysfunction: The inability of a man to achieve an erection.

CHAPTER TWO

LITERATURE REVIEW

This chapter describes the theoretical underpinnings of the study and a review of the relevant literature concerning the specific objectives of the study. The researcher considered various conceptual frameworks such as the Biopsychosocial Model and the Quality of Life Model Applied to Cancer Survivors (QOL-ATCS) but with all the constructs in the various models, the QOL-ATCS best explained the researcher's research topic which considered the physical, psychological, socioeconomic and the spiritual wellbeing.

Subsequently, literature related to the wellbeing of unmarried men with PCa was reviewed comprehensively using the QOL-ATCS by Ferrell et al. (1991), as an organizing framework and in tandem with the study objectives. The sources of relevant literature include databases such as Science Direct, PubMed, CINAHL, and MEDLINE. Keywords used in the search for literature included "Prostate Cancer", "physical wellbeing/experiences", "unmarried men", socioeconomic wellbeing/experiences", "psychological wellbeing/experiences", "spiritual wellbeing/experiences and coping strategies. The articles used for the literature review were published from 2007 and are specifically related to the current study. However, due to the paucity of literature related to the wellbeing of unmarried men with PCa locally and internationally, some older studies and those involving men, in general, were included in the literature review.

2.1 Justification and Relevance of Model to the Study

In the search for a conceptual model to guide the study, the researcher came across the Biopsychosocial model by Engel (1977) and the Quality Of Life Model Applied to Cancer

Survivors (QOL-ATCS) by Ferrell et al. (1991). After strict scrutiny of the construct of both models, the selected model to guide the study was the QOL-ATCS.

The Biopsychosocial Model of health and illness was developed by George L. Engel in 1977 to understand the key components; biological, social, and psychological factors of health and illness. Theories such as nature versus nurture postulates that either biological, social or psychological factors could significantly alter the course of development. However, the biopsychosocial model states that interaction between one's genetic makeup, psychological wellbeing, and sociocultural environment determines the experience of their health and illness (Engel, 1977). Engel (1977) is of the assertion that to understand and react adequately to the human suffering and to give the human a sense of wellbeing, there is the need to attend to all the three dimensions of illness simultaneously.

According to Engel (1977), biological influences on health and illness include genetics, infections, physical trauma, nutrition, hormones, and toxins. Many disorders have an inherited genetic predisposition. The psychological component of the Biopsychosocial Model includes potential psychological factors that may contribute to the development of a health problem. These include a lack of self-control, emotional turmoil, and negative thinking. Individuals with a genetic vulnerability may be more likely to display negative thinking that puts them at risk for depression. On the other hand, Social factors include socioeconomic status, culture, technology, and religion.

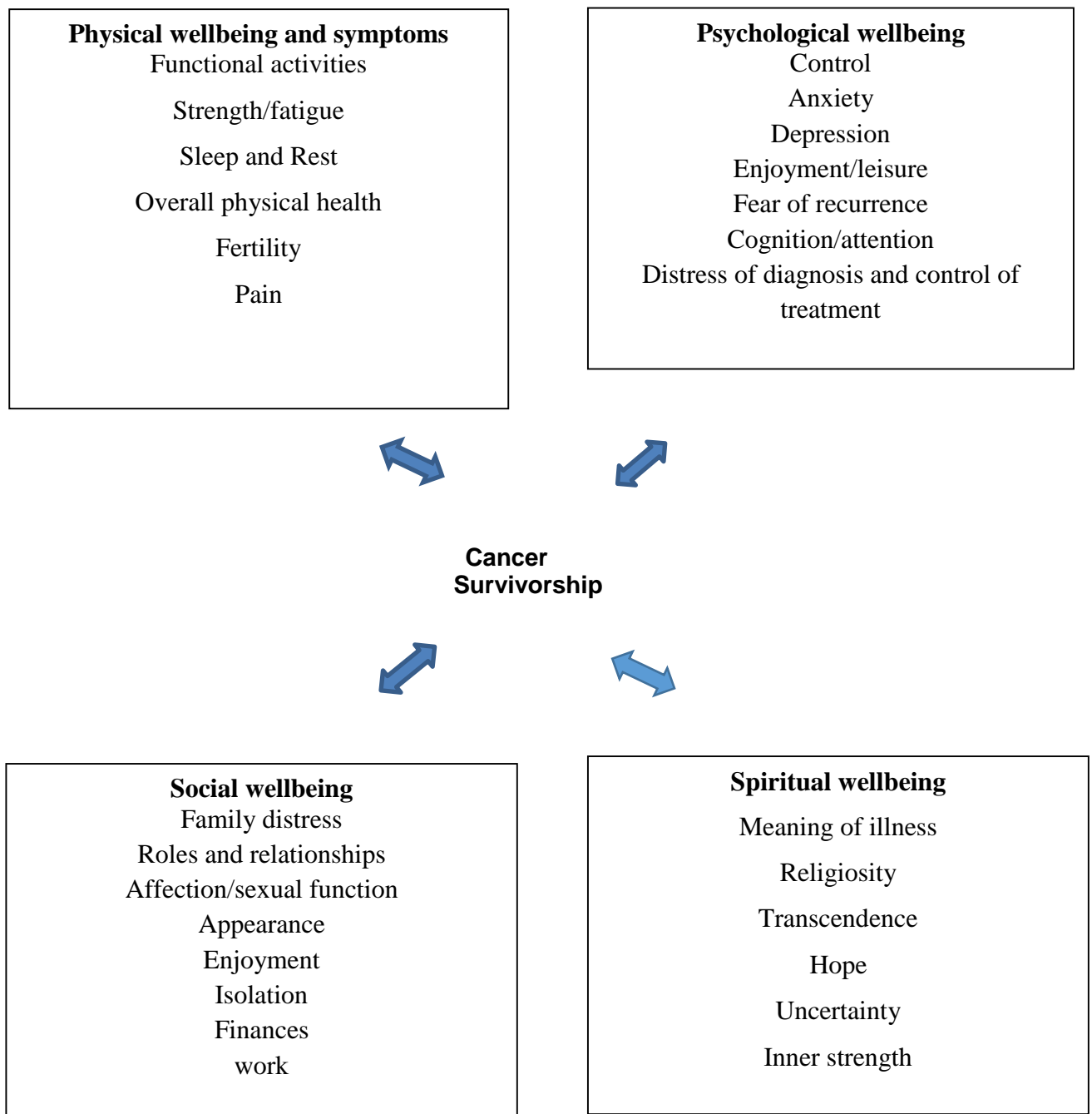
Despite its usefulness, some authors have criticised this model in the past. According to Benning (2015), the model lacked philosophical coherence, was not sensitive to patients' subjective experience, and that it engendered an undisciplined eclecticism that provides no

safeguards against either the dominance or the under-representation of any one of the three domains. Another author argued that the approach was limited to anarchy because of the suggestion that the target and focus on intervention bases on the personal preferences of the practitioner (Ghaemi, 2009).

Moreover, the Biopsychosocial model had no spiritual domain to guide the exploration of the spiritual wellbeing of study participants. Given that spirituality/religiosity as caregiver support is a key concept in the socio-cultural context of Ghana, this model could not be used as a guiding framework in this study. Therefore, the conceptual model used to guide the study was the Quality Of Life Model Applied to Cancer Survivors (QOL-ATCS) which has a spiritual wellbeing component.

2.2 Conceptual Model: Quality Of Life Model Applied to Cancer Survivors (QOL-ATCS)

The Quality Of Life Model Applied to Cancer Survivors (QOL-ATCS) by Ferrell and colleagues form the framework of this study. The QOL-ATCS has four domains: Physical, Psychological, Social, and Spiritual wellbeing. Ferrell et al. (1991) generated and validated the model through research on survivors of bone marrow transplant and breast cancer. According to the authors, physical wellbeing comprises of effects associated with all treatments of cancer. Psychological wellbeing comprises anxiety, emotional issues, and post-treatment mental distress. Social wellbeing reflects the financial implications of treatment, availability of follow-up care, and the evolution of roles and relationships after cancer treatment. Lastly, spiritual wellbeing takes account of power, self- transcendence, and religiosity. All these domains interact to determine the complete quality of life of persons suffering from cancer.



Source: Ferrell et al. (1991)

Figure 2.1: Quality of Life Model Applied to Cancer Survivors (QOL-ATCS)

2.2.1 Physical Wellbeing of Unmarried Men with PCa

The disease process and the physical experiences of men with PCa alter their social, family and affective relations, and may even generate personal conflicts due to the conditions imposed by the treatment, as is the case of radical prostatectomy, that may have as side effects, the incontinence of urine and sexual impotence (Moscheta & Santos, 2012). The experience of being ill with cancer modifies an entire existence since it affects the body both objectively, and subjectively. These are changes that involve life habits, side effects to treatment, loss of autonomy, feelings of impotence and isolation (Modena, Martins, Ribeiro, & Almeida, 2014). Men with PCa can also experience urinary incontinence and erectile dysfunction from the side effects of the treatment of PCa. This can lead to the experience of dysfunctional ejaculation and subsequent reduced sexual drive in men with PCa (Saitz, Serefoglu, Trost, Thomas, & Hellstrom, 2013). Subsequently, there is a loss of identity, mainly due to failure of men to reach and or maintain an erection (Brahmi et al., 2016). Again, there is withdrawal from social activities resulting from the embarrassment of incontinence which generates annoyance, frustration, and embarrassment to the male being (Ferrão et al., 2017a).

In the literature, erectile dysfunction is described as the commonest effect among men receiving PCa treatment, be it surgical or radiation therapy. Few qualitative studies have explored the life experiences of men with PCa and identified the challenges of sexual function after therapy. In a qualitative study by Hanly, Mireskandari, and Juraskova (2014), erectile dysfunction was largely experienced by men with PCa after receiving treatment. In addition, men may experience ejaculatory dysfunction and a decreased libido (Saitz et al., 2013). Given that sexual dysfunction as the commonest side effect of both prostatectomy and radiation

therapy (Mols et al., 2009), counselling and teaching men how to adjust to this potential side effect is an essential aspect of holistic care.

Similarly, some studies have earlier shown increased rates of erectile dysfunction among men with PCa, including those under surveillance (Saitz et al., 2013). A Scandinavian PCa study identified erectile dysfunction among patients (84%) who had undergone radical prostatectomy, those on active surveillance (80%), and those with non-prostate cancer controls (46%) (Johansson et al., 2011). The findings proposed that PCa had a direct relationship with erectile function, regardless of the type of therapy. Contrary to this, the PCa Intervention versus Observation Trial (PIVOT) identified the lesser erectile dysfunction in the patient with PCa who are being observed compared to those who had undergone radical prostatectomy (Wilt et al., 2012). The difference may be a result of demographic variations such as age, and severity of the disease, differences in erectile dysfunction definition employed for the assessment. Despite these variations, both studies confirmed a larger occurrence of baseline erectile dysfunction.

Though current management for advanced PCa prolongs life, the quality of such a long life is questionable because they continue to experience the devastating effects of the disease. To this effect, several studies have attributed pain, deteriorating bone health, and hot flashes experienced by men to prolong effects of the disease and treatment (Crawford, Petrylak, & Sartor, 2017). Similarly, loss of libido, erectile dysfunction, increased fat mass, sarcopenia, fatigue and cognitive decline were also associated with disease and therapy (Gilbert et al., 2017; Resnick & Penson, 2012). Again, other symptoms identified include erectile dysfunction, incontinence, hot flashes, and decreased muscle and bone mass (Aning, 2016; Resnick et al., 2015). A study by Chambers et al. (2018), identified physical effects such as erectile

dysfunction, fatigue, lack of libido, pain, incontinence, hot flushes, sarcopenia, vertigo, weight gain, loss of balance, dyspnoea, and mental instability.

Cancer Pain is one of the most feared effects of the condition (Dunham, Ingleton, Ryan, & Gott, 2013; Jain, Pai, & Chatterjee, 2015), and is a major reason for health-seeking behaviour and hospitalization among cancer patients (Boni & Afrane, 2016; Zaki & Hairi, 2014). As indicated by some researchers, the experience of pain among cancer patients is complex and multidimensional, hence it requires a better understanding of effective management (Hackett, Godfrey, & Bennett, 2016; Krause & Stanford, 2011). Notably, patients experiencing initial pain have shorter recovery times (Armstrong, Garrett-Mayer, De Wit, Tannock, & Eisenberger, 2010).

The intensity of pain explains the severity of the pain as perceived by patients and several studies have reported varying degrees of pain intensity among cancer patients (Gupta, Sahi, Bhargava, & Talwar, 2015; Iwase et al., 2015; Kahan, 2014). According to Zhu and N Weingart (2012), cancer patients experiencing pain graded their intensity of pain as moderate or severe. This variation may be dependent on the type or the stage of cancer (Matthie & McMillan, 2014; Pina, Sabri, & Lawlor, 2015). Patients with advanced cancers tend to experience intense pain than those with non-advanced/non-metastatic cancers (Alexopoulos, Koutsogiannou, Moratis, Mestousi, & Jelastopulu, 2011). Pain is mostly severe and undertreated in men who have metastasised prostate cancer (Autio et al., 2013). The intensity of pain is well understood from the patients' perspective (Weingart et al., 2012).

Sleep deprivation was related to cancer as one of the most prevalent symptoms affecting patients' quality of life (Araújo, Barbosa, & Barichello, 2014). A study among men with PCa being treated with hormone therapy verified that these men experienced problems both falling

to sleep and during sleep, with a mean score of 2.7 for night time awakening (Hanisch et al., 2011). Additionally, studies conducted in other settings reported the experience of poor sleep among men with PCa (Marianna, 2011; Van Onselen et al., 2010). In a comparative study, however, Garrett et al. (2011) reported that patients with breast cancer experienced sleep disturbance more frequently and with greater severity than patients with PCa.

The experience of pain and sleep disturbances seem to have a bidirectional relationship; an increase in pain intensity may interrupt the sleep pattern of the individual experiencing the pain. According to Lavigne, Nashed, Manzini, and Carra (2011), a disturbed sleep/poor sleep intensifies the experience of pain. Conversely, the influence of pain on sleep quality of patients is enormous (Hong, Kim, Shin, & Huh, 2014). Similarly, cancer patients who experience pain are known to have an interruption in their quality of sleep which is continuous and gets poorer over some time (Krause & Stanford, 2011). However, cancer patients with a mild intensity of pain are less likely to experience sleep disturbances (Mercadante et al., 2015).

Fatigue among patients with cancer is also an important health problem and is commonly experienced by cancer patients during and following treatment. Fatigue is a common effect among men with prostate cancer, particularly those prescribed hormone therapies (Langston, Armes, Levy, Tidey, & Ream, 2013) and increased fatigue is associated with decreases in patients' functional status and QOL (Dodd, Cho, Cooper, & Miaskowski, 2010; Maliski, Kwan, Elashoff, & Litwin, 2008). In another study aimed at examining the long-term impact of androgen-deprivation therapy on physical function and quality of life, physical deterioration and fatigue were experienced by men PCa (Alibhai et al., 2015). In a very recent study, prostate cancer patients receiving Androgen Deprivation Therapy (ADT) demonstrated

a trajectory of worsened fatigue following treatment initiation relative to the control group (Nelson et al., 2016).

Although PCa will not lead to death in the majority of men (Albaugh, Sufrin, Lapin, Petkewicz, & Tenfelde, 2017), the quality of life of men can be greatly affected by the long-term side effects of treatment. Notably, sexual dysfunction being the commonest side effect for all therapies (Hanly et al. , 2014). While erectile dysfunction (ED) is a gradual effect from prostate cancer, some studies have shown that the experience of ED is a common phenomenon among men who had radical prostatectomy (Iyigun, Ayhan, & Tastan, 2011). This had been reported to be high (85%) after prostate surgery (Emanu, Avildsen, & Nelson, 2016). This is as a result of the disruption of normal anatomy and nerve supply which governs the functional aspects of erection during prostatectomy, regardless of the surgical technique (Hamilton & Mirza, 2014). Urinary incontinence is also a reaction mentioned by most patients who underwent radical prostatectomy (Ferrão, Bettinelli, & Portella, 2017b).

In addition to the physical effects of ED, decrease libido, urinary incontinence, fatigue and other clinical features mentioned in the above literature, PCa patients can also experience painful ejaculation, burning, and pain during urination, anaemia, and having catheter in-situ. These effects can seriously affect the masculinity of men with PCa especially unmarried men because of a lack of spousal support.

2.2.2 Psychological Wellbeing of Unmarried Men with PCa

Though PCa is seen as a disease that does not cause death immediately (Bourke et al., 2015), the periods between pre-diagnosis and cure, remission, and recurrence or death, are ones in which the patient undergoes experiences that are peculiar to him (Cordova, Riba, & Spiegel, 2017). The extent and nature of the experiences differ between individuals and these patients

may need help and support to face the changes that occur in their lives (Bourke et al., 2015). Men with advanced PCa experience a poor quality of life, increased psychological distress, and higher possibility of ending one's life compared with men with localized PCa (Chambers et al., 2016). That notwithstanding, patients with PCa are riddled with psychological and emotional torment (Klett, 2014) and face deteriorating functional capabilities due to illness and ageing; urinary problems, fatigue, pain and sexual disorders (King, Brooks, Featherstone, & Topping, 2014).

Psychological problems manifest in 30–50% of PCa patients regardless of the stage and progression of cancer or the type of treatment being taken (De Sousa et al., 2012). A meta-analysis by Watts et al. (2014) noted increased rates of anxiety and depression across the treatment stages of PCa. It is also related to sub-clinical distress and consequent reduction in quality of life (Bill-Axelson et al., 2013; Smith et al., 2009).

Additionally, Albaugh et al. (2017) reported psychological issues among men with PCa resulting from the treatment-related sexual dysfunction. These include anxiety, depression, and suicidal thoughts. There were reports of people preferring to other lose parts of their body such as the limbs than suffer penile dysfunction. Others described the challenges with sexual function as “feeling abnormal”, “unnatural”, and “less of a man” (Albaugh et al., 2017). This goes to confirm earlier findings that PCa survivors have an increased risk of depression (Bill-Axelson et al., 2011; Jayadevappa, Malkowicz, Chhatre, Johnson, & Gallo, 2012). Again, depression has emerged as a significant issue among PCa patients with the prevalence reported between 16% to 30% (Sharp, O'leary, Kinnear, Gavin, & Drummond, 2016).

Again, the experience of the diagnosis of PCa may also confront the individual with stressful events and the impairment of physical integrity, especially of the aspects that involve

sexuality. This arouses negative feelings which lead to the experience of emotional and psychological stress (Klett, 2014), and these may be dependent on the length of illness after confirmation of the diagnosis of PCa. Though the most distressing stage of PCa is still unclear, Oba et al. (2017) and Watts et al. (2014) revealed PCa patients showed a high risk for experiencing emotional distress in the first six months after diagnosis and the peak of psychological risk was within the first month. Consequently, the repercussions of emotional and psychological stress influence the process of illness, from the acceptance of diagnosis to the effectiveness of treatment of cancer (Ferrão, Bettinelli, & Portella, 2017a).

Consequently, side effects of treatment have been identified to increase the anxiety and depression among PCa patients (Couper et al., 2010b). Anxiety and depression fluctuates in the trajectory of the PCa. It is noted to be high in patients who are yet to undergo treatment, low in patients undergoing treatment, and high again in patients who have completed treatment (Watts et al., 2014). In another study, the depression rate among men with PCa is high with an estimated rate between 8% and 25% among men who receive Androgen Deprivation Therapy (ADT) (Watts et al., 2014).

There are some studies do not support a linkage between depression and ADT (Hervouet, Savard, Ivers, & Savard, 2013). This variation may be due to weaknesses in the methodology that affect the interpretation of results and its generalizability. Other studies have also used self-report measures of depressive symptoms rather than the gold-standard diagnostic interview for depression. Nonetheless, to address many of these limitations in methodology, Lee et al. (2015) in a sample of men with PCa who were treated with ADT, used a longitudinal design to ascertain the influence of the depression treatment. The assessment was

done after 6 months and the findings revealed that people on receiving treatment had higher symptoms of depression as compared to those without treatment.

Available studies indicate that suicide ideation is common among patients diagnosed with prostate cancer. Recklitis, Zhou, Zwemer, Hu, and Kantoff, (2014) and Zhou, Hu, Kantoff, and Recklitis (2015) posited that 12–18% new cases of PCa had suicidal thoughts. PCa patients are at higher risk of death due to suicidal thoughts (Klaassen et al., 2018). According to Smith et al. (2018), suicidal thoughts affects the psychological wellbeing of PCa patients with manifestations such as depression. Other associated symptoms include pain, insomnia, fatigue, loss of autonomy and independence, poor social support, impaired physical functioning, demoralization, and emotional distress (Hughes, 2016).

Depression increases the risk of suicide (Turecki & Brent, 2016) therefore the rising incidence and prevalence of depression in men with PCa are a cause for concern. Studies have shown an increase in suicidal thoughts among survivors of PCa (Recklitis et al., 2014). Generally, the increase rate of suicide among cancer patients is alarming (Robson, Scrutton, Wilkinson, & MacLeod, 2010) and Anguiano, Mayer, Piven, & Rosenstein, (2012) reported PCa has been identified as one of the cancers that have increased suicidal rates, with older men being the majority.

Furthermore, the sexual dysfunction resulting in negative emotions is commonly seen among unmarried men with PCa as indicated by Iyigun et al. (2011). This is probably due to the fear of not being able to get married and live a normal life. Notwithstanding, a qualitative study by Nelson et al. (2015) reported the experience of negative emotions by married men who suffered erectile dysfunction following PCa treatment. In the same vein, a study by Zaider, Manne, Nelson, Mulhall, and Kissane (2012) using a quantitative approach also reported similar

finding indicating that men who experience a loss of manhood after therapy were likely to be worried by erectile dysfunction. The majority related their erectile dysfunction to “feeling like less of a man,” (Albaugh et al., 2017). Despite the methodological differences, the experience of negative emotions and distress has been widely reported in both qualitative and quantitative studies.

Nevertheless, it is worth noting that the experience of psychological distress among PCa survivors is predicted by the cancer-related signs and symptoms. In a quantitative study by Sharp et al. (2016), the risk of depression, anxiety and distress were significantly higher in men with higher urinary and androgen deprivation therapy (ADT)-related symptoms, fatigue, dyspnoea, and insomnia. It is not surprising then that post-treatment side-effects have been found to increase anxiety and depression (Couper et al., 2010), which can impact on already reduced sexual function.

Conversely, other studies have recounted relatively fewer feelings of anxiety and depression. As indicated by Love et al. (2008), there were no substantial variations in the prevalence of depression, and slightly raised anxiety levels in men with PCa as compared with community controls. Similarly, Donovan et al. (2016) noted lower anxiety levels and depression.

Interestingly, there are major differences in the psychological effects (anxiety, depression and suicidal ideation) experienced by prostate cancer survivors (Nelson et al., 2009). Anxiety and distress are less prevalent in older patients while depression is more prevalent in older patients (Kiffel & Sher, 2015). This indicates that young and old cancer patients react differently to the impact of having cancer and undergoing treatment. This calls for a focused approach to dealing with the psychological effects of prostate cancer rather than a generalised

one. Again, the stereotyping of having prostate cancer, and possible impairment in sexuality, may prevent these patients from seeking adequate social and psychological support which may lead to a continual deterioration of mental health (Penner, Phelan, Earnshaw, Albrecht, & Dovidio, 2017). This leads to anxiety and depression, especially those who are younger and yet to receive treatment (Watts et al., 2014). However, current research has shown an association between some treatment options and anxiety and depression. As found by Dinh et al., (2016) men with PCa who were receiving Androgen Deprivation Therapy (ADT) had a higher risk of developing newer depressive symptoms as compared with those without the treatment.

2.2.3 Social Wellbeing of Unmarried Men with PCa

Men with PCa usually experience feelings of embarrassment or social isolation during, and even after, their cancer battle. Not every man with PCa will experience these feelings, and even for those who do, the extent of these feelings and need to take action on them will vary from person to person. Despite being common for men with PCa, experiencing feelings of embarrassment or social isolation can be debilitating and frustrating, especially among men who are not married. Because of this, it is common for men to avoid discussing these struggles with other people. However, the culture of silence about these issues may result in a more devastating impact on a man's overall wellbeing, including leading to anxiety and depression (Watts et al., 2015).

In a descriptive exploratory study by Ettridge et al. (2018), some participants perceived a stigma associated with PCa, which sometimes interferes with disclosure. However, peer support reduces isolation and enhances interaction thereby promoting the sharing of experiences, knowledge, and skills in the trajectory of illness (King et al., 2015). The bidirectional nature of communication was experienced as empowering and served as a sense

of meaning to men with this disease (Galbraith, Hays, and Tanner, 2012). This positively influenced their adjustment to their condition. Spouses, family members, and friends were described as a key source of support by men (O'shaughnessy, Ireland, Pelentsov, Thomas, & Esterman, 2013; Schover et al., 2012).

Additionally, Bradley, Neumark, Luo, and Schenk (2007) found that men with PCa in active employment may experience reduction in their productivity or may become unemployment. This has consequences on income levels and pensions (Chambers et al., 2018). Moreover, the financial burden imposed on PCa patients is enormous (Fenn et al., 2014). The causes of financial stress in cancer patients are multifaceted; treatment costs such as costs of medications, radiation, and surgery, as well as home health care and travel expenses to treatment centres. However, the magnitude of this financial burden is largely influenced by factors including severity of disease, insurance schemes, socioeconomic status, and household income (Fenn et al., 2014). This implies that the degree of financial burden among unmarried men with PCa can be variable. According to Kale and Carroll (2016), the financial burden is pronounced in low-income patients than high-income patients. Again, insurance coverage and the extent of the disease can also affect the economic burdens of the cancer (Nipp, Powell, Chabner, & Moy, 2015).

In another setting, a quantitative study by Zafar et al. (2013) among a group of insured patients indicated that 85% reported some level of the financial burden from their expenses on the condition. Similarly, reported from other works have rated the high experience of the financial problem among patients with PCa (Pisu et al., 2015; Zafar et al., 2014). However, these findings are in sharp contrast to that of Fenn et al. (2014) where a relatively low proportion of patients (30.4%) reported having ever experienced financial problems as a result of cancer.

This contradiction is probably due to the differences in the study participants included in both studies, where some participants had never reported a diagnosis of cancer in their lifetime.

It is worth noting that, men living with PCa encounter several financial difficulties which make them likely prevent or delay them from seeking medical care and psychological care, thereby putting their psychological and physical health in jeopardy (Kent et al., 2013). Similarly, Shankaran, Jolly, Blough, and Ramsey (2012) revealed that cancer patients with financial burden may not be able to purchase their medications. This puts them at risk with their conditions. It is therefore important to note the impact of finance on cancer patients on a broader aspect affects their total wellbeing. It is also important to identify coping skills in managing these challenges.

Carter, Bryant-Lukosius, DiCenso, Blythe, and Neville (2011) indicated that functional issues, information needs, and emotional distress were the three domains of need that must be addressed among PCa patients. More recently, Paterson et al. (2017) did a study among eight men with advanced PCa and noted challenges within the domains of interpersonal and intimate needs of PCa patients. Notably, both studies identified the gap in support in giving information to these patients. Again, none deeply explored issues related to sexual function or the social and public health concerns of PCa patients. Nonetheless, Zaider et al. (2012) reported low levels of sexual function and affection among men with localized prostate cancer.

2.2.4 Spiritual Wellbeing of Unmarried Men with PCa

Recently, there is more emphasis on the relationship between spirituality and spiritual, emphasising the importance of the impact of spiritual well-being on health (Clay et al., 2010). Spirituality can be defined as “the personal quest for understanding answers about life, about meaning, and about the relationship to the sacred or transcendent, which may (or may not) lead

to or arise from the development of religious rituals and the formation of the community” (King & Koenig, 2009). The evidence in contemporary literature reveals that spiritual well-being is positively associated with the purpose of life, social support, lower stress levels, and lower depression rates, and has an impact on better health (Bredle et al., 2011) which is a drive for exploration of the spiritual wellbeing of men with prostate cancer.

In a study by Kiffel and Sher (2015), men with PCa reported a high level of spiritual well-being. Furthermore, literature revealed that at critical times, such as being diagnosed with PCa, people get closer to the divine (Salman & Zoucha, 2010) and praying becomes useful in facilitating the process of health and promoting the sense of hope during such critical times and the crisis (Doucet & Rovers, 2010).

Religiosity is one factor on which many individuals rely when faced with a life-threatening illness such as cancer (Holt, Oster, Clay, Urmie, & Fouad, 2011). In the advent of religious proliferation, many people use religion for comfort and support when faced with a life-threatening illness such as cancer (Biegler et al., 2012) and people who had previously disregarded religion and spirituality may become more religious when faced with illness (Gall, Guirguis- Younger, Charbonneau, & Florack, 2009).

There have been some studies examining the level of religiosity and spirituality among people with cancer and noted that religion and spirituality are positively correlated to effective coping (Biegler et al., 2012). Additionally, cancer patients with high levels of intrinsic religiosity and spiritual well-being had significantly higher hope and positive mood than those patients low in intrinsic religiosity (Holt et al., 2011). However, Hunsberger, Cheng, and Aslakson (2014) are of the view that simplistic associations between religiosity/spirituality and

coping are inadequate to explain the religiosity/spirituality needs of patients for coping and responding to stress.

A study by Haugan and Innstrand (2012) reported that Men at their terminal stage of PCa experience self-transcendence which has previously been found to be a positive correlate. Self-transcendence is the attempts by the individual to attain maturity regarding psychological, social, and spiritual issues bothering on existence. It includes a holistic expansion of the self-boundaries intrapersonally, interpersonally, transpersonally, and temporarily. Hence, self-transcendence motivates an individual's searching for new perspectives, meaning, and well-being and allows him or her to overcome ego concerns (Haugan & Innstrand, 2012).

Moreover, inner strength is reported as important resource for PCa patients and other terminal illnesses. Inner strength is embracing the challenges imposed by illness and adopting a positive approach to dealing with them (Lundman et al., 2011). To have inner strength is to believe in your ability to make informed decisions and drive towards meaning and purpose. Inner strength also means to courageously seek meaning in life regardless of adversity. As reported by Viglund, Jonsén, Lundman, Nygren, and Strandberg (2016), men with prostate cancer self-rated their inner strength as high. In times of crisis, mutual love and support was shown to be key in experiencing inner strength (Boman, Häggblom, Lundman, Nygren, & Fischer, 2015). Since people who exhibit inner strength has improved physical health and better social relationships (Lundman et al., 2012), perhaps the promotion of support services that enhance inner strength among PCa patients would be beneficial in the course of illness.

Literature revealed that providing spiritual care facilitates effective coping hence curbs depressive symptoms and improves overall adjustment to ill-situation (Gonzalez et al., 2014). Also, spirituality enhances a sense of purpose, peace, meaning in life, and relationship

(Edwards, Pang, Shiu, & Chan, 2010). Results from Gonzalez et al. (2014) study indicate that spiritual well-being can be an asset to cancer survivors as it can serve as a buffer against stress and maladaptive coping. Moreover, Gonzalez et al. (2014) recommended the consideration of spiritual well-being in clinical practice to bolster the quality of life in cancer survivors, particularly their psychological well-being.

2.2.5 Coping Strategies of Unmarried Men with Prostate Cancer

Addressing the psychological, social and physical needs of patients with PCa, presents a challenge to health care professionals, especially nurses, who per the nature of their work, spend a greater part of their working time with patients when they seek healthcare (De Sousa, Sonavane, & Mehta, 2012). As a result, LeSeure and Chongkham-ang (2015) placed much emphasis on the value of support from family and friends in rendering health care to PCa patients. This is very important because a spouse may represent an economic advantage and may help men with PCa to acquire knowledge, process important information, and provide them with practical assistance and care (Li et al., 2013). More recently, Chambers et al. (2018) indicate that partners are the main source of emotional support and physical care for their spouses.

The socioeconomic and psychological effects accompanying prostate cancer, and its coping strategies employed by men with this condition are very crucial. Coping with the disease as understood by men is the mobilization of psychosocial resources, requires adaptive responses to deal with the stress arising from the illness (Ferrão et al., 2017b). Coping may involve “external (e.g. information seeking, engaging social support networks) and internal (e.g. humour, cognitive re-framing) strategies” (Taylor & Stanton, 2007).

Wenger and Oliffe (2014) indicated that, across the types of cancer, males adopt several strategies that can be categorised as “fortifying resources (knowledge building and physical strengthening), maintaining the familiar (e.g. shield others from distress), or getting through (e.g. restricting emotion)”. Several coping strategies had also been narrated among men with PCa precisely (Green, Wells, & Laakso, 2011). More recently, Wittmann et al. (2017) recommend that selecting coping strategies has multiple processes such as identifying potential coping strategies, self-goals, and severity of the condition. Coping is also vital in regulating emotions and solving problems, and given the role of coping, unmarried men, particularly those who lack social support, may have a higher risk for coping effectively and its related morbidity.

Several studies examined coping styles and how these styles could be inculcated in the context of the diagnosis of prostate cancer. Avoidance, minimisation, and withdrawal have been reported as key coping strategies adopted by men with prostate cancer (Spendelow, Joubert, Lee, & Fairhurst, 2018). The strategies attempt to assist men to avoid confronting the psychological consequences of PCa. In other studies, avoidance strategies were reported to involve distraction (McSorley et al., 2014) and alcoholism (Hanly et al., 2014). Avoidance of the condition involved not engaging with searching for the information and Hanly et al. (2014) found out that some participants reported that they did not read the information on their condition. In other studies, some participants mentioned “minimisation” of symptoms and “not wanting to make a big deal” out of their condition (Eziefula, Grunfeld, & Hunter, 2013) and avoidance of social contact (Hedestig, Sandman, Tomic, & Widmark, 2005a). This was discussed by other researchers and termed as ‘withdrawing into themselves’ (Appleton et al., 2015), ‘emotional distancing’ (Levy & Cartwright, 2015), or ‘going it alone’ (Kazer et al., 2011).

Additionally, other strategies adopted to cope with PCa involved efforts to consciously reframe how the symptoms were observed. This mainly involved describing PCa symptoms as normal consequences of ageing, rather than completely part of a condition (Appleton et al., 2015; Dieperink, Wagner, Hansen, & Hansen, 2013; Gannon, Guerro-Blanco, Patel, & Abel, 2010). For instance, according to Gannon et al. (2010) some participants viewed ED as a result of old age. Hence, others struggled to shift spouse priorities in the relationship away from sexual contact and viewed their spouses as their best friend (Hagen, Grant-Kalischuk, & Sanders, 2007). Some men narrated emphasis the benefits of treatment (Appleton et al., 2015) and adopting a positive approach towards prognosis (McSorley et al., 2014) as ways to cope with side-effects of treatment. According to Kazer et al. (2011) participants rely positively on the health professionals and placing their clinical competences in faith (Kazer et al., 2011). However, shared support and continues acquaintance with peers with similar conditions was an important source of social support (Öster, Hedestig, Johansson, Klingstedt, & Lindh, 2013). Consequently, it is worth noting that self- reported coping strategies such as “acceptance” as well as “positive reframing” have consistently been linked with the benefit that the PCa patient will gain (Pascoe & Edvardsson, 2016).

Again, directing cognition and attention among men with prostate cancer has been identified by other researchers. This involves efforts to orientate, direct, and or positively reframe thoughts about PCa. These strategies influence perception and create a positive attitude both at present and in the future. In terms of attitudinal, some researchers reported strategies such as “think positively”(Appleton et al., 2015) and ‘waiting hopefully’ (Maliski, Rivera, Connor, Lopez, & Litwin, 2008). However, Wenger and Oliffe (2014) indicated that men with prostate cancer use strategies that can be grouped as “ ‘fortifying resources’ (knowledge

building and physical strengthening), ‘maintaining the familiar’ (e.g. shield others from distress), or ‘getting through’ (e.g. restricting emotion)”. Green et al. (2011) also reported strategies as creating a relationship between coping strategies and disease outcomes. Specifically, Tosoian et al. (2015) recommended strategies such as “approach (seeking information, acceptance, positive reappraisal), problem and emotion-focused (seeking practical support, humour)” all linked with favourable psychological outcomes.

Matheson et al. (2016) suggested that adjustment in men with prostate cancer relies on the extent to which they can negotiate two key transitions labelled “gaining a sense of perspective over threats to testicular cancer” and “striving to get on with life and restoring normality”. Subsequently, success in the adjustment with the first transition phase was said to involve strategies such as “reflecting on positive meaning, positive reframing of cancer threat, active support seeking, and more flexible adherence to masculine values (amongst others)” (Spendelov, et al., 2018). The next transition was categorised into actions such as “normalising bodily changes and resuming pre-illness occupational and social roles”. Thus, “acceptance and positive reframing” have been linked to the benefits in PCa (Pascoe & Edvardsson, 2016).

Studies in Canada (Carter et al., 2011) and Scotland (Paterson et al., 2017) have previously highlighted the persisting support services gap for men with advanced PCa and suggested more qualitative research elucidating men’s experiences is needed if we are to develop effective supportive care interventions.

Coping is a dynamic state of adjustment which is based on what it is intended to, given that the condition and the effects change throughout survivorship. The need to cope with the diagnosing of PCa is not peculiar to the experience of unmarried men. A multiple approach is desired to appreciate the impact of PCa among blacks. Studies indicated the impact of stigma

and psychological wellbeing on the outcome of being diagnosed with PCa (Jones, Steeves, & Williams, 2010; Penedo et al., 2013). Complications such as incontinence of urine, and sexual dysfunction after treatments, can also have an adverse effect on the patient's quality of life. It is essential to assess the issues associated with PCa treatment, as the number of survivors has increased over the past 25 years (DeSantis et al., 2014).

2.3 Summary of Literature Review

In summary, the comprehensive literature review focused on the experiences of unmarried men with PCa. The review covered physical wellbeing, social wellbeing, psychological wellbeing, spiritual wellbeing, and coping strategies of men with PCa. Both qualitative and quantitative research articles that are current and related to the current study were considered for review. Though the focus of the study is on unmarried men, the literature on the experiences of men with PCa, in general, was reviewed due to paucity of literature on unmarried men specifically, both locally and internationally.

From the literature reviewed, the effects of PCa on men, in general, are widely studied and well documented. The review showed that men with prostate cancer experienced physical experience (pain, fatigue, erectile dysfunction, rest and sleep), psychological experiences (anxiety, depression, distress, suicidal ideation) and social experiences (Family distress, work related activities, isolation, finance, spousal support). The spiritual wellbeing (religiosity/spirituality, inner strength, transcendence) of men with prostate cancer was reported by some researchers. Despite the availability of significant studies on the topic under review, literature in the Ghanaian setting is almost non-existent. A thorough search for literature on a wide range of search engines did not yield any results of a study on the experience of unmarried men with PCa in Ghana.

CHAPTER THREE

METHODOLOGY

This chapter outlines the methods used in this study. It presents the research design, the study setting, target population, sample size and sampling technique, inclusion and exclusion criteria. In addition, this chapter describes the data collection tool and data collection procedure, data management and analysis, methodological rigour and ethical considerations.

3.1 Research Design

Research designs are strategies and measures for research that span the decisions from broad assumptions to detailed approaches to data gathering and analysis. According to Parahoo (2014), a research design is a plan, that specifies who, where and when data are to be collected and analysed. Research design can either be quantitative, qualitative or mixed (Creswell & Creswell, 2017); both of which are guided by divergent paradigmatic and philosophical underpinnings. Grove, Burns, and Gray (2012) have posited that a study design must be chosen that is appropriate for the topic being investigated to answer the research questions. Underpinning this statement, a qualitative approach that is exploratory and descriptive was used to explore and describe the wellbeing of the unmarried men with PCa.

Qualitative research is an inductive approach used to gain in-depth information/knowledge about the phenomenon under study. It aims to get a better and deeper understanding of a phenomenon through first-hand experience, truthful reporting, and quotations of actual conversation (Polit, Beck, & Hungler, 2006). Kornhaber, de Jong, and McLean (2015) also explain that qualitative research explores and describes all dimensions of a phenomenon or experience for a better understanding. In exploratory research, the researcher seeks to investigate the full nature of phenomena and provide an insight into the comprehension

of an issue or situation, rather than simply observing and explaining the phenomena (Polit & Beck, 2008). Therefore, the exploratory-descriptive design was considered appropriate for this research as it is a generic design that seeks to explore and describe the wellbeing of unmarried men with PCa.

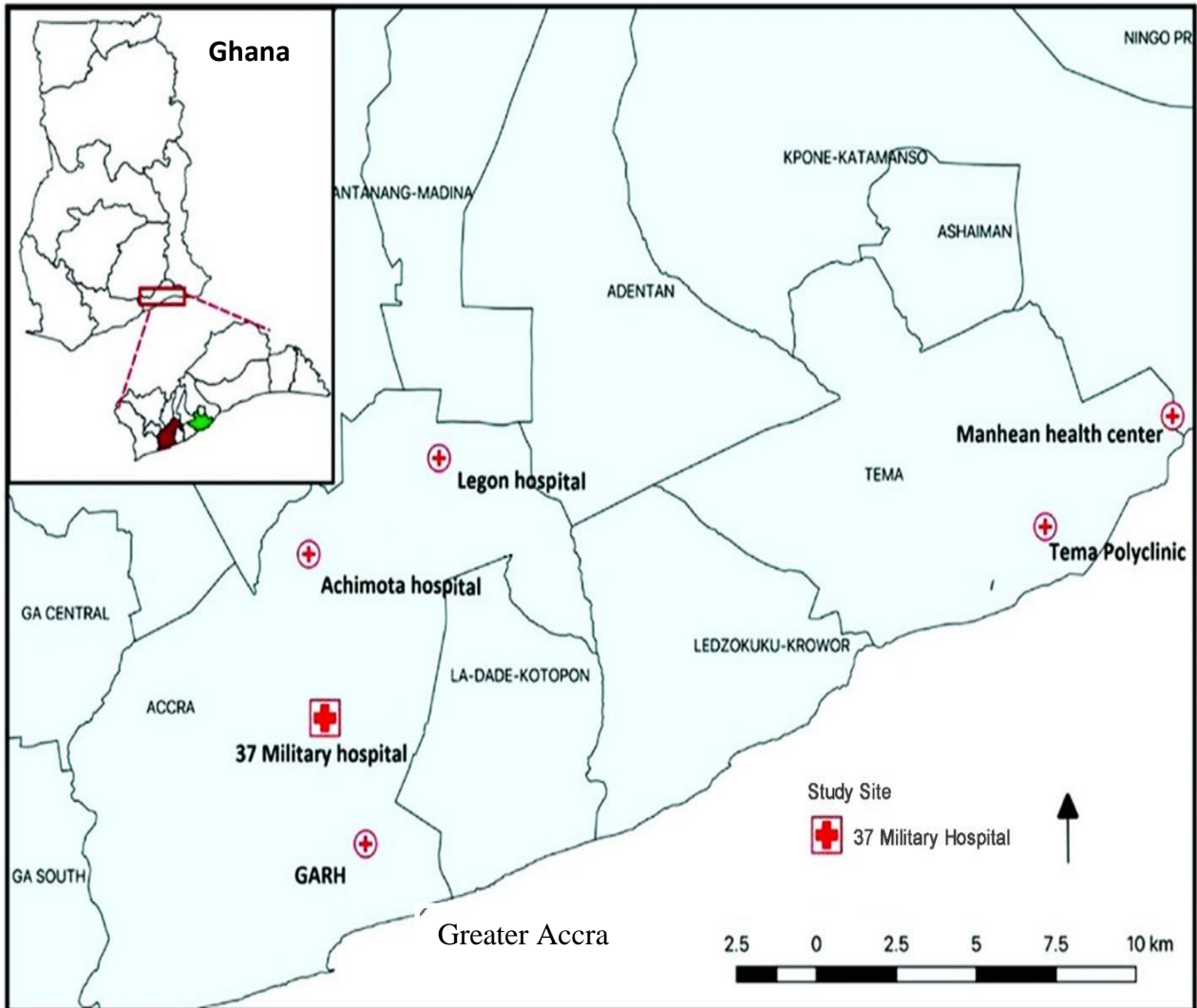
3.2 Research Setting

The study was carried out in the Accra Metropolis that hosts the out-patient's department of 37 Military Hospital as the outlet for recruiting the participants for the study. Accra Metropolis is one of the sixteen Metropolitan Municipal and District Assemblies of the Greater Accra Region of Ghana. It covers a land size of about 173 square kilometres with a total population size of about 1,665,086 people (Ghana Statistical Service, 2014). The Metropolis is subdivided into 11 sub-metropolitan areas namely: Ablekuma Central; Ablekuma North; Ablekuma South; Ashiedu Keteke; Ayawaso Central; Ayawaso East; Ayawaso West-Wuogon; La, Okaikoi North; Okaikoi South; and Osu Klottey. The housing facilities within the metropolis is classified into three: the low income, middle income, and high income areas (Ghana Statistical Service, 2014).

The main indigenes of the metropolis are Ga; however, nearly half of the population in Accra are migrants from other parts of the country with diverse ethnic characteristics and cultures, making the city cosmopolitan. Apart from the Ga language, other languages such as Ewe, Adangbe Hausa, and Twi are spoken by people in the Accra Metropolis. Ghana's premier University (University of Ghana) in addition to other state and private-owned educational facilities are located within the metropolis. With regards to health, there are several health facilities in the metropolis including government, quasi-government, mission, and private facilities which provide healthcare services.

The 37 Military Hospital is one of the quasi-government hospitals in the Accra Metropolis and is a 400-bed general hospital situated about 4 Kilometers from the Accra Kotoka International Airport on the main Airport-Accra-Central Road (Independence Avenue Road) in the Accra Metropolis. The Hospital is centrally located and very accessible from every direction by vehicle. In the event of air evacuation of patients, it is the most convenient health facility in the country by its close proximity to the Kotoka International Airport.

It serves as the Government's Emergency and Disaster Hospital and the United Nations Level IV Hospital in the West Africa sub-Region. It provides health care services to several International Organizations and NGOs operating in Ghana and West Africa in general. It serves as a referral centre and receives referrals from all parts of the region and beyond. The facility provides a wide range of services including general outpatient department service, radiology, physiotherapy, emergency recovery/casualty services to its clients including those with cancer.



Source: Nuvey et al. (2018)

Figure 3.1: Map of Greater Accra region showing 37 Military Hospital

3.3 Target Population

The target population for the study was the unmarried men with PCa living in the Accra Metropolis.

3.3.1 Inclusion Criteria

According to Caldwell, Henshaw, and Taylor (2011), the establishment of inclusion and exclusion criteria increases the precision of a study and strengthens evidence produced. In this study, PCa patients who had never been married in their entire lives, those who are divorced or widowers and un-partnered were all included.

3.3.2 Exclusion Criteria

- a. Men with PCa who were seriously ill and on admission.
- b. Men with PCa who are mentally challenged.

3.4 Sample Size and Sampling Technique

Ideally, every researcher would want to study the whole population to get the view of every single individual who qualifies to be part of the study. However, it is usually impossible to do this; hence the need to choose a sample from the population. According to Gerrish and Lacey (2010), a sample is a subset of a target population, which is typical of the population itself. In this study, the researcher recruited 10 participants for the study but data saturation was considered when all leads had been followed and no new data was emerging.

The selection of the sample size was done by a non-random sampling technique. Specifically, the purposive sampling method was used to recruit the participants. Purposive sampling involves the handpicking of the cases to be included in the study based on the researcher's judgment of typicality or possession of particular characteristics being sought

within the population (Tansey, 2007). Before participants were recruited for inclusion, they were referred to the researcher by the Urology consultants after being seen at the OPD consulting room. Verbal consent was sought and their names, together with their telephone numbers, were then collected. The researcher then contacted the participants and discussed the purpose of the study with them through the information sheet prepared and those who were willing to participate were recruited. Purposive sampling technique was considered appropriate for this study. Participants were interviewed to elicit an in-depth understanding of their experiences until the tenth participant (saturation) where data collection was halted (Bowen, 2008).

3.5 Data Collection Tool

A semi-structured interview guide (Appendix C) was used to guide the in-depth interviews. The guide had two sections: Section A captured the participants' demographic data including their age, level of education, occupation, place of residence, marital status, number of children, religion, language spoken, duration of the disease as well as the type of treatment they were undertaking. These helped the researcher to establish rapport and describe the participant's characteristics. Section B was developed based on the constructs in the theoretical model for the study, the QOL-ATCS and in tandem with the study objectives. It consisted of open-ended questions that explored the participants' wellbeing with the disease. The semi-structured interview guide was used for data collection because it allowed the researcher to explore/probe participant's wellbeing about the phenomenon (Ritchie, Lewis, Nicholls, & Ormston, 2013). Additionally, data that was not verbally articulated such as facial expressions and mannerisms were captured in a field notes book during the interviews.

3.6 Data Collection Procedure

Prior to data collection, ethical clearance was received from the Noguchi Memorial Institute for Medical Research (NMIMR) (Appendix E). An introductory letter from the School of Nursing and Midwifery of the University of Ghana, permission was also sought from the Institutional Review Board of 37 Military Hospital which is the recruitment outlet (Appendix F). Potential participants were identified through the assistance of the staff at the outlet and the researcher offered an overview of the study to them. Subsequently, the venue and time for the interview sessions were agreed upon with the participants who voluntarily accepted to participate in the study. Potential participants who agreed to participate in the study were required to sign or thumbprint a consent form (Appendix B) to which they reserved the right to withdraw from the study at any point in time they wished to do so.

In each interview session, participants' demographic data were confirmed directly from participants and/or their folder before the main interview. To ensure a conducive atmosphere and free expression of participants' feelings, flexible open-ended and descriptive questions, as well as intentional silence during the interview, was employed. Further probing was done to obtain detailed information to better understand the participants' wellbeing. The interviews lasted between 30 – 50 minutes. All the interviews were also audio recorded with an electronic audio recorder after participants consented to it.

3.7 Piloting Interview Guide

The interview guide was piloted at the Accra Regional Hospital (Ridge) with two unmarried PCa patients who meet the inclusion criteria, after seeking permission from the hospital management (Appendix D). These men were contacted with the help of the Urology OPD nursing staff. This exercise helped to ascertain the clarity of the questions in the interview

guide and also determined whether the questions sought to answer the research questions. The details of the study were explained to the identified participants who met the inclusion criteria. Those who were willing to participate in the pilot study then signed a consent form and a schedule for the interview based on their preferred time and venue was agreed on. These interviews were recorded electronically and transcribed verbatim, and the common concepts from the participants were used to improve the clarity of the questions in the interview guide for the main study. This pilot study was not added to the main participants of this study but was added to the research.

3.8 Data Management

Qualitative data management is aimed at organizing and storing data in a manner to enhance easy accessibility and interpretation of the data collected (Ritchie et al., 2013). The researcher used NVivo in assisting in data analysis. The researcher assigned numbers (001 – 010) to the participants in order of their recruitment into the study. Pseudonyms (local Ghanaian names) were later used to replace the numbers. The interviews were conducted in the English language interspersed with the Twi language. Soft copies of the transcripts data were saved on a password protected computer and external drive. The hard copies of the information obtained from participants were labelled and kept by the researcher, and the supervisor at her office.

3.9 Data Analysis

Section A which captured the participants' demographic data was analysed using descriptive analysis, putting the items in the range and finding the average age. Both manual and Computer based data management software (NVivo) was used to manage and assist in data analysis. It was first done manually with my supervisor for adequate understanding before the use of the NVivo. Interviews conducted in English were transcribed verbatim while those

conducted in Twi were translated into English based on the understanding of the researcher and crosschecked by an expert in the Twi language for accuracy. However, participants' confidentiality was ensured; hence participants' identity was not disclosed to the expert in the process. Each interview was read and re-read and given a unique code from the starting, for easy identification. Soft copies of the transcripts were saved on a password protected computer and an external hard drive while the hard copies and the signed consent forms were kept separately under lock and key by the researcher. Data analysis was done concurrently with data collection. As indicated by Vaismoradi, Turunen, and Bondas (2013), this will help improve upon the depth and quality of the interview as the initial analysis will provide some direction in the subsequent interviews. The data was categorised in themes and content analyses were used to analyse the data.

3.10 Methodological Rigor

According to Gerrish and Lacey (2010), rigor in qualitative research refers to how strong a body of research is, in terms of confirming that all procedures have been followed judiciously and that the reader judges conclusions to be dependable or trustworthy. To ensure trustworthiness in qualitative research, credibility, transferability, dependability, and confirmability were identified as the major criteria by Lincoln and Guba (1985).

3.10.1 Credibility

Credibility explains the extent to which participants and readers of the research identify the phenomena described in the research as reality or some instances similar to their own experiences (Houghton, Casey, & Shaw, 2013; Lincoln & Guba, 1985). To ensure credibility, the interview guide was pretested among two patients who met the inclusion criteria. This allowed the researcher to make necessary modifications to aspects of the interview guide that

seemed not to elicit responses that are relevant to the study. Additionally, a purposive sampling technique was employed to ensure only participants who could give a vivid account of their experiences were recruited. Probing and iterative questioning was also used to elicit responses from participants and situations where there were ambiguities in the responses; clarifications were sought from the participants.

3.10.2 Transferability

This refers to the extent to which the results of a study can be applied to other similar contexts or settings (Lincoln & Guba, 1985; Shenton, 2004). In other words, transferability means that the research findings can fit into other contexts outside the study situation and when readers regard findings as meaningful and find it applicable within their contexts and experiences (Koch, 2006). To achieve this, the research process was described in detail so that others can evaluate the applicability of data to other contexts and settings. Records of the transcribed interviews and the analysis, as well as the results of the study, were kept for audit trail.

3.10.3 Dependability

It refers to the extent to which similar studies in the same context using the same method among the same participants yields similar results over some time (Shenton, 2004). To ensure dependability in the study, a semi-structured interview guide was used for all the interviews to ensure consistency in the line of questioning among the participants. Again, a detailed description of the study design, sampling method, data collection, and analyses were as well documented.

3.10.4 Confirmability

Confirmability concerns with the degree to which the findings of a study can be re-established or authenticated by others. It is to ensure that the researcher's beliefs and assumptions do not influence the interpretation of the data collected (Houghton et al., 2013). To ensure confirmability, the context of data collection was documented in a field note during the interview. This enhanced interpretation of the data during analysis to reflect the exact responses of the participants. The researcher also bracketed his experiences and presuppositions to avoid any influence in the interpretation and analysis of the data.

3.11 Ethical Considerations

Ethical considerations are important aspects of the research process. The ethical principles underlying research are general and concern issues such as privacy, anonymity, confidentiality, honesty, and respect for fundamental human rights (Winter & Munn-Giddings, 2001). In conducting research, the principles of confidentiality and the provision of appropriate information about the research must also be maintained (Fouka & Mantzourou, 2011). In view of this, the research proposal was submitted to the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, and ethical clearance was given prior to data collection. Additionally, a letter from the School of Nursing and Midwifery, University of Ghana was submitted to the commander of 37 Military Hospital, and ethical clearance was also given by the IRB to conduct the study in the facility. The participants recruited were assured they reserved the right to withdraw from the study they so wished. They were assured it will not affect the care they received in the hospital would not be affected. Unmarried men with PCa who met the inclusion criteria and agreed to avail themselves were allowed to sign or thumbprint the consent form. The principle of anonymity and confidentiality was also adhered

to; hence, the identity of participants was not a requirement during the interview and the information provided is strictly confidential. The researcher assigned numbers (001 – 010) to the participants in order of their recruitment into the study and later replaced them with pseudonyms (local Ghanaian names). The researcher informed participants that the research will identify their wellbeing and the various coping strategies, and that would be used by the health professionals especially nurses to improve their care. Moreover, the participants were assured that in case of any risks, a professional psychologist will be called upon to see them at no cost to them. None of the participants were referred to the psychologist since no participants experienced psychological risks while sharing their wellbeing. Finally, participants did not enjoy any direct benefits, nonetheless, their wellbeing shared would inform Health professionals to give holistic care to unmarried men with PCa.

CHAPTER FOUR

FINDINGS OF THE STUDY

This chapter presents the findings of the study. These findings have been organised into themes in relation to the constructs in the Quality of Life (QOL) Model Applied to Cancer Survivors (ATCS) which was used as the theoretical framework for the study, and the objectives of the study. The findings presented here represent the product of in-depth interviews obtained from unmarried men with prostate cancer in the Accra Metropolis. Content and thematic analysis were used, five (5) themes emerged which were physical wellbeing, psychological wellbeing, social wellbeing, spiritual wellbeing, and coping strategies. These themes and their corresponding sub-themes are presented with verbatim quotations from the participants in the study using their pseudo-names. The chapter also describes the demographic profile of all the participants.

4.1 Description of Study Population

The study participants were ten (10) in number and between the ages of 55 and 80 years. In terms of the level of education, five (5) participants had education up to the university level, three (3) had polytechnic level, one (1) was secondary school level and one (1) was basic school level. Nine (9) participants were Christians and one (1) was a Muslim. All participants had children ranging from two to seven. Out of ten participants, one (1) had seven children, two (2) had two children and another two (2) had five children. The last two (2) participants had four and three children respectively. Eight (8) participants were government workers and are on retirement but two (2) of them were engaged in consultancy work before the onset of the condition. The other two (2) participants were self-employed and were still engaged in active service. All of them speak English and Twi and some of them also speak Hausa, Ga, Ewe, and

Larteh. The participants have been with the condition between one to ten years. Nine (9) participants were managing their condition with medications and only one (1) had surgery done.

4.2 Organisation of the Themes

The study used thematic content analysis and five (5) major themes emerged from the wellbeing of unmarried men with PCa. The five major themes that emerged are physical wellbeing, psychological wellbeing, social wellbeing, spiritual wellbeing, and coping strategies. Out of the five themes, four of them (physical wellbeing, psychological wellbeing, social wellbeing, spiritual wellbeing) were consistent with constructs of the Quality of life model for cancer survivors which served as a guide for the study. The other theme (coping strategies) was an additional finding to the model and emerged from the content analysis of the data. A total of twenty three (23) sub-themes were identified and categorized appropriately under their respective major themes. Table 4.1 presented the details of the major themes and subthemes.

Table 4.1: Organisation of Major Themes and Sub-themes

Major Themes	Sub-themes
1. Physical wellbeing	<ul style="list-style-type: none"> • Fatigue • Rest and Sleep • Pains • Erectile function • Edge for sex • Catheterization
2. Psychological wellbeing	<ul style="list-style-type: none"> • Anxiety • Depression • Distress of diagnosis and control of treatment • Suicidal ideation
3. Social wellbeing	<ul style="list-style-type: none"> • Family distress • Work related activities • Roles and relationships • Isolation • Finance • Affection and sexual function • Spousal support
4. Spiritual wellbeing	<ul style="list-style-type: none"> • Religiosity • Meaning of Illness • Hope
5. Coping strategies	<ul style="list-style-type: none"> • Lifestyle modification • Social contact • Acceptance

4.3 Physical Wellbeing

Participants narrated their physical wellbeing based on their experiences from the onset of the disease process through to the treatment administration. The physical wellbeing of the participants depended on the number of years the participant had lived with the condition, early detection of the condition, the type of treatment being received and the adherence to the treatment. The subthemes that emerged from the physical wellbeing were Fatigue, Rest and Sleep, Pain, Erectile function, Urge for sex, and Catheterization.

4.3.1 Fatigue

Fatigue is one of the concepts under physical wellbeing. The study revealed that fatigue is a common experience among men with PCa; with different factors accounting for this experience. Waking up at night to urinate (nocturia) led to the experience of tiredness as four of the participants narrated their ordeal.

“I urinate four times but now two times, but when I drink more water then I urinate three times. I sometimes felt tired of those times...” (Akwasi).

“I sometimes felt tired but now I am a bit ok. I try as much as possible to go to work, I tie the urine bag on my thigh which enables me to be able to work, or sometimes I put it in my pocket” (Yaw).

“The condition did not make me feel tired, but the urinating four to five times in the night, which reduced my sleep time made me feel very tired” (Kwabena).

The intake of medication (treatment regimen) was also identified to be associated with the experience of fatigue as some participants narrated that they were tired of taking medication since they were diagnosed with prostate cancer.

“...I was put on medications but the retention continued and I was still taking the medications for over 7 years was later changed to injection. I feel tired especially because of taking medications for this prostate. I wish I would be cured soon” (Kwasi).

“I was put on medications and after taking it for some time now. I am tired of the condition and taking the medicine” (Jojo).

Additionally, pain resulting from the retention of urine also led to the experience of fatigue as narrated by one participant.

“When I had the urge to urinate, I felt sharp pains and then tired of this pain. Am sometimes relieved when I take paracetamol” (Yaw).

Consequently, the experience of fatigue limited the movement of some participants and confined them to their homes.

“My movement is limited. I feel very tired and if I walk like 30 minutes I get very tired” (Akwasi).

“The urine flow little at a time with severe pains and I felt very weak and could not do anything which really limited my movement, I could not go anywhere, was always at home” (Kwame).

4.3.2 Rest and Sleep

Inadequate rest and sleep was a common experience in the study as most participants disclosed that they were not able to sleep well, leading to inadequate rest. The experience of difficulty in sleeping (insomnia) was as a result of frequent urination (polyuria) in the night. Two participants narrated how frequent urination affected their sleep.

“The urine comes very frequently and it affected my sleep. When I feel like urinating I have to go to the washroom. I go to the washroom several times, at times I have to go like four times” (Kwabena).

“In fact, my main problem was the urinating at night which was at times about four to five times. You go to the urinal and urinate and within a short period after coming back to bed and you go and urinate again as if there is residual

urine in the bladder. At times too when I go, it's just a little urine that comes"
(Fifi).

It is worth noting that their experience of polyuria which resulted in difficulty in sleeping was due to excess drinking of water at night before sleeping.

"I usually take water around 8 pm before I sleep and urinate a lot about six or seven times in the night, but now at least about four or five, that's my problem"
(Kwasi).

"First because of the frequent urinating, I am not able to sleep. I urinate four times but now two times, but when I drink more water at night than three times"
(Akwasi).

To ameliorate the experience of sleeplessness, some participants tried to reduce the frequent waking up at night to the washroom by getting a chamber pot (urinal) beside the bed to reduce the movement.

"I cannot even count the number of times I urinate in the night. When I drink water about 500mls around 8 pm, then no sleeping throughout the night. I have to get a chamber-pot so that it will limit my frequent movement to the washroom"
(Jojo).

However, having a urethral catheter in situ was the solution to the experience of inadequate sleep and rest as espoused by some participants. Two participants said they were able to sleep because they had a catheter in situ connected to a bag, therefore no need to wake up to urinate at night, but only need to empty the bag when full.

"I do have enough sleep now because the urine flows into the bag, but before the bag, I urinate three to four times at night which affected my sleep. It was really worrying me but now unless the bag is full that I wake up at night to go and empty it"
(Yaw).

"... With the catheter inserted now, it has saved me from the frequent waking up and urinating at the night, so I can sleep now"
(Jojo).

4.3.3 Pain

The experience of pain was commonly reported by participants in this study, which was largely due to urine retention. Some of the participants shared their experience of severe pain resulting from urinary retention.

“I always feel severe pains when I feel like urinating and the urine was not coming” (Kwasi).

“The penis pains me especially when I feel like urinating. I learned the prostate is blocking the penis and prevent the urine from flowing” (Yaw).

“I sometimes experience very severe pains during urine retention when I feel like urinating” (Jojo).

The experience of pain was also associated with ejaculation during sexual intercourse as one participant disclosed how he felt the pain after he had ejaculated. However, the pain diminished after the commencement of medication.

“...Sometimes when I ejaculate, I feel the pain but now I don't feel pains again because of the injection I am taking” (Akwasi).

These narrations illustrate the magnitude of the pain experienced by prostate cancer patients. The experience of severe pain, which is a consequence of urine retention led to the hospitalization and urethral catheterization or suprapubic puncture among some participants in this study.

“Because of the severe pains I am always rush to the Hospital Emergency for treatment. They insert a tube through my abdomen. Sometimes I spend two or three days before being discharged” (Kwasi).

“The urine was not flowing and I was feeling severe pain, so we came to 37 Military Hospital Emergency and they tried to pass catheter but it was blocked, but later they have to force and pass the catheter and since then, the urine has been flowing” (Yaw).

The experience of pain before, during, or sometimes immediately after passing urine was also revealed by some participants in this study. However, the pain subsided after they were put on medication.

“I was also feeling pains at first but now I don’t feel pains. Then, before I urinate I have to suffer before it comes with severe pain. From the time I started the injection, it has come down” (Akwasi).

“The penis pains me when I feel like urinating. I learned the prostate is blocking the penis and prevent the urine from coming. Sometimes I feel a sharp pain in my penis but when I started taking the medicine for two weeks the sharp pain has reduced but if I want to urinate, the urine will come small and in drops” (Yaw).

“I felt pains in the penis when I felt the urge to urinate and after, which radiated to my back (pointing the waist) and then the whole body. It was very hectic pains. I did not know this can lead to pains like that. I have gone through ‘hell’ (a showing sad face). This has reduced when I started taking the medications” (Kwame).

4.3.4 Erectile Function

Erectile dysfunction is one of the concepts of the physical wellbeing of men with PCa. This was widely experienced in this study as all the participants described their penis as weak and did not feel for sex.

“The strength of the penis is very weak. When the condition started I realised that there was no ejaculation, and I did not even feel for sex” (Jojo).

“For the penis, I just urinate through it without paying any attention to it. I do not feel any strength in it. It does not wake up, I don’t think about sex at all” (Kwadwo).

“There is no strength in the penis. It is definitely weak, because unlike previously that sometimes I do feel small strength, now I don’t feel anything, so don’t think about sex” (Fifii).

The return to normalcy of the penis after treatment was a concern expressed by one of the participants. However, some participants expressed optimism of the return to normalcy of their penis after taking treatment.

“...Also at times my penis becomes small and at times becomes a bit normal, but I feel it is weak. I am alone now so I don't feel for sex, it doesn't come to mind. I don't know whether the strength will come back after cure” (Kwame).

“Yes, I feel an abnormality in the penis. It is not like the first time. Because of the sickness, it has changed, it is not strong but I know because of the injection the strength will come back” (Akwasi).

The findings also revealed a diminished spirit of manhood due to the experience of erectile dysfunction. This was narrated by some participants in the study.

“When I was diagnosed as having PCa, the penis was so weak and I felt I am not a man” (Kwadwo).

“The penis was weak, sometimes I feel it is not working, since it recoils-in, I feel I am not a man as I used to be” (Kwasi).

As may be expected, the experience of the weakness of the penis (erectile dysfunction) also affected ejaculation.

“I think the prostate enlargement has really affected the strength of the penis and that has affected my ejaculation” (Jojo).

“... there is no strength in the penis and I have also not experience having any ejaculation at all” (Fifi).

4.3.5 Urge for Sex

Due to the experience of erectile dysfunction, people with PCa usually have a low urge for sex. In this study, the experience of low urge for sex was largely related to a lack of spouse. Some men revealed how the absence of their spouses diminished their sexual desire.

“Sometimes when I tell my friends I have not gone for sex for the past 8 years since my wife died, they think that I am joking, but I don’t feel like going in for sex...” (Kwasi).

“No feelings for sex, for so many years no sex, because even when my wife was there it was weak, for over 8 years” (Kojo).

“The strength of the penis is weak, as I said my wife passed away 10 years ago and I decided to stay away completely, so I did not have the urge for sex. The urge for sex is completely off my mind” (Fifi).

“For my penis, I can’t remember the last time it got ejaculated, for about a year there is no wife, so I don’t feel for sex and it has not even ejaculated” (Kwame).

Another participant also narrated how hospitalisation reduces his desire to have sex.

“I do not have the urge to have sex, I don’t feel like having sex, especially also when am in the sick bed” (Kwadwo).

4.3.6 Catheterization

Having a urethral or suprapubic catheter in situ is almost always inevitable among patients with prostate cancer. It was revealed that some of the participants were having the catheter in situ which enable them to pass urine to reduce their pain.

“I had urinary retention and I went to Adenta Medimoses centre, where they pass a catheter into my penis, which enables me to pass urine to relief my pains” (Yaw).

“...I was not able to urinate and having severe pains so I had to report to our family doctor who stays close to our house, and he inserted the catheter and connected to a bag. I had to use it for some time before it was removed” (Jojo).

However, some participants narrated that they had to change the catheter frequently because either it had come out from the penis or it linked through the side.

“After they decided to pass the catheter, I was going to the hospital almost every week from home. Sometimes during the day the catheter comes out, and I would be feeling pains on urinating. They then rush me to the hospital emergency very often for the catheter be passed again” (Kwasi).

“Initially when they put the catheter, it developed a fault (urine linking through the side) and I used to urinate into my attire. They pass the catheter again and I used to manage it for about a month before changing it” (Kwadwo).

A participant said he depended on the catheter and the urine bag to be able to urinate, so he had to maintain the urine bag because of the odour, by cleaning it with disinfectant.

“It is only the catheter and the bag that help me to urinate. The urine bag, I do open it and use Dettol to wash it every morning and evening to reduce the scent” (Yaw).

4.4 Psychological Wellbeing

In answering the research question, “*what is the psychological wellbeing of unmarried men with prostate cancer?*” psychological wellbeing was identified as a major theme to describe the psychological experiences of men with prostate cancer. The subthemes include anxiety, depression, distress of diagnosis and control of treatment, and suicidal ideation that emerged as a new subtheme.

4.4.1 Anxiety

Some participants showed anxiety about their condition and the effect it has on the penis. They also expressed worries about the treatment and its cost. The following extracts indicate how some participants narrated their worries about the condition.

“Well, when it was detected that I had prostate, I got worried because everybody knows the effects of PCa, which could lead to a lot of things so I got disturbed” (Fifi).

“I was worried about the condition which made me discuss the condition always with the doctor and my children” (Kwabena).

Worries about treatment and recurrence of symptoms also caused anxiety in this study. Other participants said that apart from being worried about the condition, they were also worried about the treatment and recurrence of symptoms.

“I was afraid of this disease because I was told it was cancer and after the doctor gave me the cancer medicine, my fear became more but I later knew that I would be ok” (Akwasi).

“The retention really took me by surprise after the first one. The second one the doctor didn’t tell me anything about the medication, whether to continue or stop, so I was worried when it happens again” (Jojo).

Another participant was worried about hospitalization because of being detained as a result of urinary retention.

“Since I was born I have not been to hospital before, so that day when I was detained because of urinary retention, I was afraid, so I pray to God and unfortunately nothing happened to me and was able to come home” (Yaw).

4.4.2 Depression

From the findings, the majority of participants expressed the experience of depression. It was observed that some participants expressed their depression being as a result of the frequent urinary retention, severe pains, and catheterization. Others also expressed theirs as being as a result of lack of money. The experience of symptoms such as urine retention also led to the experience of depression.

“The retention really took me by surprise after the first one. The doctor did not tell me about continuing the medication, so I was worried when it happens again. I became very depressed when I experienced urinary retention” (Jojo).

“I was shock and depressed when I was experiencing frequent difficulty in passing urine, so I had to be rush to the hospital for treatment. I thought would never get better until I started the medication and now am better” (Akwasi).

Others too recounted that their depression was as a result of the severe pains they were experiencing due to the urine retention.

“It was bad, the pains were so severe that I was very depressed and I even told my daughter that it is better I die, you could see a man crying. The pains were too much to bear” (Kwame).

Sometimes, human nature, I felt depressed due to the severe pains in the penis. After a few months I became used to the condition and it became like a habit (Kwasi).

Embarrassment from having to be with a catheter in public also led to the experience of depression as recounted by one participant.

“I was so depressed when the catheter was passed by the doctor at my first retention and I had to move around by securing the catheter on my thigh or putting it in my pocket. It was so embarrassing” (Yaw).

One participant was depressed initially as he felt not being a man because of the weakness in the penis but had the hope of getting the strength back after treatment.

“Before I was diagnosed as having the PCa, the penis was weak and I feel I was not a man, so I was depressed till the doctor informed me of getting my manhood back after the treatment” (Kwadwo).

The burden of having to purchase medication, coupled with lack of money also led to depression among some participants.

“If my boss had known about my condition she would not have let me come to work and I need the money to manage my finances. It really disturbed me because I needed to take care of my medications and family. The whole staff are not aware, it was between me and my God” (Yaw).

“The medicines are expensive and as a pensioner, every three months you go and ‘vomit’ 1500gh for drugs. It is not easy and that’s not the only medicine I am buying. I am on diabetic medications too and I had to buy these drugs too. I am not happy at all. I have to squeeze to be able to afford these medicines” (Fiifi).

4.4.3 Distress of Diagnosis and Control of Treatment

From the findings, participants lamented over being sad and disappointed in life when they were experiencing symptoms of PCa and were diagnosed as such.

“It was 2015 that I was finally diagnosed with PCa at 37Military Hospital. I was experiencing frequent urination and pains in my penis, with weakness. I was so sad, seeing a strong man like me suffering like that” (Kwasi).

“About two years ago that I was diagnosed with PCa when I reported to the hospital, and I was disappointed in life but when I came to the Military Hospital and saw other patients I realised mine was ok” (Kojo).

Additionally, others related their distress to local medications but concluded that they felt their symptoms had reduced when they started the orthodox medications.

“I first went for local medicine and did not really work, so I had to end up at the hospital and since I came for the injection I have never taken local medicine again. The injection am taken I know that I will be ok” (Akwasi).

“I was coming to the hospital and they did a lot of examinations and gave me medications but I did not see any improvement. It was later that I chose the injection and was taking it every three months. I started getting better and I have so far taken it for five times” (Kojo).

“I was admitted and the catheter was passed. I was put on medications upon discharge. I realised the medicines reduced all the symptoms and was feeling quite better” (Kwasi).

4.4.4 Suicidal Ideation

The findings from the study revealed that some participants contemplated suicide due to the experience of symptoms and some other complications of the disease. They thought it was better for them to die than live with pains or without their manhood. Three participants narrated their ordeals.

“My pains were so severe that it was bad. I could not do anything, was always in the house. You could see a man crying. The pains were too much to bear. At times I tell my daughter it is better I die” (Kwame).

“The pains were so severe that it radiated from the penis to the waist and if I stand for a long time as if my knees cannot support the weight. I felt like leaving this world of body pains everywhere” (Fifi).

Additionally, a participant expressed his suicidal ideation as;

“The penis was so weak that I felt I could not perform like a strong man again. I was worried and sometimes I was wondering if it is better for me to die than to deny myself of sexual intercourse...” (Kwadwo).

4.5 Social Wellbeing

This section answered the research question “*what is the social wellbeing of unmarried men with PCa*”? The sub-themes that were identified are; family distress, work related activities, roles and relationships, isolation, finance, affection and sexual function, and spousal support.

4.5.1 Family Distress

With regards to family distress, all the participants revealed the absence of their spouses as the major reason for a shift of responsibilities to their children. They reported that the condition had great distress on their family which their children had to leave their homes and work to care for them.

“After the insertion of the catheter, it was then that my daughter has to leave her house and work, and send me to the hospital almost every week from here (house far from the hospital). I have to be rushed very often to the emergency. It was a worry, if my wife was around he will have supported me” (Kwasi).

“My main support is my daughter. I know she has really tried because she had to leave her work for her workers and take care of me; my feeding, washing, taking me to the hospital and buying my drugs” (Kwame).

Additionally one of the participants added that his daughter had to move to stay and take care of him because of the demise of his wife.

“The only problem was that (quite for 2 minutes), as I said I lost my wife, and my children are all grown now, and they are all away, so I live alone here. It was quite recently about two years ago that my last daughter opted to come and stay with me and take care of my feeding” (Kwasi).

Some participants reiterated that their children were in distress because they did not have enough funds to support their father’s condition.

“At first my wife used to support me but she is no more and my children are not working, so they are always disturbed that they cannot support me” (Akwasi).

“The children are my only family, and they had to use the little they earn to support me even though it is not enough, it takes care of my feeding. It is not easy all” (Kojo).

Despite the distress, there was enormous support from family members as espoused by some of the participants. Three participants said their children gave them all the support they needed to survive, without any hesitation. Others further disclosed that their children discussed issues of the condition with them.

“Am alright, (quite for some minutes) my children have not neglected me, they contribute always for my upkeep” (Kwasi).

“My family were not worried about my condition, because when I bring the report they read it and discuss it with me. They even explain it to me and

encourage me. We even decided on the choice of treatment together”
(Kwabena).

“My children are grown so they should know about the condition, if they don’t know it, they can be taking by surprise, so as soon as I was diagnosed, I informed them and they also showed their concern and have been given me all their support” **(Fifi).**

4.5.2 Work Related Activities

Even though the majority of the participants interviewed were on pension, some were engaged in other avenues to earn some money to support their pension money, but because of the condition, they are unable to work.

“Now I cannot go to my cocoa farm, because my movement is limited because of the condition. My junior brother is taking care of it” **(Kojo).**

“This condition had limited me. I had a small store around the house when I came on a pension, but now because of the tiredness, I could not go to the store and have to leave it for my worker” **(Kwabena).**

Kwadwo was worried because he only goes to the work place when his services are really needed if not his apprentices do the work.

“It has really affected my work. I had to send my boys to the site (work), and when it is critical I had to take a taxi to the site to go and help. I did not want to lose my customers. I was lucky I had finished with the big projects before the surgery” **(Kwadwo).**

Some participants were more troubled because either their businesses had collapsed or they were not able to work because of ill-health.

“I have spent a lot of my time in Europe, I only came down for business and this condition was detected. My business has collapsed, and I had to sell my house to take care of my hospital expenses” **(Kwame).**

“I retired very strong from the military and then became an engineer at the Ghana Airways, flying up and down everywhere and now I am being pinned down because of this condition for the past two years” **(Kwaku).**

But Kwaku was very hopeful that he would regain his strength and be able to go back to his job.

“...that I can get some strength and be cleared by my doctor to be able to drive to the airport and come back in the evening. I can then go there and work small, just to relief my thinking of this condition. My biggest prayers were that God would take me out of this condition” (Kwaku).

As for Yaw he was able to go to work and had to hide the condition from the boss and colleagues to avoid being sacked from his job.

“Even my work side, they do not know that I have this condition, even my madam who helps me to see the first doctor is not aware of my condition. She does not know I have a catheter on for almost two months. If she knew she would have let me stop work and I need the money to manage financially. It is between me and my God. When I feel like urinating at work, I just go to the urinal and open my trousers to empty the urine bag and dress up” (Yaw).

4.5.3 Roles and Relationship

This sub-theme described the change in roles of the unmarried man because of the PCa and the relationship that has been created between them and their family mainly in terms of finance. All participants were disturbed about the high cost of treatment and house chores and had to rely on their small pension money, family or friends for support. Participants narrated that their sole finance was from their little pension pay.

“Now am a pensioner and not getting money as previous. The money that comes is just from ‘hand to mouth’, and it will be very difficult for me to get the money to buy the injection or do surgery” (Yaw).

“I depend on my pension pay, I use it to buy my injection and other things, and all the time I have at the back of my mind that in a month or two, I have to go

and buy my injection, therefore I have to save. I need money, it's very difficult”
(Kojo).

Three participants further lamented the lack of support from family and friends in the management of their conditions.

“There is no support from any place. My children are not working. Every month I get small money from my pension pay and that is what I use to buy the medicine. No money from any place. No friend to help me. At first, my wife gives me small money but she is no more” **(Akwasi).**

“My extended family member has nothing to give to me, they rather even want money from me. I don't have anything to give to them now” **(Fifi).**

“By God's grace, he said he will supply all our needs according to his riches. I have no support from any family member, even my brother, I was supporting him, but now I can't because of this condition and am also a pensioner” **(Jojo).**

However, financial support from children was revealed by other participants. They narrated how their children are very supportive:

“My children are very supportive and apart from them, nobody is supporting me. The children are my children and if I need something that is within their means they definitely support. They are all working” **(Fifi).**

“One of my sons is working, so he had been helping me small, even though it is not much, he had been sponsoring some few things” **(Kwadwo).**

“My last daughter is the one supporting me fully. I have really put a lot of pressure on her, although am not demanding for it, and her other sisters are also supporting a lot” **(Kwaku).**

Apart from the support they get from their children, others also received some support from their extended family members and friends.

“...Sometimes too some of my nephews together also give me a little money to supplement my medication and personal items. I am always grateful to them” **(Kwadwo).**

“Some family and church members sometimes gives me money especially during occasions and I have two members of the church who gives me 300.00 Ghana

cedis every month to support my upkeep. I don't ask but when they see me at church service they give me the money" (Kwasi).

4.5.4 Isolation

The clinical manifestations of PCa and the stench from the urine on participants' dresses prevented them from participating in social events. However, some were able to manage some events with a catheter in situ. Participants reiterated their inability to attend social functions because of the symptoms of polyuria and weakness.

"I do not go to other people's house or functions because if I feel like urinating and I do not have the diaper on, I have to move out frequently to the washroom to urinate and sometimes I soiled myself which is embarrassing. It has really limited me. I do not participate in the evening activities - evening church service or if you invite me in the evening, I will not come" (Kwasi).

"I used to go out a lot, but now I cannot do that. I used to visit the family people but now I cannot do it, sometimes even in Accra here, I will not go. I cannot afford urinating frequently in somebody's home" (Kojo).

"For social functions I do not have any pleasure in doing that much, except may be somebody very close to me, but if it is my family, I will not go, because since I left my hometown I have never gone there, I have been in Accra throughout and with this PCa, I will not go" (Kwaku).

Jojo added that apart from the frequent urination, sometimes the stench from the trouser is embarrassing.

"Sometimes I wear black trousers, so that other people do not see the trouser being wet with urine, but the problem is the smell of the urine" (Jojo).

A participant said he had to stop travelling because of the embarrassment faced when travelling with passenger vehicles. However, those participants who had a catheter in situ were able to attend social activities and they had to visit the washroom only when the urinary bag is full.

“When it started and when I took a passenger car, they will have to stop several times on the way for me to urinate. I did not like the idea but I had nothing to do because I cannot control that” (Akwasi).

“The time I had the catheter on, when I feel the bag is full I just go to the washroom and empty it, so I was able to go places until the catheter was removed” (Kwadwo).

“With the catheter, it has saved me from the frequent urinating. It has saved me especially when I go to places such as gatherings and church service” (Jojo).

A participant added that he only goes to places where he would feel comfortable.

“Rather now the place I go are the places I really know if I go there and I feel like urinating I easily go and urinate and will not feel bad, so places I do not really know I will not go. For family meetings, I attend because am used to the place” (Fifi).

4.5.5 Finances

All the participants acknowledged that they had some financial burdens. Some participants indicated that financial inadequacy was a big burden to them, creating a lot of financial imbalances. Others had financial assistance from family members, church, friends, and children. Pension benefits were of significant and enormous support to them. Other participants who engaged in their own businesses became insolvent they spent huge sums of money to survive. Some participants disclosed that the high cost of hospital bills and medication triggered their financial burdens. Other participants narrated they had to rely heavily on the financial support of their children for survival.

Participants narrated that they had to depend on their children to support them financially.

“Am fed alright by my daughter, and the other children send their contributions, so am alright. I use part of it to pay my hospital bills and medications, electricity bills and other utility services. I also use some for my fuel and maintenance of the car. I am alright, my children have not neglected me, so I do not feel that the allowances I receive from my church is small” (Kwasi).

“One of my sons is working, so he has been helping me, even though it is not much, he has been taking care of some expenses” (Kwadwo).

“...That is why am saying that about my daughter. I have really put a lot of pressure on her, although am not demanding anything, she buys everything I need, and she makes sure I am happy. My daughter and other sisters are those supporting me” (Kwaku).

Others added that they received some financial support from family members and friends.

“I have really suffered and lost a lot of money. Sometimes too some of my nephews gave me little money to supplement the medications, surgery and take care of myself. Also sometimes my doctor who I have been working for helps me financially. Sometimes when I come to the hospital he gives me some money for medication” (Kwadwo).

“There was one man (petrol dealer) who was supporting me, but I did not want to go to him all the time. Four months ago he gave me 2000.00 Ghana cedis” (Kojo).

A participant also had some assistance from the church.

“My local church normally gives me small allowance about 300.00 Ghana cedis every month to support my expenditure which is supporting me to some extent” (Kwasi).

The high cost of PCa medications and hospital bills was also a serious burden among some participants.

“The medicines are very expensive so every month when my money comes, I keep some and every three months I used it to buy the injection” (Akwasi).

“In fact for the injection unless by God’s grace, I don’t have the money, when I went to ask, its 15million old cedis for every three months. I do not know what to do, thus my problem” (Yaw).

“Financially, the medicines are expensive and as a pensioner, every three months I have to ‘vomit’ 1500 Ghana cedis for drugs. It is not easy and that is not the only medicine I am buying, you have other medicines too to buy. I have diabetes and I have to take control of those drugs too, that is a worried. I have to squeeze to be able to afford these medicines” (Fifi).

Some participants hinted that they do not receive any support from their family members, and even they find it difficult to support those they used to assist financially. Interestingly, it is rather their family members who wish to depend on them for support.

“I have no support from any family member, even this my brother that I was talking about, I was supporting him some times. Now I can't support him again because of this condition and also me being a pensioner” (Jojo).

“For the extended family, they even want from me rather” (Fifi).

“No money from any place. No family member to help me. At first, my wife gives me small money but now she is no more” (Akwasi).

A participant revealed that his business had become insolvent because of the condition.

“My business collapsed, and I have to sell my house and the little that I have. I have to use it my hospital expenses and some family land. All my money is finished” (Kwame).

4.5.6 Affection and Sexual Function

All participants expressed their diminished affection and interest for sexuality especially as they lost their partners. They reported that as their penis was weak and had no strength, the urge for sex was completely out of mind and also their health situation was not conducive for them to even engage in sexual activities. Some participants had lost interest in re-marrying as they see no need to go for a woman in their situation.

The feeling of re-marrying was completely out of the minds of some participants, as they had been staying alone for the past years.

“I don’t have a wife but I have been staying here for 8years. Even during the life time of my wife I was not having much sex with her, so I don’t feel like going in for another woman or that sort of thing. Sometimes when I tell my friends that I have not gone for sex for the past 8 years, they think I am joking, but I don’t feel like going in for sex or perceiving the idea of getting somebody to get married” (Kwasi).

“The strength of the penis is weak, as I said, my wife passed away 10 years ago and I decided to stay away completely from any woman” (Fifi).

Other participants further associated their lack of urgency for sex to the weakness of their external reproductive organs.

“...when it ejaculate, you feel that you need a woman but the feeling for sex is completely absent” (Kwasi).

“For the feeling of sex no no no, for so many years no sex, because even when my wife was there it was weak, so for sex, it is far from my mind. I do not see it as part of my life now” (Kojo).

“My manhood is not functioning; weak and pains. I do not even have the strength for sex and I do not have a woman with me, for me to even think about that” (Akwasi).

“...so I did not have the urge for sex. There is no strength in the penis. It is definitely weak, because unlike previously that sometimes it comes up small, now I do not feel anything. I have also not experience having any ejaculation at all” (Fifi).

Others also narrated that they are not healthy to engage themselves in sexual activities.

“I don’t feel like having sex, especially when am in sick bed. For the penis, I just urinate through it without paying any attention to it. I don’t feel any strength in it. It does not wake up, I don’t think about sex at all” (Kwadwo).

“Initially when my wife was around I even did not have the urge for sex, my concentration was on my condition. Now there is a total loss of pleasure for sex since they introduce the catheter” (Kwaku).

The participants also reiterated that they still did not have the urge for sex even though they had gained the strength of their penis.

“Sometimes I can see that the strength of my manhood is ok, but it doesn't keep long. Since I started having this problem, I have not to try to have sex or think about it” (Yaw).

“...but the catheter was removed, the urge was there but sex was out of mind especially when no wife” (Jojo).

“After the operation, I started feeling it was moving now. It took me a long time before feeling that. The doctor told me it will take some time about nine months before I will feel the strength, but I don't feel like having sex” (Kwadwo).

4.5.7 Spousal Support

Spousal support was an important issue that unmarried men expressed as they lack the support and companion of their wives in terms of finance, discussing the condition, and physical care. Participants recognised the importance of their spouses' support in their life and narrated that no support can be compared to that of their spouse.

“I don't have a wife but as I said I have been staying here for the past 8years. I miss my wife, she provided everything I needed, no support can be compared to my dear wife and we were happily married until she was called by God” (Kwasi).

“Anything I tell my children, they give their contributions, but my wife would have understood me more and also take care of my diet and all other things” (Kojo).

Some participants said that they can discuss much closed information with their spouses.

“As I said it was my wife who even helps me to detect the condition. A partner is always a partner and can discuss intimate relationships and problems with her” (Fifi).

“My wife is not there, only my wife could have given me better support. We share all information and we were so happy” (Kwame).

“My wife is no more, so I do not have that close monitoring of my health, and discussing intimate worries. My wife was the one who told me about the weakness of my penis and complains to the doctor the first time we went to the hospital” (Kwaku).

A number of these participants disclosed that their spouses provided everything that they needed.

“My wife provided everything I needed. She was even having a chemical shop, so any time I run short my drugs she gets it for me immediately” (Kwabena).

“...I miss my wife. She provided everything I needed and we were happily married until she was called by God” (Kwasi).

Others reiterated that they received much support from their daughters.

“I have four children who are all contributing to my health. They are all doing well and taking care of me especially my daughter who is with me and provides everything I need. I don't have a problem” (Kwabena).

“I will say that the earlier I get over this the better. I will say that I have actually worried about my daughter so much. She has a special love for me. She has been with me throughout, she takes me to the hospital always and does everything for me. Making sure I eat three times a day” (Kwaku).

“As I said I lost my wife and the children are all grown, they are all away so I live alone here. It was only quite recently about two to three years that my last daughter opted to come and stay with me, to take care of me. Am fed alright” (Kwasi).

4.6 Spiritual Wellbeing

This theme seeks to answer the fourth research question; *‘How do unmarried men manage prostate cancer disease and treatment spiritually?’* The subthemes were religiosity, meaning of illness, and hope.

4.6.1 Religiosity

A total of nine of the participants were Christians and only one was a Muslim. All the participants sought to express their religiosity in different ways. All the participants had inspirations from God to be able to manage their condition.

“I have never consulted any spiritual leader to pray for me, I only asked God to get me out of this condition, so that I can enjoy my normal life again and I believe he will do it” (Fifi).

“I believe with Christ in the vessel will smile at the storms, therefore by God’s grace the sickness will go” (Akwasi).

“For me, I believe my God and believe this thing that has to happen on me, it’s not me alone, and will get well soon by his grace” (Yaw).

Some participants resorted to prayers since they held the belief that prayer could be of great help to them in terms of finding a cure.

“I have people that I can call them now and they will help but I don’t want to rely on people. I pray to God about it” (Kojo).

“Our God is good and great. I have been praying always and committed my condition in his hands. I prayed on this cancer when I went for the biopsy. I pray that the cancer cells should die of its root and get out of my body” (Jojo).

“I pray over my health every time for God to help me to come out from this situation. That’s my biggest prayers that God will take me out of this. I don’t feel any evil for anybody at all, I enjoy life” (Kwaku).

Support from other colleagues, pastors, and significant others in terms of prayer was also disclosed by some participants in the study. These participants narrated how they are supported in prayers.

“Sometimes my church members come to the house to pray for me and we have a place that we meet in the morning for prayers, so I at times go to the morning devotion. I know God will heal me” (Kwadwo).

“I have not told any spiritual leader about my condition but we pray in our fellowship” (Jojo).

“...but I seek spiritual help, I pray to God, and my pastors too help in prayers, they even come to my house to pray for me. I can’t go to church” (Kwame).

Again, the effects of PCa on the health state of participants did not have a negative effect on religiosity of some participants. As indicated by two of them, their current state of health did not prevent them from attending church to seek God's favour.

“Ever since this thing started over one year, before God and man, I give praise to God, It had not disturbed me for me to say I could still go to church to pray for God's intervention” (Yaw).

“With my condition, I still go to church, thus Methodist/Presbyterian church at Arakan to fellowship with my colleagues and attend men's fellowship meetings” (Akwasi).

However, others could not attend church or go to the mosque due to their state of health. Other further revealed how their religious leaders help them in prayer due to their inability to attend religious functions. Their narratives are presented below.

“Am a Moslem, because of my predicament, am not able to go to the mosque again, but after getting my strength back I will start to go, I miss the mosque” (Kojo).

“I cannot go to church, but I seek spiritual help because even for movement I cannot walk straight, I have to be guided by my daughter” (Kwame).

“...but I seek spiritual help, I pray to God, and my pastors too help me in prayers, they even come to my house to pray for me. I cannot go to church” (Kwame).

4.6.2 Meaning of Illness

From the study findings, it was revealed that all the participants had their own meaning to their condition with inference from their faith. They gave diverse interpretations of their situation. Participants described their situation as spiritual and suspected other people as being responsible for their condition.

“You know when the retention occurred the third time, I thought some people were doing it, so I was suspecting that it might have come from my family or

friends or somebody else, but now I have discarded all those things, it is just a disease” (Kwasi).

“Spiritually, (quite for a minute) any way something can happen and you will think there is an evil thing behind it or something like that. I thought it is spiritual and that my external family in my village were causing it, so some of my pastors have been praying for me” (Kwadwo).

Other participants were of the view that their situation was both physical and spiritual. They expressed confidence in both man and God for a cure as narrated below.

“I know God will heal me and also once am in the hands of Doctor (name), I will be healed. He has been advising me so I know things will get better” (Kwadwo).

“I am a child of God at Restoration Power church at Kasoa. First I was seeking traditional help but I later knew that it was not helping, so I have to seek my God. Sometimes you have to seek those help even though you are for God” (Kwame).

However, other participants believed in God and associated their condition to a natural cause but not spiritual.

“I don’t have it in mind that it is a spiritually cause. For me, I believe in my God, and these things that have happened to me, people have experienced it before. The day I was admitted, I saw three people having the same problem, so I saw it like old man’s condition. I took it as a sickness and I pray to God that as it came, the same way it will go” (Yaw).

“There was no time that I thought this condition was spiritual, if you believe in that, it will affect you. Thinking that the devil is working on me, no. I do not believe that somebody is doing it. God will not allow that. If I die I believe that it is natural, and it is God’s appointed time” (Kwabena).

“I have never thought my condition is spiritual. I know what it is and I know nobody has sat somewhere and thrown something at me. I do not believe in those things. I pray over it” (Fifi).

Furthermore, other participants considered their situation as a test from God.

“I am a little prayerful and am associate pastor. So what is happening I know God is trying to test me, I have that faith and courage and I have been telling myself that, this is not the condition that will send me to the grave, I have made agreement with my creature, that the year that he has given me, I have to spend all, nothing can send me to the grave. It was an agreement I had with God, so this one I know it has come and it will go” (Yaw).

“This is the funniest question about our discussion. Not at all. I believe in my destiny, so I have accepted it and wait to see what God will do” (Kojo).

The only participant who considered his condition as a natural phenomenon was hopeful of healing through a natural process.

“I believe that this condition is man’s disease and every man can get it, so I do not blame anybody. I know the disease has come and it will go like it came”
(Akwasi).

4.6.3 Hope

Hope also emerged as sub-theme under the spiritual wellbeing of participants in the current study. All participants articulated strong faith or belief in God, with some being hopeful for quick recovery from their conditions.

“I have strong faith in my God and believe he has already done it and will be heal from these problems. It is just a matter of time” **(Kwasi).**

“I hope God can help me to cure my condition. I believe in the ultimate God and know he will do it” **(Akwasi).**

Furthermore, some participants hoped for healing from God. Specifically, two participants (Kojo and Jojo) put all their hopes in God and emphasised that they could not rely on a man.

“You see I do not want to put my hope in people, I put my hope in God. I have people that I can call them now and they will help but I do not want to rely on people. I pray to God about it. I do not want to put my hope on my family. I put my trust and everything in God” **(Kojo).**

“I pray for myself and believe God will do it. I put all my trust in God and hope all my effort will not be in vain, I do not rely on man” **(Jojo).**

“The day I met the doctor and was told I needed the prostate injection medication. I went to ask the price which I realise I cannot avoid, but I have faith that my good lord will surely heal me” **(Yaw).**

“If you have PCa, you should not worry, just pray to God and he will cure you. Believe that he is the ultimate healer and he is all you need. I do not worry about some things. I know God is in control. I take my drugs and that is all, am ok”
(Kwabena).

That notwithstanding, there were expressions of hope for a cure from orthodox medicine by some participants. They recounted the benefits of medical and surgical treatment of their condition.

“The surgery was very good, just one month, I have been healed, went to the Central hospital for dressing and just a few days am healed. I think the surgery was better for me. If I had not done it, I do not know what could have happened to me” (Kwadwo).

“I believe as far as treatment process has started I will get better” (Kwame).

4.7 Coping Strategies

Coping strategies were an additional finding in this study. The study identified coping strategies as an additional major theme since the participants sought to describe how they were able to cope and tolerate their condition. The study revealed that, participants employed diverse strategies of coping with their condition. Subsequently, three subthemes were identified; lifestyle modification, social contact, and acceptance. It is worth indicating that the sources of knowledge about these strategies as disclosed by the participants include health care professionals, electronic media, reading books and interaction with peers.

4.7.1 Lifestyle Modification

The majority of the participants developed some lifestyle modification strategies to cope with the urinary problems. They tried to control the stench of urine from the body by wearing diapers, and frequent washing and changing of their boxer pants. Some had to cope with the indwelling urethral catheter when they are out of home and others had to reduce their fluid intake to avoid polyuria. Some participants narrated how they tried to control the stench from their urine.

“...for the past two years, I have been using diapers, which have been helping me to go through this frequent urinating and the stench from the urine” (Kwasi).

“I am wearing diapers because it is not every place I can go that I can urinate. Sometimes when I feel like urinating, by the time I get to the washroom, the urine had to soil my dress and cause severe scent on me. Very embarrassing when in public” (Kojo).

“I have been changing my boxer pants frequently because of the stink. So I have a lot of boxer pants in the house and when I see it has changed colour I burn it. I have really suffered” (Kwadwo).

One participant described how he managed the indwelling urethral catheter.

“... I tie the bag on my thigh or put it in my pocket and I dress up to work and also to the church. For my outing am not limited” (Yaw).

For another participant, reducing fluid intake when going to bed was very helpful to him in reducing the frequency of urinating at night.

“This time around if I don’t take water before sleeping, I urinate like 2 or 3 in the night. Sometimes I urinate only ones around 3 am” (Kwabena).

Another participant also gave an account of how he empties his bladder before and after church service.

“When I go to church I make sure I empty my bladder completely before and church service when going home so that I don’t stop on the way to urinate” (Jojo).

4.7.2 Social Contact

Social contact was another sub-theme that emerged from coping strategies. The majority of the participants had to resort to avoiding social functions as a way of coping with their condition. Some narrated how they avoided social events due to stresses from the condition.

“As much as possible I try to avoid going out to my workplace, funerals, church service, and my hometown, because it is not every place that I can go and urinate and sometimes the urine comes before I get to the washroom” (Kojo).

“It has affected my movement and also now am not doing anything, am not working, being in the house. I do not go to any event to disgrace myself because of the urine” (Akwasi).

“...but when I had no catheter the urine was frequent so because of that not all meetings and funerals that I attend. If I see it is not necessary I do not go. I stay in the house and relax” (Kwadwo).

However, one participant mentioned that he was able to attend social events.

“I go to church regularly and attends all the important events. My church members did not know I was staying very far from the church. Last two years we even went to an outreach program for three months out of home. Our pastor even called me ‘Abrantee’” (Jojo).

4.7.3 Acceptance

The findings from this study revealed that some of the participants accepted their conditions and were able to live a normal life. One participant narrated his acceptance:

“...but now I have discarded all those things, it is just a disease to me now. I am living on with my life” (Kwasi).

Subsequently, some of the participants indicated that the disease is a male condition and one can recover from it. One participant (Kwabena) expressed his optimism of being healed by the medications.

“I believe that this condition is man’s disease and every man can get it, so I do not blame anybody. I know the disease has come and it will go like it came” (Akwasi).

“I do not worry about some things and know God is in control. I take my drugs and that is all, am ok” (Kwabena).

4.8 Summary of Findings

The total number of participants who took part in the study was ten (10) unmarried men with PCa and aged between the ages of 55 and 80years. With the thematic content analysis, five (5) major themes emerged from the wellbeing of unmarried men with PCa. In terms of physical wellbeing, the findings revealed that fatigue, rest and sleep, pain, erectile dysfunction, urge for sex, and catheterization were experienced by participants. These experiences were largely dependent on the number of years participants had lived with the condition, early detection of the condition, the type of treatment being received and the adherence to the treatment. Psychologically, anxiety, depression, distress of diagnosis and control of treatment and suicidal ideation were exhibited by participants. Worries about treatment and recurrence of symptoms and erectile dysfunction caused anxiety among participants. Some participants were depressed as a result of frequent urinary retention, severe pains and having to deal with an indwelling catheter whereas others associated their depression with the cost of treatment and erectile dysfunction.

Additionally, the social wellbeing of participants had to do with family distress, work related activities, roles and relationships, isolation, finance, affection and sexual function, and spousal support. Key among them is the fact that all participants were disturbed about the high cost of treatment and house chores and had to rely on their small pension allowance, family or friends for support. However, some participants lamented the lack of support from family and friends in the management of their conditions. Spiritually, nine of the participants were Christians and only one was a Muslim, hence all the participants had inspirations from God to be able to manage their condition. Some participants resorted to prayers since they held the

belief that prayer could be of great help to them in terms of finding a cure. It was further revealed that all the participants had their own meaning to their condition with inference from their faith.

Finally, the study identified coping strategies as an additional major theme since the participants sought to describe how they were able to cope and tolerate their condition. The study revealed that participants employed diverse strategies of coping with their condition. Subsequently, three subthemes were identified; lifestyle modification, social contact, and acceptance. It is worth indicating that the sources of knowledge about these strategies as disclosed by the participants include health care professionals, electronic media, reading books and interaction with peers.

CHAPTER FIVE

DISCUSSION OF FINDINGS

The study explored the wellbeing of unmarried men with PCa in the Accra Metropolis, using the Quality Of Life (QOL) Model Applied to Cancer Survivors (ATCS) as a theoretical framework. Taking the research objectives and the constructs of the model into consideration, the discussion was organised and presented based on the major themes that emerged from the study: physical, psychological, social, and spiritual wellbeing, and coping strategies. However, a brief discussion of the demographic profile of participants was presented first, and then a discussion of the major themes followed.

5.1 Demographic Characteristics of the Participants

The age range of participants in this study was between 55 to 80 years. This is not surprising because PCa develops mainly in older men and this risk increases significantly after the age of 50 (Perdana, Mochtar, Umbas, & Hamid, 2016). According to Gupta et al. (2015), PCa is generally considered a cancer of the elderly, and the median age of presentation is 68 years. However, the literature on PCa contains reported cases of prostate cancer among men of less than 40 years of age (Hussein, Satturwar, & Van der Kwast, 2015). Principally, the finding of Hussein et al. (2015) may be a consequence of the widespread introduction of prostate-specific antigen (PSA) screening for men at all ages in the western world.

In terms of education, all the participants in the current study had formal education at different levels, with a good number of them (5) attaining education up to the university level. This is probably due to the urban nature of the study setting located in the capital city of the country. In addition, this could probably be attributed to the assumption that educated people are more likely to avail themselves for PSA screening. This is consistent with Haque et al.

(2009) that PSA screening and initiation of therapy are less common among men with lower levels of education and socioeconomic status. Similarly, higher educational attainment was positively correlated with PSA screening (Hararah et al., 2015). However, Turkan et al. (2016) reported some form of illiteracy among men with PCa in Turkey. Since there is a direct correlation between education and knowledge levels of the patients about PCa (Winterich et al., 2009), the participants' knowledge about their condition in the current study is attributable to their educational status.

Moreover, the participants were largely Christians 90% (9) and 10% (1) was a Muslim. This demonstrates that the population of the Accra Metropolis largely practice the Christians faith, which is consistent with figures from the Ghana Statistical Service (GSS) in recent times. According to the Ghana Statistical Service report (2014), the majority of residents in the Accra Metropolis (78.8%) are Christians whereas only 17% are affiliated to the Islamic religion.

Regarding treatment, nine participants were managing their condition with orthodox medications and only one had surgery done. All the participants whose conditions were managed by orthodox medications were on Androgen Deprivation Therapy (ADT). It is worth indicating that the effectiveness of treatment was not revealed by the majority of the participants; nonetheless, two participants lamented the lack of improvement after being on medications for several years. Though the optimal treatment of localized PCa remains controversial (Smith, 2011), primary treatment with ADT is frequent, despite a lack of evidence from clinical trials to support its use as monotherapy for localized PCa (Wong et al., 2009). However, regular monitoring of men with less aggressive PCa, who are older and or have comorbidities is recommended rather than immediate treatment (Shappley III et al., 2009). That notwithstanding, newer types of ADT have been recommended in recent years to manage

advanced PCa that is resistant to traditional hormonal therapy (Beer et al., 2014; Ryan et al., 2013).

5.2 Physical Wellbeing of the Participants

The physical wellbeing of unmarried men with prostate cancer in this study is largely associated with the disease process of PCa and the effects of treatment. The findings from the current study revealed that fatigue resulting from the medication and nocturia are the common experiences encountered among men with PCa. This finding supports other studies where men with PCa experienced fatigue. As reported by Langston et al. (2013), fatigue is a common symptom for men with PCa, particularly those prescribed hormone therapy. Additionally, the long-term effect of ADT among men with PCa includes physical deterioration and fatigue (Alibhai et al., 2015). The association between fatigue and treatment of PCa was further confirmed in a case control study by Nelson et al. (2016), where PCa patients receiving ADT demonstrated a trajectory of worsened fatigue following treatment initiation relative to the control group. Consequently, the experience of fatigue limited the movement of some participants in the study and confined them to their homes.

Pain associated with cancer is one of the most feared effects of the disease and is a major reason for health seeking behaviour and hospitalization among most cancer patients (Boni & Afrane, 2016; Zaki & Hairi, 2014). Participants in this study also reported the experience of pain and sleep disturbances as a consequence of PCa. These symptoms were due to urine retention and polyuria at night respectively. These findings corroborate the findings of earlier studies that reported pain among PCa patients (Dunham et al., 2013; Jain et al., 2015) and sleep disturbance (Hanisch et al., 2011; Van Onselen et al., 2010) as a consequence of PCa. Though participants in this study did not associate their sleeplessness with pain but rather polyuria, the

experience of pain and sleep disturbances seemed to be associated with both sides. According to Lavigne et al. (2011), a disturbed or poor sleep intensifies the experience of pain. Conversely, the influence of pain on sleep quality of patients is enormous (Hong et al., 2014) and cancer patients who experience pain reported interruption in their quality of sleep which is continuous and gets poorer over some time (Krause & Stanford, 2011).

Moreover, erectile dysfunction which is commonly associated with PCa was widely experienced by participants in the current study. Similarly, other studies have revealed an increased in erectile dysfunction among men with PCa. According to Johansson et al. (2011), erectile dysfunction was reported in patients who have undergone surgery, active surveillance and non-prostate cancer controls. Given that all the participants in this study experienced erectile dysfunction, the findings of (Johansson et al., 2011) suggest that the mere diagnosis of PCa is associated with decreased erectile function, regardless of the treatment option selected. However, Wilt et al. (2012) identified low experience of erectile dysfunction in patients with PCa undergoing observation compared to total removal of the prostate. This discrepancy may be linked with the differences in the age of the respondents and the severity of their conditions. Nonetheless, physiological symptoms generally include incontinence, erectile dysfunction, hot flashes, and decreased muscle and bone mass (Aning, 2016; Resnick et al., 2015).

As may be expected, the experience of erectile dysfunction coupled with the lack of spouse of participants in this study led to the experience of a low urge for sex. This finding was supported by Saitz et al. (2013) where men with erectile dysfunction experienced ejaculatory dysfunction and decreased libido. However, the lack of sexual feelings does not have a link with the lack of interest in sexual relationships (Donovan, Walker, Wassersug, Thompson, & Robinson, 2015). That notwithstanding, It was noted that ADT negatively affects erectile

function, sexual desire, ability to become aroused, ability to achieve orgasm, and self- image, which may impede a sexual function and interrupt sexual relations (Donovan et al., 2015). Hence, while new treatments for advanced PCa prolong life, this means men are living longer with the effects of treatment and disease progression including deteriorating bone health, pain, hot flushes, loss of libido, erectile dysfunction, increased fat mass, sarcopenia, fatigue and cognitive decline (Gilbert et al., 2017).

5.3 Psychological Wellbeing of the Participants

Psychological issues arise in 30–50% of PCa patients irrespective of the stage and progression of cancer or the type of treatment they receive (De Sousa et al., 2012). From the findings in this study, the psychological issues experienced by participants include anxiety, depression, distress of diagnosis and control of treatment, and suicidal ideation. As indicated by participants of the study, Prostate cancer is largely associated with sub-clinical distress and decreased quality of life (Bill-Axelson et al., 2013; Smith et al., 2009) as seen in their report of sleep disturbances and pain.

Some participants in this study revealed being anxious about the condition and also expressed worries about the treatment and the cost associated with it. Worries about hospitalisation and recurrence of symptoms also caused anxiety among some participants. This finding is largely consistent with what has been widely reported (Albaugh et al., 2017; Couper et al., 2010; Watts et al., 2014). As may be expected, being diagnosed with PCa can lead to anxiety, but not to the same extent in every patient. Obviously, men with advanced PCa become more anxious than men with localised PCa (Johanes et al., 2013). However, the previous history of anxiety, lack of family support, activity limitations due to cancer, other comorbidities, and unresolved cancer pain are factors that could increase the risk of anxiety in cancer patients

(Drummond, O' Leary, Gavin, Kinnear & Sharp, 2016). Therefore, the level of anxiety exhibited by participants in this study is attributable to the experience of physical symptoms and lack of spousal support.

The majority of participants in this study experience depression. This is consistent with prior studies indicating an increased risk of depression among PCa patients (Bill-Axelson et al., 2011; Jayadevappa et al., 2012). Other studies have also reported the experience of depression among men with PCa and depressive symptoms were relatively higher among men who receive ADT (Sharp et al., 2016; Watts et al., 2014). Nevertheless, depression seems to reduce when patients are initiated on testosterone- replacement therapy (Khera et al., 2012) suggesting that those who are receiving ADT may have their depression associated with androgen deprivation (Lee et al., 2015). This probably explains the depression espoused in the current study since the majority of the participants were on medical treatment. On the contrary, Hervouet et al. (2013) revealed that ADT does not significantly lead to depression among PCa patients. Despite that, depressive symptoms were noted to be higher among the ADT group compared with the control group (Lee et al., 2015).

Moreover, it was observed that some participants expressed their depression is a result of frequent urinary retention, severe pains, and catheterization. Others also expressed their depression due to lack of money. These findings agree with the findings of some earlier researchers on PCa. According to Jayadevappa et al., (2012), PCa cancer related depression may be a consequence of uncontrolled pain, fatigue, erectile dysfunction or urinary incontinence after prostate surgery. Again, PCa pain was found to have a strong relationship with depression (De Sousa et al., 2012) and the increased risk of depression reportedly resulting from loss of sexual function (Sharpley, Christie, Bitsika & Miller, 2017).

It is also worth indicating that the experience of anxiety and depression is largely associated with erectile dysfunction and loss of masculinity. In a study where an increase in loss of masculinity was documented, depressive and anxious was predictive of lower perceived masculinity (Sharpley, Bitsika, & Denham, 2014). Additionally, Albaugh et al. (2017) reported psychological issues among men with PCa as a result of sexual dysfunction resulting from treatment. This comprised many reports of depression, anxiety, and suicidal ideation. However, the reduction in testosterone levels accounts for depression among middle and aged who do not have cancer (Amore et al., 2012).

Beyond the experience of anxiety and depression, the findings from the current study also revealed that some participants contemplated suicide due to the experience of symptoms and some other complications of the disease. They thought life was not worth living without their manhood. Similar to what was found in this study, men with advanced PCa have a lesser quality of life, increased levels of psychological distress, higher suicide risk and more unmet supportive care needs (Bill-Axelson et al., 2010; Chambers et al., 2016). Given that depression is associated with an increased risk of suicide (Turecki & Brent, 2016), the exhibition of depression and suicidal ideation among participants in the current study is worrying. This is particularly so, because studies have shown the association between depression and suicidal risk among men with PCa (Frémont et al, 2012). More recently, suicidal ideation is a manifestation of the impact of the psychological consequences of PCa (Smith et al., 2018). Again, Rice et al. (2018) found a very significant influence of depression on suicidal ideation. As such, the counselling and psychological management of men with PCa should be a priority in all cancer treatment centres.

Also, it is worth indicating that blacks experienced reduced levels of physiological and psychological health when compared to the levels observed in white men in previous studies (Chhatre, Wein, Malkowicz & Jayadevappa, 2011). However, a study by Hamilton et al. (2017) revealed that blacks associate attitudes of fear and fatalism with a cancer diagnosis.

5.4 Social Wellbeing of Participants.

Generally, it is common for men with PCa to experience feelings of embarrassment or social isolation during, and even after, their cancer battle. The experience of isolation was largely reported by participants in this study. The clinical manifestations of PCa and the stink from the urine on participants' dresses prevented them from participating in social events. Agreeing to this finding, perceived stigma and social isolation were most commonly reported as a physical consequence of treatment and/or side effects (Ettridge et al., 2018). In another study, PCa support group leaders described their experience of isolation and neglect in the disease process (Dunn et al., 2018). Since peer support was noted to enhance coping (King et al., 2015), the involvement of peers in the treatment of PCa should be encouraged.

Additionally, the inability to work and earn a living was reported by participants in this study. Even though the majority of the participants interviewed were on pension, those who were engaged in their private businesses were unable to continue work because of the effects of PCa. In line with finding, Bradley et al. (2007) reported that men who are employed may experience low productivity at the workplace or may loss of job and work-related benefits. More recently, some men revealed their inability to work effectively which negatively affected their income and retirement plans (Chambers et al., 2018).

Consequently, all participants were worried about the high cost of treatment and house chores and had to rely on their small pension allowance. For men with PCa, the causes of

financial stress are multifaceted; treatment-related costs including costs of chemotherapy, radiation, and surgery, as well as home health care and travel expenses to treatment centres. Given that low-income patients have been shown to have a disproportionately high financial burden than high-income patients (Kale & Carroll, 2016), the experience of financial burden in this study is attributable to the low income status of the participants, the majority of them had retired from active service. Similar to this finding, a study by Zafar et al. (2013) revealed that men with PCa reported at least some degree of the financial burden from cancer-related expenses. Other studies also reported the high experience of financial burden among PCa patients (Pisu et al., 2015; Zafar et al., 2013).

Moreover, some participants lamented the lack of support from family and friends in the management of their conditions. However, other participants revealed that they receive financial support from their children and other family members. This goes to give credence to the earlier findings that families and friends were a significant support to men who are in this situation (O'shaughnessy et al., 2013; Schover et al., 2012). Again, some men with PCa also indicated that family and friends often provide practical assistance to them (Chambers et al., 2018) which is inadequate. Evidence from the literature it was suggested that patients who are financially affected by cancer, delay in accessing their medical treatment, thereby putting their physical health in jeopardy (Weaver et al., 2010). However, the emergence of health insurance has impacted positively on the financial burden associated with prostate cancer diagnosis and its treatment in many jurisdictions. According to Jung et al. (2012), costs of treatment for PCa is expensive and payments may vary among public and private insurance plans. As such, almost all Australian men with PCa had either employer-sponsored medical insurance or Medicare/Medicaid (Gordon et al., 2017).

With regards to family distress, all the participants revealed the absence of their spouses as the major reason for a shift of responsibilities to their children. They reported that the condition had great distress on their family which their children had to leave their homes and work to care for them. This might be due to an increased burden because they needed to be involved in treatment for PCa (Wootten et al., 2014). Eventually, some participants reiterated that their children were in distress because they did not have enough funds to support their father's condition. Though family distress was not a direct experience of participants in this study, thoughts of what their families go through to support them was a source of worry. Despite the distress, there was enormous support from family members as espoused by some of the participants. Some participants said their children gave them all the support they needed to survive. This finding is consistent with that of Chambers et al. (2018) where enormous family support was reported by men with PCa. This presupposes that family involvement is crucial in the management of men with PCa.

Furthermore, all participants expressed diminished affection and interest for sexuality especially as they lost their partners. As may be expected, this was largely associated with the experience of erectile dysfunction. Corroborating this finding, Zaider et al. (2012) found low levels of masculine identity and affection among men with localized PCa. However, Manne et al. (2011) argued that when men are worried about their erectile dysfunction, it may have less to do with their sexual performance and more to do with the resulting changes in self-worth and quality of their relationships.

The quality of marital affection and intimacy in men's relationships has been postulated to impact significantly on masculine identity such that open communication, affection, and support from a partner may counter any sense of the attack on male identity (Manne et al.,

2010). Again, the literature has shown that married men with PCa received adequate support from their wives and assist with seeking information (Wallace & Storms, 2007). However, participants in the current study were not married; thus, it is essential to determine the sources of information and support for men who are not married.

5.5 Spiritual Wellbeing of the Participants

Among men with PCa, spiritual well-being is an important predictor of quality of life. According to Bredle et al., (2011), spiritual well-being is associated with the purpose of life, social support, lower stress levels, and lower depression rates. Participants in this study reported a high level of spiritual well-being; with religiosity, meaning of illness and hope, emerging as the subthemes of spiritual well-being. This agrees with the findings of a study by Kiffel and Sher (2015) where men with PCa reported a high level of spiritual well-being. However, the factors within the religion and spirituality domain consist of belief, prayer, and the use of complementary and alternative medicine (Dickey & Ogunsanya, 2018).

In terms of religiosity, nine of the participants were Christians while only one was a Muslim. All the participants had hope from God to be able to manage their condition. Some participants resorted to prayers since they held the belief that prayer could be of great help to them in terms of finding a cure. Corroborating this finding, other researchers revealed that people get closer to the God at critical times, such as being diagnosed with PCa, (Salman & Zoucha, 2010) and praying becomes useful in aiding the process of health and promoting a sense of hope (Doucet & Rovers, 2010). Earlier, the landmark study by Farran, Herth & Popovich, (1995) using the Nowotny's Hope Scale found that hope did not differ significantly between CA patients who died and those who survived. Despite a lower QOL score among those who died, they were able to deal with their difficult situation and maintain hope in late

life. The trend is not surprising because, in the advent of religious proliferation, many people use religion for comfort and support when faced with a life-threatening illness such as cancer (Biegler et al., 2012). An important finding under religiosity is that none of the respondents in this study resorted to spiritual or healers for support of any kind. However, support from other colleagues, pastors, and significant others in terms of prayer was disclosed by some participants in the study. Though some were unable to attend religious functions, their religious leaders helped them in prayer.

In the context of hope as a sub-theme under spiritual wellbeing, all participants articulated strong faith or belief in God, with some being hopeful for quick recovery from their conditions. Some participants hoped for healing from God, put all their hopes in God and emphasised that they could not rely on a man. In previous similar studies, faith was multifaceted and not necessarily limited to religious practice or faith in a spiritual being. Faith was evidenced in the men's talk of existential concerns and struggles as they dealt with their disease. It provided a way by which men could move from facing a death sentence to integrating the PCa into their lives and feeling a sense of having a new beginning (Maliski et al., 2010).

That notwithstanding, there were expressions of hope for a cure from orthodox medicine by some participants. This hope is probably grounded in the awareness of clinical benefits of therapy for men with PCa and improved quality of life (Donovan et al., 2015). In recent times, ADT has been shown to improve the survival rate in men with PCa (Cornford et al., 2017; Mottet et al., 2017). Participants further recounted the benefits of medical and surgical treatment of PCa. Although the therapy is palliative, it increases the survival rate effectively hence promoting quality of life with minimal side effects such as sexual dysfunction, fatigue, anaemia,

osteoporosis, and muscle loss (Nguyen et al., 2015). As such, men who experience these effects during ADT are likely to express less hope and frustrations in life.

Though the experience of inner strength was not expressed in this study, it has been widely reported by previous researchers. To have inner strength is to be creative and flexible and to believe in one's abilities to act, to make choices, and to influence life's trajectory in a meaningful direction (Lundman et al., 2019). As such, men with PCa self-rated their inner strength as high (Viglund et al., 2018). Since people with a higher degree of inner strength have better physical health and more satisfying social relationships (Lundman et al., 2012), the promotion of inner strength should be a major aim in the management of people with PCa. Again, Spirituality is associated with better PCa treatment decision making experiences (Mollica, Underwood, Homish, Homish, & Orom, 2016); hence the need to consider the spirituality of man in the management of PCa.

5.6 Coping Strategies Reported by the Participants

Coping is very critical in managing emotions and solving problems. Considering the context, unmarried men, particularly those who have limited social support, may have a higher risk for ineffective coping and its related morbidity. Disease coping, which involves the mobilization of psychosocial resources requires adaptive responses to deal with the consequences of illness (Ferrão et al., 2017b). According to Taylor and Stanton (2007), coping comprise of external and internal strategies such as information seeking, engaging social support networks, humour and cognitive re-framing. Given the psychological, socioeconomic, spiritual and negative outcomes related to PCa, coping strategies are of great importance. As such, this study identified coping strategies as an additional major theme since the participants sought to describe how they were able to cope and tolerate their condition. It was therefore

revealed that participants employed diverse and multiple strategies of coping with their condition; lifestyle modification, social contact, and acceptance. This is in tandem with the evidence that men with cancer generally use multiple coping strategies such as knowledge building, physical strengthening, shielding others from distress and restricting emotion (Wenger & Oliffe, 2014; Green et al., 2011).

The findings from this study revealed that some of the participants accepted their conditions and were able to adjust to their daily activities. Some of the participants indicated that the disease is a male condition and one can recover from it. In line with this finding, PCa symptoms were considered normal effects of ageing rather than being associated with comorbid states (Appleton et al., 2015; Dieperink et al., 2013). Some studies reported a focus on the treatment benefits (Appleton et al., 2015) and adopting a positive attitude towards the condition (McSorley et al., 2014) as ways to cope with side-effects of treatment. Essentially, self-reported coping strategies such as acceptance have consistently been beneficial to people with PCa (Pascoe & Edvardsson, 2016).

The majority of the participants developed some lifestyle modifications strategies to cope with the urinary problem. They tried to control the stench of urine from the body by wearing diapers, and frequent washing and changing of their boxer pants. Some had to cope with the indwelling urethral catheter when they are out of home and others had to reduce their fluid intake to avoid polyuria. These are strategies aimed at coping with the physical consequences of the condition and the side-effects of treatment. Hanly et al. (2014) agree with this finding that men with PCa minimise their intake of fluid to cope with issues involving bladder control. Similarly, the adjustment in PCa focuses on the depth to which men can navigate through gaining a new outlook over fears of testicular cancer and striving to live a

normal life (Matheson et al., 2016). On that account, successful adjustment involved approaches such as reflecting on the positive outcomes, positive restructuring of the risks, constant support seeking, and supple approach to masculinity (Spendelow et al., 2018).

Subsequently, avoiding social contact emerged as another coping strategy to deal with the social, psychological and physical adverse effects of PCa. The majority of the participants had to resort to avoiding social functions as a way of coping with their condition. Some narrated how they avoided social events due to stresses from the condition. In support of this finding, men with PCa isolated themselves from other people and social activities (Spendelow et al., 2018). In an earlier study by Hedestig et al. (2005b), men with PCa reported active avoidance of social contact. Other studies described men with PCa avoiding social contact in terms like “withdrawing into themselves” (Appleton et al., 2015), “emotional distancing” (Levy & Cartwright, 2015), and “going it alone” (Kazer et al., 2011).

Furthermore, it is important to note that the application of the knowledge about these strategies as disclosed by the participants came from health care professionals, electronic media, reading books and interaction with peers. The patterns of seeking information and support by participants are consistent with other studies. Men in a previous study revealed some resources for information and support about PCa, which include literature, the internet, and relatives and peers (Kazer et al., 2011). The use of books and articles has been the commonest method of acquiring disease-related information for the past years. The increase reports on the use of the internet to acquire knowledge about the are consistent with previous work and will likely have expanded its use in the future (Horrigan, 2008).

5.7 Summary of Discussion

In summary, this chapter presented a detailed discussion of the findings in the current study and compared them with the existing literature on the wellbeing of unmarried men with PCa. Generally, the wellbeing of men with PCa is multidimensional and interrelated. Men with PCa experience physical, psychological, social, and spiritual consequences of the disease. Though these experiences are largely universal, the interrelations differ significantly across individuals suffering from PCa. From the discussion presented above, the findings in the current study were widely supported by existing literature on the subject matter. Though participants in this study were not married, there were no significant differences in the experiences when compared to that of married men.

The physical experiences as espoused in this study are the physical manifestations of the disease process of PCa. Fatigue, poor rest and sleep, pain, erectile dysfunction, reduced urge for sex, and having to deal with a urethral catheter in situ affect physical wellbeing. However, these physical manifestations are dependent on the number of years the participant had lived with the condition, early detection of the condition, the type of treatment being received and the adherence to the treatment. Consequently, psychological issues due to the physical manifestations of the disease include anxiety, depression, distress of diagnosis and control of treatment, and suicidal ideation. The social wellbeing has to do with family distress, work related activities, roles and relationships, isolation, finance, affection and sexual function, and spousal support. Subsequently, people with PCa resort to prayers since they hold the belief that prayer could be of great help to them in terms of finding a cure. However, participants employed diverse strategies of coping that helped them deal with these effects. It is worth indicating that

the sources of knowledge about these strategies include health care professionals, electronic media, reading books and interaction with peers.

5.8 Evaluation of the Model

The Quality Of Life Model Applied to Cancer Survivors (QOL-ATCS) was used as the theoretical framework to guide this study. The objectives and research questions of the study were developed based on the constructs of the model used in the study. The QOL-ATCS has four domains: physical wellbeing, psychological wellbeing, social wellbeing, and spiritual wellbeing. The model was considered appropriate for this study because it has a spiritual wellbeing component that is missing in other models that were considered earlier. All four domains of the model were explored.

The physical wellbeing domain of the model was explored in terms of the physical experiences of men with PCa. It was revealed that participants experienced fatigue, poor rest and sleep, pain, erectile dysfunction, reduced urge for sex, and having to deal with a urethral catheter in situ. This was not completely consistent with the model since catheterisation which emerged in the current study is not part of the proponents' description of physical wellbeing. According to the authors, physical well-being includes functional activities, strength/fatigue, sleep and rest, fertility, pain, and overall physical health. Therefore, the physical wellbeing of participants in this study does not completely support the model.

Psychologically wellbeing, according to the model comprises emotional issues, anxiety, depression, fear of recurrence, enjoyment/leisure, and distress of diagnosis and control of treatment. This was largely consistent with this study as anxiety, depression, distress of diagnosis and control of treatment and suicidal ideation were described as psychological experiences by participants. Though suicidal ideation was not described by the proponents of

the model, the experience of anxiety and depression could be accountable for its presence in the current study. Nonetheless, it could be considered as an addition to the model.

The social domain of the model was described in terms of family distress, roles and relationship, affection/sexual function, appearance, isolation, finances, work, and enjoyment. In support of the model by the current study, family distress, work related activities, roles and relationships, isolation, finance, affection and sexual function, and spousal support was supported by participants. Furthermore, the spiritual domain of the model takes account of the meaning of illness, religiosity, hope, uncertainty, inner strength, and self- transcendence. This was supported by the current study as the spiritual experiences were religiosity, meaning of illness, and hope.

However, an additional theme emerged from the data which is not consistent with the domains of the QOL model. The study identified coping strategies that men with PCa adopted to deal with the consequences of their condition. The study revealed that participants employed diverse strategies of coping with their condition; lifestyle modification, social contact, and acceptance. Therefore, the researcher recommends a modification of the model to integrate coping strategies as part of the major constructs of the model. This will allow future researchers to explore coping strategies as a major objective in order to unravel other coping strategies used by men with PCa. Additionally, the experience of financial burden has the greatest impact on dealing with the PCa trajectory, especially in lower – middle income countries where poverty is inherent. In this regard, the proponents of the model should revise the ‘social wellbeing’ construct to ‘socioeconomic wellbeing’. Finally, having to deal with a urethral catheter in situ (catheterisation) which is not part of the current model emerged in this study as a subtheme of

physical wellbeing. Since the use of catheter is almost inevitable in PCa, the researcher recommends the inclusion of catheterisation to the physical wellbeing construct of the model.

CHAPTER SIX

SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSION, AND RECOMMENDATIONS

This is the last and final chapter of the study. It presents a summary of the entire study, discusses the implications of the study, limitations to the study and the conclusions drawn from the study. The chapter also includes the recommendations that were made based on the findings of the study.

6.1 Summary of the Study

The study explored the wellbeing of unmarried men with Prostate Cancer (PCa) in the Accra Metropolis with a specific focus on describing the physical, psychological, social and spiritual wellbeing of the participants. The Quality Of Life (QOL) Model Applied to Cancer Survivors (ATCS) by Ferrel et al. (1991) was used as the conceptual framework for the study. With an exploratory descriptive study design, ten (10) unmarried men with PCa were selected as respondents using a purposive sampling technique. During data collection, a semi-structured interview guide was used to conduct in-depth face-to-face interviews with the participants. Both manual and Computer-based data management software (NVivo) was used to manage the data. Data collection and analysis were done concurrently until the tenth participant where an in-depth understanding of the wellbeing of unmarried men with PCa was achieved. With the thematic content analysis, five (5) major themes emerged from the wellbeing of unmarried men with PCa. The five major themes that emerged were: physical wellbeing, psychological wellbeing, social wellbeing, spiritual wellbeing, and coping strategies. A total of twenty three (23) sub-themes were identified and categorized appropriately under their respective themes.

In terms of physical wellbeing, the findings revealed that fatigue, rest and sleep, pain, erectile dysfunction, urge for sex, and catheterization were experienced by participants. Consequently, these physical experiences had a devastating effect on the psychological, social and spiritual wellbeing of participants in the study. Psychologically, anxiety, depression, distress of diagnosis and control of treatment and suicidal ideation were exhibited by participants. Worries about treatment and recurrence of symptom, and erectile dysfunction caused anxiety among participants. The social wellbeing of participants had to do with family distress, work related activities, roles and relationships, isolation, finance, affection and sexual function, and spousal support. Key among them is the fact that all participants were disturbed about the high the cost of treatment and house chores and had to rely on their small pension allowance, family or friends for support. However, some participants lamented the lack of support from family and friends in the management of their conditions.

Spiritually, some participants resorted to prayers since they held the belief that prayer could be of great help to them in terms of finding a cure. It was further revealed that all the participants had their meaning to their condition with inference from their faith. Some described their situation as spiritual and suspected other people as being responsible for their condition whereas other participants believed in God and associated their condition to a natural cause but not spiritual. Nonetheless, other participants were of the view that their situation was both physical and spiritual. Then again, the study identified coping strategies as an additional major theme since the participants sought to describe how they were able to cope and tolerate their condition. The study revealed that participants employed diverse strategies of coping with their condition. Subsequently, three subthemes were identified; lifestyle modification, social contact, and acceptance. It is worth indicating that the sources of knowledge about these strategies as

disclosed by the participants include health care professionals, electronic media, reading books and interaction with peers.

6.2 Implications

The implications have been grouped into nursing practice, nursing education, nursing research as well as health policy implications. The implications of the study are discussed below.

6.2.1 Implications on Nursing Practice

From the study findings, fatigue, poor rest and sleep, pain, erectile dysfunction, reduced urge for sex, and having to deal with a urethral catheter in situ affect physical wellbeing. Consequently, psychological issues due to the manifestations of PCa include anxiety, depression, distress of diagnosis and control of treatment, and suicidal ideation. The social wellbeing has to do with family distress, work related activities, roles and relationships, isolation, finance, affection and sexual function, and spousal support. Subsequently, people with PCa resort to prayers since they hold the belief that prayer could be of great help to them in terms of finding a cure.

These findings from the study have some implications for nursing practice; notably oncology (urology) nursing of unmarried men with prostate cancer. Considering the fact that these men have to deal with a urethral catheter in situ, patient education should be a priority when rendering care to patients. Nurses can take a lead role in educating patients and their caregivers on hygienic catheter care and discuss the option of homecare with other family members. Additionally, integration of family members, religious leaders, and significant others in the care of PCa is very essential since they play a key role in the cancer experience. Moreover, nurses in oncology (urology) departments should consider counseling as a major part of nursing

care to PCa patients and their caregivers as well. This will reduce the psychological effects of the condition and help them develop appropriate coping mechanisms for the cancer experience, hence improving their quality of life.

6.2.2 Implications on Nursing Education

In nursing, education forms the central part of nurses' strength of knowledge to impact care for patients. Apart from educating patients, caregivers, and other family members, findings from the study have some implications for nursing education in terms of training. Hence, there should be a curriculum developed on oncology to train nurses as specialist in the various health training institutions. This will equip nurses with the skills in rendering holistic care to patients with PCa and their caregivers (families) as well.

6.2.3 Implications on Nursing Research

The study also has some implications for Nursing Research. There are significant research gaps in the understanding of the wellbeing of unmarried men with PCa and the impact of economic burdens on their family members in Ghana. This study provides a starting point for other researchers to explore the wellbeing of unmarried men with PCa, with much focus on their coping strategies. Further research is also required to explore the experiences of other family members who are involved in the care of unmarried men with PCa. A comparative study on the quality of life of married and unmarried men with PCa is an appropriate area for future research.

6.2.4 Implications on Nursing Policy

The findings have significant implications for policy formulation and implementation in the area of prostate cancer, with special attention to unmarried men. Considering the financial burden experienced by participants in the study, it is necessary for stakeholders in the hospitals

to develop policies that will assist men with prostate cancer. Furthermore, policy change is required to include cancer related symptoms and treatment such as pain medications in the National Health Insurance Scheme (NHIS) benefits package and gradually include all forms of PCa treatment to moderate the financial burden on PCa patients and improve their quality of life.

6.3 Limitations of the Study

Regardless of the methodology employed, every research has some form of limitations, as such; the current study has some limitations in terms of the sampling. The study focused on the wellbeing of only unmarried men with PCa. It is likely that, this might have influenced the findings in this study as this may not be the case among married men with PCa, hence limiting the findings in the current study to only unmarried men. Additionally, the findings may be peculiar to the study setting in which data collection was done, though it may be transferable to similar settings.

6.4 Conclusion

The study explored the wellbeing of unmarried men with Prostate Cancer (PCa) in the Accra Metropolis using the Quality of Life Model Applied to Cancer Survivors (QOL-ATCS) as a theoretical model to guide the study. Clearly, men with PCa experienced physical effects such as fatigue, lack of rest and sleep, pain, erectile dysfunction, reduced urge for sex, and having to deal with a urethral catheter in situ. Consequently, these physical manifestations had a devastating effect on the psychological, social and spiritual wellbeing of participants in the study. These effects are varied and include anxiety, depression, isolation, and financial burden. This suggests that psychological, social and spiritual effects of PCa are largely due to the physical symptoms of the disease. As such, men with PCa experience poor quality of life, go

through a lot of stress and consequently harbour suicidal ideations. However, there are diverse strategies of coping that can help men with PCa deal with these effects. Despite the usefulness of the Quality of Life Model Applied to Cancer Survivors (QOL-ATCS) in answering the research questions of the study, an additional theme (coping strategies) that affected the wellbeing of men with PCa emerged. Hence, if the model could be expanded to integration of coping strategies it would better describe and explain the wellbeing of cancer survivors.

6.5 Recommendations

Based on the findings of the study, some recommendations were made to the appropriate bodies for possible implementation. The following recommendations have been made to the Ministry of Health, Ghana Health Service, Nursing and Midwifery Council of Ghana, Religious groups and the Command of the 37 Military Hospital.

6.5.1 Recommendations to the Ministry of Health

The Ministry of Health should:

- Lobby government and other agencies of health for the total payment of costs for diagnostic tests and prostate cancer treatment in the National Health Insurance Scheme (NHIS). This will reduce the financial burden on men with PCa and improve their quality of life.
- Increase the training of oncology (urology) professionals (Clinicians) such as nurses, doctors, psychologists, and counsellors.
- Collaborate with the Ghana Health and the security agencies to clamp down on prayer camps that retain patients living with chronic conditions such as prostate cancer and prevent them from seeking treatment and care from hospitals.

6.5.2 Recommendations to the Ghana Health Service

The Ghana Health Service should:

- Establish oncology (urology) units in all District, Municipal, Metropolitan and Regional Hospitals where care can easily be accessible to patients living with prostate cancer. This will also ensure the early detection and treatment of PCa to prevent complications.
- Make counselling and psychological management of men with PCa a priority in all cancer treatment centres and include counselling units to every oncology centre. These units should be managed by professional counsellors and psychologists.
- Implement policies on regular patients' education on advanced PCa treatment and coping mechanisms. This will enhance their understanding of PCa and demystify the misconceptions associated with the condition.

6.5.3 Recommendations to the Nursing and Midwifery Council of Ghana

The Nursing and Midwifery of Ghana in collaboration with the Ghana College of Nurses and Midwives should:

- Integrate oncology (urology) nursing in the current training curriculum of all health training institutions as a general course. The course tutor or lecturer must be a specialist in oncology (urology) nursing. This would ensure that the nurse trainees will receive the requisite training in oncology (urology) nursing to enable them to provide basic urology services to patients.
- Develop and implement a policy on continuous professional development in basic principles of oncology (urology) nursing for all nurses.

6.5.4 Recommendations to Religious Groups

All Religious Groups should:

- Make it mandatory that all religious leaders who wish to provide health counselling in churches, mosques, and other worshipping centres are qualified as professional counsellors from accredited institutions.
- Ensure that religious leaders are educated on PCa to enable them to offer the right support services to patients living with PCa.
- Refrain from needless prophecies and spiritual healing, and refer their congregants who are diagnosed with PCa for experts counselling and treatment.

6.5.5 Recommendations to the Management of 37 Military Hospital.

The Management of 37 Military Hospital should:

- Design an in-service training schedule that will provide quarterly training for the clinical staff at the urology department on assessment and management of physical manifestations of PCa. This will update the staff's knowledge and skills for effective assessment and management of symptoms.
- Develop protocol for comprehensive assessment and management of PCa, taking into consideration the socio-cultural and religious beliefs of the clients.
- Liaise with counselling experts to provide regular counselling services for men with PCa at the urology department.
- Institute support systems to assist in diverse ways to patients who lack family support such as unmarried men with PCa.

- Collaborate with churches and other religious groups to ensure that religious leaders who provide counselling for their members, give appropriate counselling to patients and caregivers.

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APPENDICES

Appendix A: Demographic Profile of Participants

Pseudonyms	Age (Years)	Level of Education	Occupation	Marital Status	Number of Children	Religion	Language Spoken	Duration of Disease (Years)	Type of Treatment
Kwasi 001	80	University	Reverend Minister	Widower	6	Christian	English, Twi	5	ADT
Kojo 002	74	Polytechnic	Ex Soldier	Divorce	5	Moslem	English, Twi, Dagbani, Ga	2	ADT
Akwasi 003	65	Technical	Ex Soldier	Widower	2	Christian	English, Twi	2	ADT
Kwadwo 004	55	Primary	Plumber	Divorce	5	Christian	English, Twi	2	SURGERY
Yaw 005	69	Secondary	Company Supervisor	Widower	4	Christian	English, Twi, Lartey	4	ADT
Kwame 006	65	University	Trader	Divorce	3	Christian	English, Twi	4	ADT
Jojo 007	74	University	Journalist	Widower	2	Christian	English, Twi, Hausa	4	ADT
Kwabena 008	75	Secondary	Insurance Manager	Widower	4	Christian	English, Twi	2	ADT
Fifii 009	79	University	Director	Widower	4	Christian	English, Twi, Hausa	12	ADT
Kwaku 010	77	Technical	Ex Soldier	Widower	7	Christian	English, Twi	2	ADT

Appendix B: Consent Form

CONSENT FORM

Title: Exploring the wellbeing of unmarried men with prostate cancer in the Accra Metropolis.

Principal Investigator: Elvis Otenkorang Annan

Address: School of Nursing and Midwifery, University of Ghana, Legon, Accra.

Phone Number: +233 246647296

Email: eoannan003@st.ug.edu.gh / elvisannan2015@gmail.com

General Information about Research


I am a second year **masters in nursing student** at the University of Ghana conducting a study on the wellbeing of men with Prostate cancer. This study is for academic purposes, and it is aimed at understanding what unmarried men with Prostate cancer go through.

You have been selected to be a participant, though, it is not compulsory for you to participate in this study. I would like you to provide me with information on your experiences in terms of living with the disease.

If you agree to participate, you will sign two copies of this form (one will be kept by you and the other with me). Thereafter, an interview will be scheduled with you at your own time and convenience which is expected to last between 30 to 60 minutes. This interview will be conducted in English, Twi, or Ga according to your preference.

Before the interview begins, your consent will be sought to record the conversation. You have the right to withdraw your participation at any time and this will not affect you in anyway.

1



Possible Risks and Discomforts

You will not be exposed to any risks as you participate in this study. However, you will have to offer your time.

Possible Benefits

There may be no direct benefits from participating in this research, however, the findings that are gathered from this research could help in the improvement of the knowledge on Prostate cancer which health professionals especially nurses can use to provide care of patients with prostate cancer in the future.

Confidentiality

I will not use your name or any identifying information in my report. In addition, any identifying information about you will not be written in this study. Also, all the information you will provide will be accessible to me and my research supervisor only and will be used solely for research purposes. All information pertaining to this study such as audio recordings and reports will be stored in a password protected computer, accessible only by me. **The hard copies will be kept by the supervisor in her office at the institution, and will be destroyed 5years after the study.**

Compensation

As a sign of appreciation, you will be given some refreshment in the form of snacks and water, and a University of Ghana branded gift item. This will be given to you at the end of the interview.



Voluntary Participation and Right to Leave the Research

Your participation in this study is voluntary. You can decide to withdraw from the study at any point in time. Your withdrawal will not bring any penalty or affect your treatment. As soon as you withdraw, all information about you will be destroyed.

Contacts for Additional Information

In case of any questions or further clarification please contact any of the following individuals:

Name: Elvis Otenkorang Annan

Contact: +233 246647296

Name: Dr. Lydia Aziato

Contact: +233 244719686

Name: Dr. Gideon Puplampu

Contact: +233 507893242

Your rights as a Participant

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



Appendix C: Information Sheet and Interview Guide

EXPLORING THE WELLBEING OF UNMARRIED MEN WITH A PROSTATE
CANCER

SECTION A: BACKGROUND INFORMATION FORM

Code Number

Demographic Information

1. Age (years)

2. Level of Education

3. Occupation

4. Place of residence

5. Marital status

6. Number of children


7. Religion

8. Language spoken

9. Duration of disease

10. Type of treatment

1



SECTION B: INTERVIEW GUIDE

1. Please how do you feel about your condition?
2. Please how do you feel about the treatment process?
3. Please what problems are you experiencing in your life now due to the PCa physically?

Probe:

- Tiredness
- Difficulty in Sleeping
- Urinary incontinence
- Decrease in edge for sex
- Erectile not responding
- Pain when releasing sperm and urination

4. Please what are some experiences concerning your emotional health

Probe:

- Anxiety
- Depression
- Helplessness
- Fear of recurrence
- Suicidal tendencies
- Feeling of abnormal (not being a man)

5. Please what are some your experiences concerning social health

Probe:

- Family distress
- Roles and relationships with family and friends (support)
- Affection/sexual function
- Social Isolation
- Finances
- Work related activities
- Any changes in responsibilities

6. Please how do you manage your life with the condition spiritually

Probe:

- Prayer
- Avoidance



- Withdrawal
- Hope in God
- Consultation with spiritual leaders
- Uncertainty
- Inner strength

7. Please did you use the internet as a source of information or support?
8. Please what are the three most important things that helped you cope with having prostate cancer?
9. Please is there anything else you want to share with me on your condition?



VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title (Exploring the wellbeing of unmarried men with prostate cancer) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date Name and signature or mark of volunteer

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

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

Date Name and signature of witness


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

Date Name and signature of person who obtained consent



Appendix D: Introductory and Permission Letter

Public health




UNIVERSITY OF GHANA
SCHOOL OF NURSING AND MIDWIFERY

SON/A.12 February 6, 2019

Ref. No.:.....

The Administrator
Greater Accra Regional Hospital
Ridge - Accra



Dear Sir/Madam,

LETTER OF INTRODUCTION

This is to introduce to you Elvis Otenkorang Annan, an MPhil second year student of the School of Nursing and Midwifery, University of Ghana who wants to pilot his research tool in your facility.


The Institutional Review Board of Noguchi Memorial Institute has approved his study on the topic: "Exploring the Wellbeing of Unmarried Men with Prostate Cancer in the Accra Metropolis".

I would be grateful if you could offer him the necessary assistance.

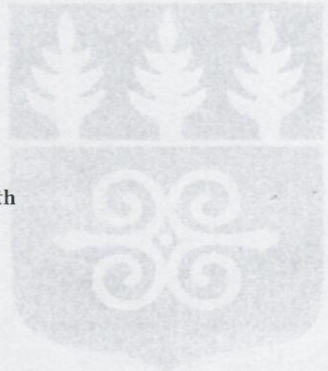
Counting on your usual co-operation.

Thank you.

Yours faithfully,



Dr. Gladys Dzansi
Ag. Head, Dept. of Adult Health



HRH
HRH,
for your attention
Mfintse
14/2/19

COLLEGE OF HEALTH SCIENCES

P. O. Box LG 43, Legon, Accra, Ghana.
• Telephone: (0) 303 970 801 / 0553 089 267 • Email: nursing@ug.edu.gh • Website: www.nursing.ug.edu.gh

Appendix F: Ethical Clearance from 37 Military Hospital IRB



Institutional Review Board
37 Military Hospital
Neghelli Barracks
ACCRA

Tel: 0302 769667
Email: irbmilhosp@gmail.com

23 November 2018

ETHICAL CLEARANCE

37MH-IRB IPN 247/2018

On 25th October 2018, the 37 Military Hospital (37MH) Institutional Review Board (IRB) at a Board Meeting reviewed and approved your protocol.


TITLE OF PROTOCOL: Exploring the wellbeing of Unmarried Men with Prostate Cancer

PRINCIPAL INVESTIGATOR: Elvis Otenkorang Annan

Please note that a final review report must be submitted to the Board at the completion of the study.

Please report all serious adverse events related to this study to 37MH-IRB within seven (7) days verbally and fourteen (14) days in writing.

This certificate is valid until 24th October 2019.


DR EDWARD ASUMANU
(37MH-IRB, Vice Chairman)

37 MILITARY HOSPITAL
INSTITUTIONAL REVIEW BOARD

DATE 23-11-18

Cc: Brig Gen MA Yeboah-Agyapong
Commander, 37 Military Hospital