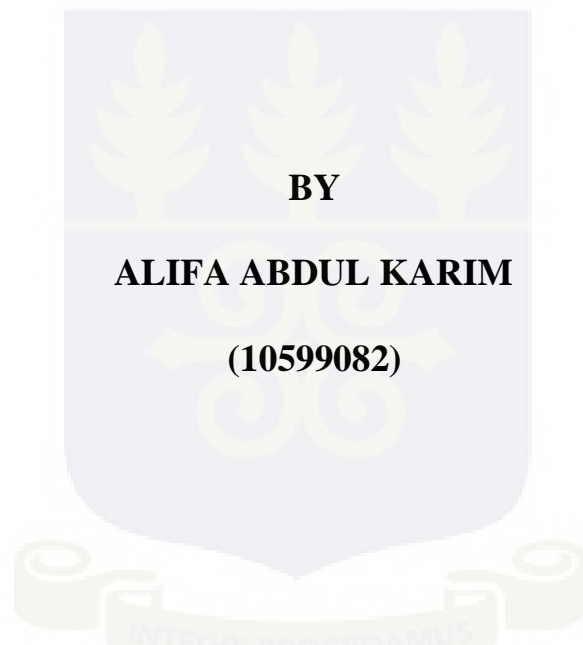


**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**

**KNOWLEDGE AND BELIEFS OF GYNAECOLOGICAL CANCER
AMONG WOMEN VISITING BATTOR CATHOLIC HOSPITAL**



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

JULY, 2017

DECLARATION

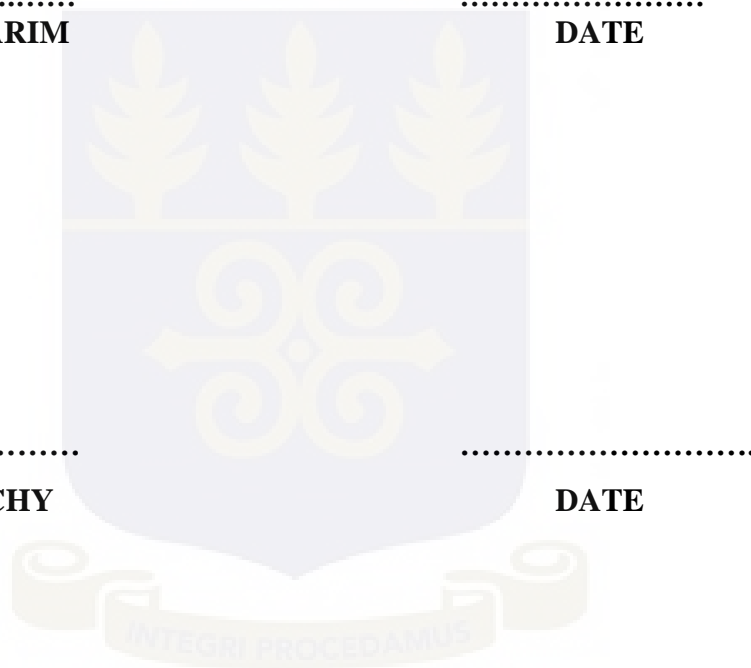
I, Alifa Abdul Karim declare that with the exception of references to other people's work which have been duly acknowledged, this work is my own work conducted under supervision and that this has not been submitted neither in part nor whole anywhere for any degree.

.....
ALIFA ABDUL KARIM
(STUDENT)

.....
DATE

.....
DR IRENE KRETCHY
(SUPERVISOR)

.....
DATE



DEDICATION

This research work is dedicated to my husband, Basim Alhassan for his support and encouragement.



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First and foremost, I am very grateful to the almighty God for his protection and guidance to me throughout my course.

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TABLE OF CONTENTS

CONTENT	PAGE
DECLARATION.....	i
DEDICATION.....	ii
ACKNOWLEDGEMENTS	iii
TABLE OF CONTENTS	iv
LIST OF FIGURES	vii
ABSTRACT.....	viii
CHAPTER ONE	1
1.1 Background	1
1.1.1 Cervical Cancer	2
1.1.2 Ovarian Cancer	3
1.1.3 Uterine/Endometrial Cancer	3
1.1.4 Vaginal cancer	4
1.1.5 Vulvar Cancer.....	4
1.2 Problem Statement	5
1.3 Justification of the Study.....	6
1.4 Research questions	7
1.5 Study Objectives	7
1.5.1 Main Objective	7
1.5.2 Specific Objectives	7
1.6 Conceptual Framework	8
CHAPTER TWO	10
2.0 LITERATURE REVIEW	10
2.1 Introduction	10
2.2 Definition and Overview of Gynaecological Cancer	10
2.2.1 Cervical Cancer	11
2.2.2 Endometrial Cancer	13
2.2.3 Ovarian Cancer	14
2.2.4 Vagina Cancer	15
2.2.5 Vulvar Cancer.....	16
2.3 Level of Knowledge of Women about Gynaecological Cancers	17
2.4 Beliefs of Women about Gynaecological Cancers.....	18

2.5 Preventive Measures against Gynaecological Cancers	21
2.6 Coping with Gynaecological Cancers	23
CHAPTER THREE	26
3.0 METHODOLOGY	26
3.1 Introduction	26
3.2 Study Area.....	26
3.3 Study Design	27
3.4 Study Population	27
3.5 Sampling Methodology	27
3.6 Data Collection Technique.....	28
3.6.1 Training	28
3.6.2 Piloting and pre-test of study tool.....	29
3.7 Data Processing and Analysis Plan	29
3.7.1 Data Processing	29
3.8 Ethical Consideration	30
CHAPTER FOUR.....	31
4.0 RESULTS	31
4.1 Introduction	31
4.2 Demographic characteristics of participants	31
4.3 Knowledge on Gynaecological Cancer	31
4.3.1 Description of Gynaecological Cancer	32
4.3.2 Symptoms of Gynaecological Cancers.....	34
4.3.3 Risk factors for gynaecological cancer.....	35
4.3.4 Preventive Strategies	36
4.4 Beliefs Associated with Gynaecological Cancer	37
CHAPTER FIVE	39
5.0 DISCUSSION	39
5.1 Knowledge on Gynaecological Cancer among Women.	39
5.2 Risk factors associated with gynaecological cancer.	40
5.3 Beliefs on Gynaecological Cancer	41

CHAPTER SIX	43
6.0 CONCLUSION AND RECOMMENDATIONS.....	43
6.1 Conclusion.....	43
6.2 Recommendations	43
REFERENCES.....	45
APPENDICES	50
Appendix A: Guide for Focus Group Discussions.....	50
Appendix B: Ethical Clearance	51



LIST OF FIGURES

Figure 1.1: Conceptual framework of knowledge and beliefs about gynaecological cancers

developed by the researcher 8



ABSTRACT

Introduction: Globally, every two minutes at least one woman dies from gynaecological cancer and out of these deaths about 80% are from developing countries. One major problem in developing countries especially sub-Saharan African is inadequate knowledge about gynaecological cancer. This study seeks to find out the knowledge women have about gynaecological cancer and the inaccurate data on gynaecological cancer by assessing knowledge and beliefs women visiting the Battor Catholic Hospital have on gynaecological cancers

Methods: The study adopted a descriptive and qualitative data collection approach. Study with the aim of assessing the knowledge and beliefs of gynaecological cancer amongst women visiting the Battor Catholic Hospital in the North Tongu district. Four focus group discussions were held with adolescents and five in-depth interviews conducted with women diagnosed of gynaecological cancer. The results were analysed using the NVIVO software.

Results: Women visiting the Battor Catholic Hospital were found to have little knowledge about description of gynaecological cancer and had a lot of misconceptions about the symptoms, risk factors and preventive strategies associated with gynaecological cancer. Women's beliefs about gynaecological cancer was poor and contributed to delay to screen for the various gynaecological cancers.

Some of the beliefs were also not supportive of women who undergo treatment for gynaecological cancer and tend to stigmatize women who have been diagnosed with gynaecological cancer. Women struggling with gynaecological cancer were believed to have been either cursed, bewitched or possessed by spirits. Treatment options were mostly concentrated on getting them free from these curses, witchcraft or spirits.

Conclusion: Women visiting the Battor Catholic Hospital had little knowledge about description, symptoms and preventive strategies of gynaecological cancer. Most women also believed gynaecological cancer was associated with spirits, being bewitched and being cursed. Therefore more education about gynaecological cancer needs to be done in the Hospital.

CHAPTER ONE

1.1 Background

Cancer is an ailment in which causes cells in the body grow uncontrollably. Cancer of the cervix, ovary, uterus, vagina and vulva are the five main kinds of cancers that affect women's reproductive system (Sekse et al., 2014). Of these, the most common ones are cervical and breast cancer. About 99.7% of cervical cancer is caused by insistent infection with high risk of Human papillomavirus(HPV) through sexually transmitted infections as reported by (Hsu et al.,2011)there are many types of HPVs, however the oncogenic ones are the ones causing cervical cancer and with the right vaccination this can be stopped. In Africa, reasons for delay in presenting symptoms of cancer to physicians are multi-factorial and complex according to the collective discoveries of two orderly reviews of literature on mutual cancers. The main reason for patients' postponement is lack of knowledge on the serious nature of the symptoms (Macloed et al.,2009) "Across the common cancers, symptom type determines delay in presentation. If a symptom is vague, or atypical in nature, dangers of delayed presentation can be increased (Asoogo and Duma, 2015)

Equally, if symptom are more severe or startling and consists of bleeding, pain or lumps then the possibility of late reporting is classically reduced. Patients fail to recognize or appreciate atypical or vague symptoms, which may facilitate delayed presentation. In cases where symptoms are assumed and thought to be serious, there is an abridged time to presentation.

The reason for presentation to a nearby clinic and Hospital is often based on when symptoms get devastating or impact on the normal activities, rather than the existence of the symptoms alone(Macloed et al.,2009)they further reported that difficulty was due to the fact that collective cancer symptoms are attributed to benign disease. The example of this can be demonstrated with

breast cancer, where there is a robust evidence that patients postpone well-known symptom of lump, associated with the less recognized non-lump symptoms, which results in more delay (Macleod et al., 2009). This compares with the evidence for urological cancers, where pain increases delay, perhaps as a result of symptoms being misinterpreted as being due to a benign cause such as cystitis (Kulkarni et al.,2015) in other cancers too, such as those of the gastrointestinal tract, probable cancer symptoms can frequently have a benign interpretation (Macleod et al., 2009).

1.1.1 Cervical Cancer

Cervical cancer affects the cervix. It is the commonest among the gynaecological cancers and the principal cause of death in the cancers that affect the reproductive system of women (WHO, 2011).

Women don't usually show any symptoms till the cells have turned to cancer and enter the deepest part of the cervix or other pelvic organs (Wong et al.,2009).Some common symptoms of cervical cancer may include irregular vaginal discharge, abnormal vaginal bleeding, vaginal odour, pain and bleeding after menses.

Cervical cancer can be prevented by regular screening and a precautionary vaccination. Since nearly all cervical cancers are caused by persistent infection with HPV, young women when vaccinated before they are sexually active can lead to the greatest prevention of pre-cancer and cancer (Hsu et al.,2011). Also, routine human papilloma test to screen for Human papilloma virus or signs of cervical cancer can be useful for early detection.

1.1.2 Ovarian Cancer

There are three forms of ovarian cancer: germ cell ovarian cancer, epithelial ovarian cancer, and stromal cell ovarian cancer. With Epithelial ovarian cancer being the commonest, and accounting for about 85 to 89 percent of all ovarian cancers. Ranking fourth in the cancer deaths among women, it causes more deaths than any other female reproductive system cancer (Carter et al.,2014).

Ovarian cancer has been termed the ‘silent killer’ since its symptoms are not believed to develop until it is nearly too late. But, recent studies have shown that certain symptoms are mostly common in women with ovarian cancer compared to women who don’t have ovarian cancer (WHO, 2013).

These symptoms comprise dangerous sudden onset of bloating, abdominal or pelvic pain, loss of appetite or feeling of full quickly and urinary indications (frequency or urgency). These symptoms are more common in women who later suffer from ovarian cancer (Goff, 2012).

It is also necessary to understand that symptoms related to ovarian cancer are common and often as a result of different causes. Nonetheless, women suffering from ovarian cancer have stated that these symptoms are insistent and a change from their body’s normal behaviour. Therefore, the incidence and occurrence of these symptoms are the core factors in diagnosing ovarian cancer (Goldstein et al., 2015)

1.1.3 Uterine/Endometrial Cancer

Uterine cancer or endometrial cancer is cancer that affects the uterus. Some possible causes of uterine cancer include the use of oestrogen without progesterone, hypertension, diabetes use

tamoxifen and late age of menopause (WHO, 2013). However, obesity is one common threat for developing uterine cancer. Obese women have higher circulating oestrogen levels which increase their risk of uterine/endometrial cancer (Low, 2012).

Women with endometrial cancer frequently experience abnormal vaginal bleeding. Early recognition of this symptom allows timely diagnosis and treatment. Other symptoms are spotting after menopause, heavy new menstrual periods or bleeding in-between periods. Women also have white or pinkish discharge from the vagina, lower abdominal pain lasting for more than two weeks and pain in the course of sexual intercourse (Goldstein et al.,2015).

1.1.4 Vaginal cancer

Vaginal cancer is one of the infrequent forms of gynaecologic cancers and usually affects women 50 to 70 years old. Vaginal cancers are mostly linked with HPV, and can be controlled by vaccinating women and girls earlier before they become sexually active (WHO, 2013).

Symptoms are not normally seen until the cancer is further advanced, and may include unusual vaginal bleeding, unusual vaginal discharge and also noticeable mass pain during sexual intercourse (WHO, 2013).

1.1.5 Vulvar Cancer

Vulvar cancer is an unusual, atypical growth on the peripheral female genitalia, usually occurs in elderly women. Fortunately, vulvar cancer is curable when detected at an early stage (WHO, 2013). Treatment can, nevertheless, have considerable dire effects on patients' sexual function, bladder, rectal function, and their body image (Low, 2012).

Women with this cancer often experience symptoms including red, pink or white bumps with a wart-like surface, a coarse whitish area, persistent itching, bleeding and discharge not associated with menstruation, burning feeling while urinating, an open sore or ulcer that lasts more than a month (Iwu, 2012).

1.2 Problem Statement

Gynaecologic cancers are the uncontrolled growth and spread of unusual cells that originate from the female reproductive organs, among which includes the uterus, cervix, ovaries, vagina, fallopian tubes and vulva. Gynaecological cancers continue to be important health problems globally. The composition of cancers in females which are of genital tract origin range from 31.6% to 35.0% in sub-Saharan Africa, 13.9% to 16.8% in France and the Scandinavian countries, 12.7% to 13.4% in North America, 15.5% to 43.1% in South America and 22.4% to 55.8% in India (Sarkar, et al., 2011).

Inadequate knowledge about gynaecological cancers and inaccurate data on gynaecological cancer is one key problem in developing countries, especially sub-Saharan Africa, hence not making it easy to reliably calculate occurrence rate for the various cancers. Reliance has to be placed on relative frequencies in Hospitals as a measure of tumour incidence (Nkyekyer, 2000). Another problem facing the health sector about gynaecological cancer is the issue of late reporting of cases. In Ghana, where the majority of women are uneducated, the knowledge on gynaecological cancers is very low, hence contributing to late reporting”.(Ebu et al., 2014).

While in developed countries endometrial carcinoma is the commonest gynaecological cancer (Sankaranarayanan and Ferlay, 2006), in African countries carcinoma of the cervix has been reported in many studies to be the commonest, with most of the patients presenting in late stages

of the disease. Age and parity are known to affect the incidence of gynaecological cancers. Endometrial carcinoma is predominantly a disease of ageing mostly affecting postmenopausal women, the peak incidence being in the 58-60 years group (World Cancer Research, 2013). It occurs later in reproductive life than carcinoma of the cervix which is seen commonly in premenopausal or perimenopausal women. Women of high parity have relatively low risk of developing endometrial cancer; pregnancy also protects against ovarian cancer sharp contrast, however, multi-parity is associated with increased risk of development of cervical carcinoma.

This work seeks to find out the knowledge and beliefs of women visiting the Battor Catholic Hospital about gynaecological cancers and also the factors that influence this knowledge and beliefs. Since the knowledge about cancers go a long way to determine the stages at which gynaecological cancers are reported, women's beliefs such as the cultural, religious and past experiences about gynaecological cancers and this affects the way they perceive gynaecological cancers. These also determine the outcome of their treatment. This work also seeks to find out knowledge of women living with gynaecological cancer.

1.3 Justification of the Study

Gynaecological cancers have become a major health concern for women all over the world. It has implications on government budgets for health, family welfare and some other members of the extended family. This study will provide further literature in addition to the studies that have been conducted on gynaecological cancers in Ghana and Africa as a whole. It will also serve as the basis for further research on how to improve on patronage of gynaecological cancer screening services in Ghana and Africa. In spite of the statistics indicating a serious concern, cancer prevention is not commonly promoted in Ghana (GHS, 2011). It is necessary to find out the level of knowledge and beliefs among women in Battor Catholic Hospital in the Volta

Region and how it influences their decision to engage in gynaecological cancer screening. This will inform policy formulation and practice among educationists and health practitioners on how to reduce the incidence of gynaecological cancer among women in Ghana as well as improve the knowledge.

1.4 Research questions`

1. What is the knowledge of gynaecological cancer among women visiting the Battor Catholic hospital?
2. What are the beliefs associated with gynaecological cancer among women who suffered gynaecological cancer and women who did not?
3. What are the preventive strategies against gynaecological cancers used by women visiting the Battor Hospital?

1.5 Study Objectives

1.5.1 Main Objective

To explore the knowledge and beliefs of gynaecological cancer among women visiting Battor Catholic Hospital.

1.5.2 Specific Objectives

1. To explore knowledge of gynaecological cancer among women visiting the Battor Catholic Hospital.
2. To ascertain the beliefs associated with gynaecological cancer among women visiting the Battor Catholic Hospital.

3. To find out preventive strategies of women visiting the Battor Catholic Hospital.

1.6 Conceptual Framework

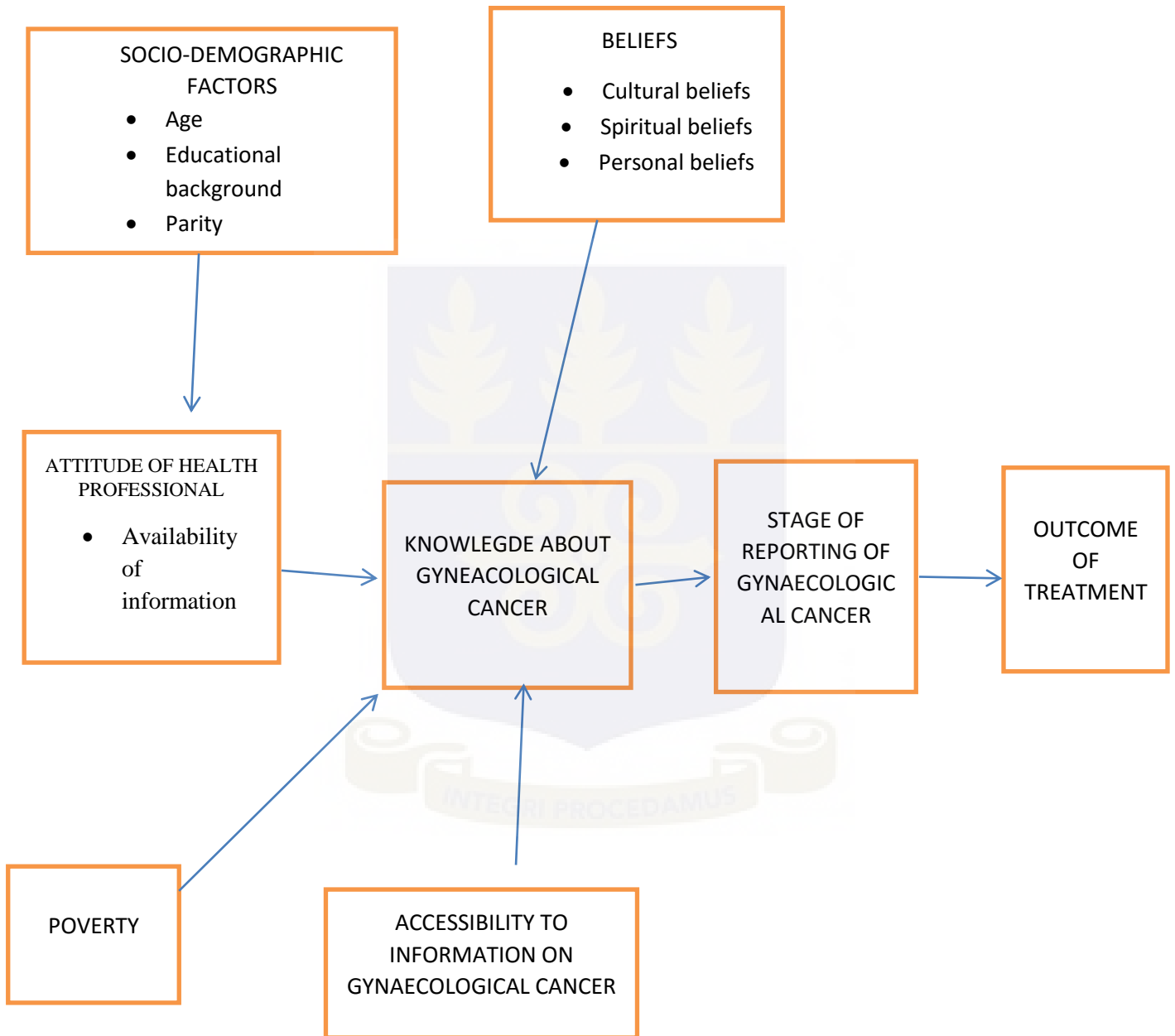
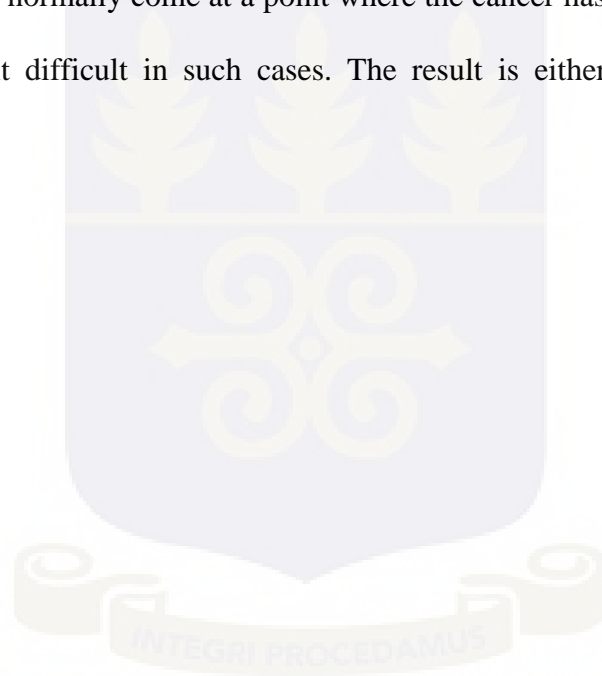


Figure 1.1: Conceptual framework of knowledge and beliefs about gynaecological cancers developed by the researcher

Knowledge and beliefs about gynaecological cancers among women go a long way to determine their readiness to access health care provided for gynaecological cancer. Socio-demographic factors such as age, educational background, and income level can affect the level of knowledge women have and determine how information about gynaecological cancer are accessed (Bekar et al., 2013). Women get more information from the experiences of other women. How other women went through certain cases and the outcome of the situation affect what women think. When women lack knowledge about gynaecological cancers, there is late reporting of symptoms to be diagnosed. Women normally come at a point where the cancer has spread and caused lot of havoc, making treatment difficult in such cases. The result is either death or loss of organ (Siegel, 2014).



CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter reviewed available literature on the knowledge and beliefs of gynaecological cancer among women. It further reveals the beliefs and perceptions of women on gynaecological cancer screening as well as the preventive measures adopted by women and healthcare personnel against gynaecological cancers. The chapter is divided into five sections: overview and definition of gynaecological cancer, knowledge of gynaecological cancers, beliefs of women about gynaecological cancers, preventive measures against gynaecological cancers, and the managing strategies adopted by women living with gynaecological cancers.

2.2 Definition and Overview of Gynaecological Cancer

Cancer consists of a number of diseases in which irregular cells in the body divide and grow abnormally.

These cells then spread to other areas of the body. This is what is referred to as metastasis. The five types of cancers that affect the female reproductive organs include uterine, vulvar, cervical, ovarian and vaginal. These are what we call gynaecological cancers. Cancers are named after the tissue or part of the body where it starts. Each of them is unique, with diverse signs, symptoms and risk factors (CDC, 2011). Gynaecological cancers have been reported by Yakasai et al., (2012) to continue to be important health problems universally, as mostly malignant female private organ tumours have a global circulation, with distribution and incidence varying from region to region. Percentage of cancers among females which are of genital tract source ranges from 12.7% to 13.4% in North America, 31.6% to 35.0% in sub-Saharan Africa, In more advance countries seeking for health and structured screening procedures have been significantly

developed (Minchew, 2011). About 11.7% of all new cancers in women are attributed to gynaecological malignancies. The American Cancer Society has estimated in 2014 that, 94,990 women in US will have been diagnosed with, while 28,790 will have died of cancer of the female genital tract by year 2020 (Siegel et al, 2014).

A comprehensive cancer data from the International Agency for Research on Cancer shows that gynaecological cancers accounted for 2.9 million cancer deaths, 19% of the 5.1 million probable new cancer cases, and 13 million with five-year prevalent cancer cases amongst women in 2002. Cervical cancer was stated to have accounted for 493 000 new cases and 273 000 deaths; 199 000 new cases and 50 000 deaths for uterine cancer; 204 000 new cases and 125 000 deaths for ovarian cancer; cancers of the vagina, vulva and choriocarcinoma all accounted for 45900 cases, more than 80% of the whole cervical cancer cases that occurred in developing countries and two-thirds of corpus uteri cases occurred in the developed world. Lack of governmental will and support to pump financial resources in health infrastructure and human resources to strengthen service delivery and availability are of utmost importance to lessen the present burden in low and medium resourced countries (CDC, 2011).

2.2.1 Cervical Cancer

“Cervical cancer is a malignant disease of the cervix, which mostly occurs in the fifth and sixth decade of life at an age of 54 years. It has a pre-malignant stage, and usually occurs in women under the age of 40 (Abdala, et al., 2016). Cervical cancer, although fundamentally preventable, is touted to be a significant issue of global concern. Though the pathogenesis and accepted history of cervical cancer is well explored, it continues to remain the main cause of female mortality in developing countries (Antilla et al., 2010). It is also identified to be the second commonest cancer among women worldwide with an estimation of 500,000 new cases and about

275,000 deaths in 2008. About 86% of these cases occur in under develop nations which represent 15% of female cancers (WHO/ICO, 2010). The prevalence of the cancer in Africa is increasing. Nevertheless, many African countries have no knowledge about these incidences, as it hasn't been reported much (Ubajaka, et al., 2015). Not many countries have operative cancer registries hence keeping records is sub-optimal. Most of the data in these countries are hospital-based, and it accounts for a small section of women dying from the cancer, as most do not seek for proper treatment at the hospital (Ebu et al., 2015). In developed countries with successful screening programs, mortality rates barely exceed 5 per 100,000 women. In 2002, survival rate were 70% for US, 66% in Europe as well as 21% in sub-Saharan Africa. (Odedina, et al., 2010). The work of Maver et al., (2013) indicates that more than 85% of worldwide cervical cancer deaths occur in low and middle-income countries, reflecting poor control and early detection measures in these countries. In Ghana, 80% out of the 10,000 women who develop cervical cancer yearly die from it (Anorlu, 2008).

Cervical cancer, as stated earlier, is an avoidable disease and a crucial feature of prevention is timely exposure of precancerous disorders through the Papanicolaou cytology screening (Pap smear), which has been recognised internationally as a competent tool for secondary prevention. Pap smears can efficiently reduce the occurrence of cervical cancer by 75-90% (Biobaku et al., 2015). Inconsistency in occurrence amongst the low- medium and high income countries can be ascribed to the lack of awareness of cervical cancer and lack of operative cytological screening programs (Ebu et al., 2015).

There are many factors associated with the evolution of cervical cancer, some of which include early sexual intercourse, high parity, multiple sexual partners, smoking, and co-infection with human immunodeficiency virus (HIV). However, the known main underlying cause is the

Human Papilloma Virus (HPV), which is the commonest sexually transmitted infection globally, and it is estimated that 50% to 80% of sexually active women are infected at least once in their lifetime (Adjorlolo, et al., 2010). HPV is a sexually transmitted infection which is spread via skin to skin contact during sexual intercourse. Some known risk factors include early age at first intercourse and several sexual partners. Luckily, infection is generally temporary and has no clinical consequence, but a minority of infected women retain the oncogenic viruses within their genital epithelium which may lead to the development of cervical intraepithelial neoplastic and possibly cancer (Ebu *et al.*, 2015). Prevention of cancer of the cervix is possible by avoiding HPV infection and promoting early detection and treatment, which significantly reduces its morbidity and mortality. Pap smear test is one of the most consistent and effective cancer screening services available.

2.2.2 Endometrial Cancer

Uterine cancer, also referred to as endometrial carcinoma is reported by Morris et al., (2010) to be the commonest female pelvic malignancy in urbanized countries and known to account for about 7300 deaths in USA annually. It commonly occurs after menopause but it has been reported that 3-5% of patients are younger than 40 years old (American Cancer Society, 2012). Most of these female have history of ovarian dysfunctions, anovulation, obesity, null-parity, hormonal disturbances and infertility (Minchew, 2011). However, a study by Fallowfield et al., (2010) indicates that endometrial carcinoma is well distinguished in younger patients and usually is in earlier stage with better prognosis. Their report further indicates that 11% of women suffering from endometrial cancer show optimistic reaction to treatment. Complex unusual hyperplasia of endometrium is a originator of endometrial adenocarcinoma (the commonly

histological type of endometrial cancer) which has 25% chances to progress into endometrial cancer (WHO,2014).

Kahu et al., (2012) found that the normal treatment for endometrial carcinoma consist of total abdominal hysterectomy staging laparotomy, and bilateral salpingo-oophorectomy with lymph node sampling, pelvic washing and evaluation of peritoneum cytology. Hoskins et al., (2014) also added that supportive therapy such as radiotherapy is also employed for high risk patients to prevent the recurrence of this cancer .Even though the ultimate treatment especially in early stages is surgery, hormonal treatment has been suggested for women who are concerned to conserve their fertility. In the last 30 years, a limited number of reports suggested that young patient with diagnosed endometrial carcinoma may be treated conventionally with progestin to preserve fertility (Morris et al., 2010). They further added that effective management of severe and reappearance endometrial cancer with progestin agents could be done successfully when early steps are taken.

2.2.3 Ovarian Cancer

Ovarian cancer is a cancerous tumour arising from the ovary. “Signs and symptoms of this cancer are normally absent and when they exist, they are mostly understated” (CDC, 2011). Ovarian cancer is reported by the American Cancer Society (2012) to cause more death than any other cancer, though it accounts for about three percent of cancers in women. “The projected yearly prevalence of ovarian cancer is 204,000 with 125,000 deaths making it the second most common gynaecological cancer after cervical cancer worldwide” (Sankaranarayanan and Ferlay, 2006). “Most typical symptoms of ovarian cancer include bloating, abdominal or pelvic pain, back pain, abnormal vaginal bleeding, constipation, and difficulty in eating and probable urinary indications”(Goff, 2012

There are numerous risk factors associated with ovarian cancer due to its proliferations with age and high occurrence in women in their late 70s (Bradbury, 2010). Women with breast cancer or have a family history of breast or ovarian cancer show only 5% to 15% of cases of ovarian cancer. Woman without children, hormonal replacement therapy and breastfeeding are at high risk. Regardless of the fact that some of the risk factors that intensify the woman's chance to develop ovarian cancer are relatively familiar, Kahu et al., (2012) reports that the real cause of this cancer is not ultimately known. Timely recognition improves a woman's chance of ovarian cancer management, but a prompt identification of ovarian cancer is problematic and reports indicate that there are no consistence screening programs currently (Kebede, 2012). Since there are not enough information regarding the associated signs and symptoms, risk and protective factors of ovarian cancer, CDC (2011) recommends that creating awareness in women could help to reduce the delay in diagnosis time, and associated rates of morbidity and mortality. Goff et al., (2012) further recounted that, if women are educated about the signs and symptoms of ovarian cancer then patient-related delays in diagnosis could be reduced and this may will have an influence on a woman's survival rate.

2.2.4 Vagina Cancer

Cancer originating from the vagina is termed vagina cancer. Though less common globally all women are at higher risk of getting it. Each year, the CDC (2011) estimates that approximately 1000 women living in the United States are diagnosed with vaginal cancer. Reports indicate that there are no sure ways as to who gets vaginal cancer, yet, these indications might increase the chance of getting it; having HPV, having a history of abnormal pap test results showing abnormal cervical cells, HIV infection or any other conditions that breaks down immune system functions, smoking and exposure to Diethylstilboestrol (DES) before birth (Biobaku et al., 2015).

Mostly, vaginal cancers do not show signs and symptoms early on, but when symptoms are present, it will include; abnormal vaginal discharge, blood in stool or urine, pains in your pelvis or abdomen during sexual intercourse or urine, and bleeding between periods or bleeding after menopause(CDC,2011).

Like all other cancers, vaginal cancer can be prevented by HPV vaccine if you are in the age group to which the vaccine is recommended. It can also be prevented by limiting the number of sexual partners to reduce the risk of getting HPV or HIV. Treatment of vaginal cancer depends on early diagnosis of the disease (CDC, 2011).

2.2.5 Vulvar Cancer

The vulva is the outer part of the female genital organ, and hence cancer origination from there is known as vulvar cancer. When vulvar cancer is detected early, treatment becomes effective. While vulvar cancer is very uncommon, reports by WHO (2013) indicates that all women are at risk. Each year, almost 3500 cases are reported in the United States of America. Signs and symptoms of vulvar cancer includes, continuous burning itching or bleeding on the vulvar, colour changes on the vulvar skin, pelvic pains during sexual intercourse, and sores or lumps on the vulvar that do not go away.

CDC (2011) reports suggest that women in their reproductive age must be vaccinated with the HPV vaccine in order to lower the chance of getting vulvar cancer. Additionally, limiting sexual partners and quitting smoking are other sure methods of preventing this type of cancer. The best ways to detect vulvar cancer early are to go for regular check-ups and to see a medical practitioner if signs and symptoms show up. A doctor may also carry out physical examination to look for changes in the skin or perform biopsy to help to diagnose vulvar cancer (WHO, 2013).

2.3 Level of Knowledge of Women about Gynaecological Cancers

Reports indicate that breast cancer screenings are well known by many Ghanaians due to much attention by the government and social groups in the country (Ofori et al., 2014) education and knowledge about all cancer is vital in the reduction of cancer-related mortality. When cancer, confined to the breast is diagnosed early, there is 95% 5-year survival rate is over 95%. Knowledge, attitudes, and beliefs toward breast cancer disease and illness have been shown to impact gynaecological cancer screening in most parts of Africa (Philips et al., 2009).

The destructive effects when diagnosed with gynaecological cancer on the health of women have numerous proportions. The horror associated with being diagnosed with cancer, the complex lengthy invasive, and collective managements, being under stress and the risk of difficulties depending on the extent of the treatment, worries about the sexual identity, the body shape and the reproduction effects standard of living of the woman, her companion and her family (Mbamara, et al., 2011). However, gynaecological cancer as other cancers is a disease that can easily be prevented and cured when diagnosed early. Nonetheless, some researches indicate that factors such as lack of formal education, lack of knowledge about scanning, the problems of attaining health services, economical problems, the fear of having pain, the false beliefs about ignoring the discretion, the embarrassment and the scanning tests being needless, African women do not get the benefit of early diagnosis (Biobaku et al., 2015).

Due to the growing interest in North American and most developed countries, worldwide health enterprises have led many of clinical outreach missions and academic programs (Rosenthal, 2011). Medical and gynaecological oncologists caring for women with gynaecological cancers are in an exceptional situation to augment the international health community with chances for training, education and policy making as related to women's cancers (Fallowfield et al., 2010).

In cases of limited resources, there is the establishment of a worldwide health component to citizenship and fellowship training programs, thus serving a duo agenda; first to raise the international knowledge base of trainees and secondly, to develop an analytic skill set to create cancer care programs where resources are scarce. Oncologists in high-income countries have advanced from a century of increasing knowledge through research and increasing therapeutic options through both drug development and biomedical engineering (Hanna and Kangolle, 2010). Traditionally, delicate set-ups must be enforced in developing countries before efficient procedures for cancer care can be accessible and sustainable for their populations. The assessment of the present global challenges for women suffering from cancer, and the current programs that seek to dialogue women's health and aspects of gynaecologic oncology can both detect areas of expertise in gynaecological oncology that can be harnessed to increase worldwide cancer care (CDC, 2011).

2.4 Beliefs of Women about Gynaecological Cancers

Cultural beliefs have an influence on the risk factors for cancer in addition to the meaning of the disease by initiating customs of behaviour and providing regulation for its members to respond, cognitively, emotionally, and socially to this disease. These beliefs mostly lead to delay in seeking medical treatment, thereby prolonging the interval between first presence of symptoms and the first doctor visit (Jugal et al., 2015). Cancer-related stigma and myth about cancer are important problems that must be addressed (Ling and Phelan, 2014). They present important challenges to cancer control, for instance they have a silencing effect, whereby efforts necessary to increase cancer awareness are negatively affected. They are reported to affect individual's behaviours, such that they are less likely to adopt cancer-risk-reducing behaviours or seek out the support and services they need when they are diagnosed with the disease (Ling and Phelan,

2014). Interviews conducted by Morris (2012), indicates that most people with cancer are of the belief that nothing can be done to prevent cancer and that cancer is always fatal. It may be seen as a punishment. Cancer patients have been known to often feel reluctant to undergo surgery because they believe if you cut into the cancer, it will spread immediately all over the body. Some others perceived cancer treatment to be as bad as, or worse than, the disease itself (Lagnado, 2010). He further indicated that cancer symptoms or body parts affected by the disease can cultivate stigma. For example, cervical cancer is highly stigmatized because the cervix is part of the body people don't talk about. Gynaecological cancers may show symptoms that women are unwilling to disclose to their doctors, and they may be even less willing to undergo the necessary physical exams to investigate the cause of such symptoms (Ling and Phelan, 2014). Individuals personally affected by cancer may often express a feeling of seclusion, silence surrounding the disease is mostly common. This kind of denial and avoidance can perpetuate a person's sense of isolation. Family members can alternatively be a source of stigma, as they try to isolate the patient. When this happens, cancer care professionals play a critical role in supporting the patient (Kasaura et al., 2011)

Treatment of cancer is deemed a financially overwhelming burden for the family since in many countries expenses for diagnosis, patient support and treatment are completely or partially paid by the patient and the family. There is a perception that a person who may have been diagnosed with cancer is too ill to be working. Thus, making it difficult for individuals with a cancer history to return back to work after an illness-related absence, or to try to secure new employment. That is why in the workplace, cancer is often kept a secret (Morris, 2012). A research carried out by Jugal et al., (2015) concluded that majority (about 60%) of patients interviewed believed that cancer is caused by God's curse. Apart from that, many patients (about 58%) assessed that 'evil

eye' is the main cause of cancer, and hence believed that treatment options are not likely at the hospitals. They further indicated that past or present sins were some of the beliefs of the people to be the cause of cancers. Few patients believed that cancer is infectious and more than half of those patients believed that since they had close contact with a cancer patient, it might be the reason for their present illness.

There are reports by the American Cancer Society (2012) that owing to few screening programs, there are most women with advanced stages of cancer in developing countries, the predicament of women with cancers in most of these developing countries are awful. Gynaecological cancers range from virally induced cervical cancers to genetically associated cancer clusters that are barely unknown by women in the developing world (Adjorlolo et al., 2010). Although complex cultural and social taboos or beliefs continue to prevent early detection in these low income countries, ethnic intermarriages may lead to increased genetic and familial associations with breast cancer (Ebu *et al.*, 2015).

In many societies in Ghana for instance, the cultural stigmatization of cancer leads to isolation of women with the ailment. In addition to the fear of abandonment by spouses because of cancer, studies show that most women in developing countries like Ghana struggle with access obstacles to care and physical circumstances such as inequalities related to place, sex, and class (Broom and Doron, 2012). In the absence of cancer screening, most women benefit from in most developed countries. These societies have few resources such as pain relief to alleviate the common causes of suffering at the end of life (Low et al., 2012). Sophisticated technology and mediations such as safe, long-term intravenous access, drainage of malignant effusions, and intestinal diversions are taken for granted in high-income countries but are unavailable in the developing world with the highest death rates from cancer. This loss of women in the community

takes a huge toll beyond the loss of that one individual. In many such societies, women are the breadwinners of the family and carry the primary responsibility for finding food, water, and providing sanitation (Abdallah et al., 2016).

A recent report concerning awareness and beliefs of gynaecological cancers in Ghana by Edwin (2010) revealed some knowledge gaps and misconceptions about gynaecological cancers such as common misunderstanding about the purpose of the Pap test, lack of familiarity with vaginal and vulvar cancers, and generally poor understanding of the female anatomy including the locations and names of reproductive organs and the possible ailments that affect those organs.

2.5 Preventive Measures against Gynaecological Cancers

While most cancer patients will survive with their disease, thousands of women and their loved ones are reported to face the challenges of managing the medical treatments and the uncertainty and unpredictability of this disease (Ebu, et al., 2015). Studies indicate that there is no universal response to the stresses of cancer. A lot depends on factors such as the woman's age, stage or level of illness, ethnicity and social context (Kazaura et al., 2011). Furthermore, the diagnosis does not necessarily mean a high level of psychological distress and a low quality of life. Many cancer patients can ultimately transform such a challenging disease into a life-affirming experience that changes their life meaning in a more positive way (Lutgendorf et al., 2012). While rate of psychiatric disorders were not higher among cancer patients than the general populace, many women in Dausch et al., (2012) report were found to experience some psychological distress often manifested by depressive symptoms. In fact, the most common side effect of cancer diagnosis and treatment is depression (Abdallah et al., 2016). Most patients in Kazaura et al., (2011) survey portrayed some behavioural manifestation of depression; insomnia, inability to concentrate, loss of appetite, thoughts of suicide, greater use of alcohol and

tranquilizers, sexual dysfunction, and disruption of daily activities as some of the major characteristics of cancer patients.

Until proper screening tools were available in Ghana, patients' education as reported by Edwin (2010), remains the most vital mediation for the prevention of gynaecological cancers. Women and healthcare providers in Ghana are advised to seek for early signs and symptoms of gynaecological cancers. They are further advised to seek medical attention if they experience any of the cancer related symptoms.. Since some of the gynaecological cancers especially ovarian and endometrial cancers do not depicts early signs, patients are further advised by gynaecologists to seek immediate attentions within two weeks of such related signs.(Edwin,2010)

The American Cancer Society found that ovarian cancer is often denoted as the silent killer due to the fact that women in most societies ignore early signs and symptoms because they are so vague and usually present with advanced diseases and poor general predictions (ACS, 2012). The Ghana Health Service, in its 2011 reports stated that women must know their family medical history and status specifically with regarding cancer, to determine if further genetic screening and prophylactic medical involvements are appropriate (GHS, 2011). Again in 2011 designated number of women were screened for cervical cancer using Papinocolou smear (PAP) and the results revealed that, out of 1116 women screened 11(1%) were cervical cancer cases (Ghana Health Service (GHS, 2011). Furthermore, in Ghana, screening for cervical cancer using visual inspection after Acetic Acid Application (VIA) is usually conducted among women between the ages of 25 to 45 years while Papinocolou (Pap) smear is done for women 21 years and above at the Ridge hospital in Accra (Ghana Heath Service Report 2011). With recent intervention of HPV vaccine, women have been educated that they can prevent only about three cancers. However, it further prevents other subtypes of gynaecological cancers. In addition, routine pap

smear screening has been highly recommended for sexually active young women despite vaccination. The World Health Organization Report (2013) further advised women that though cervical, vaginal and ovarian cancers are preventable by maintaining healthy sexual lifestyle, they should however disengage themselves from stigmatizing those people living with cancer. Young female adults are therefore constantly educated on prevention of all sexually transmitted diseases. Lastly Pharmacists worldwide play a key role in the prevention and management of chemotherapy induced toxicities. Toxicity can be prevented with the proactive assessment of organ function and recommending dosage adjustment, appropriate use of granulocyte stimulating growth factors, and antiemetic regimens. Pharmacists have further contributed to development of supportive care plans needed to provide comfort throughout treatment (WHO, 2013).

2.6 Coping with Gynaecological Cancers

It is well known that psychosocial problems are major challenges in patients with cancer. Cancer is a 'multi-factorial unkind emotional experience of a psychological, spiritual and social nature that interferes with the ability to cope efficiently with its treatment of physical symptoms (WHO, 2013)

Psychological problems are high among people with cancer, and research by Zabora et al. (2011) indicates that at least one-third of the cancer population suffers from psychological problems, and those at higher risk tend to be women and young people

Coping strategies can augment treatment outcomes and survival rates of women with gynaecological cancer. Coping strategies are exact effort, both psychological and behavioural that people use to battle stressful events(Zabora et al.,2011)

Two main coping approaches proposed by the American Cancer Society (2012) are Emotional-Focused and Problem-Focused. Problem-focused strategies involve practical actions for reducing or changing stressful circumstances, whilst Emotion-focused is about strategies that try to normalize the emotional consequences of stressful conditions to establish affective and emotional balance by controlling of emotions from stressful conditions.

It has been noted however that in continuous stressful events, emotion-focused strategies have negative impact on mental and physical health outcome (Zabora, et al., 2011). Description of coping strategies might be useful for identifying patients in need of counselling and support.

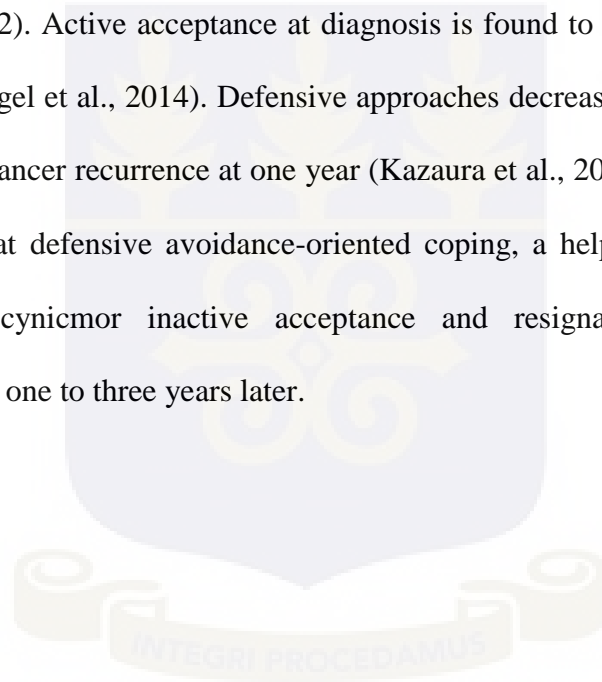
In addition, because of the vital role of women in their families, it is imperative to pay attention to maintaining and increasing the quality of life in these patients. Studies on most gynaecological cancer survivors showed that these patients perceive the benefit from their cancer treatment in the long-term (Hanna and Kangolle, 2010).

However pain is a disturbing symptom that affects the function and quality of life in these patients. Studies have also reported that adaptive coping strategies used by women before diagnosis have been found to be predictive of psychological adjustment after cancer treatment (Ebu et al., 2015). Nevertheless, it has been reported that coping efforts have varying effects. Zabora et al., (2011) found that coping through active confrontation of uncertainty prior to the diagnosis of gynaecological cancer has been associated with better psychological adjustment, whereas avoidance of coping strategies have generally been reported to have detrimental effects.

With regards to demographical variables and coping with a vulnerable or actual cancer diagnosis, maladaptive coping approaches have been found to be linked to low levels of education, in women recalled after screening to low age in women with newly diagnosed cancer, or to both of

these variables. In survivors of gynaecological cancer (McDonald, 2011) in contrast, age has been reported by Lutgendorf et al., (2012) to be unrelated to coping in a study of women before and after cancer diagnosis. Adaptive coping has been reported to be connected to older women and suspected cancer referred to clinical mammography (Mehlsen et al., 2009).

The emotional reactions following a gynaecological cancer diagnosis place extraordinary demands on women's coping abilities. It has been reported that coping strategies used during the preoperative phase of cancer have been found to be indicators of psychological adjustment after surgery (Silva *et al.* 2012). Active acceptance at diagnosis is found to predict better adjustment during the first year (Siegel et al., 2014). Defensive approaches decrease sorrow at three months but increase the fear of cancer recurrence at one year (Kazaura et al., 2011). Nevertheless, Schou *et al.*, (2014) opined that defensive avoidance-oriented coping, a helpless or hopeless coping style combined with cynicism or inactive acceptance and resignation predicted a poor psychological adaptation one to three years later.



CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter presents the study design, study area, study population, sampling method, sample size, variables, data collection technique, data processing and analysis, quality control, ethical consideration and pretesting of data collection tools.

3.2 Study Area

This study was conducted at the Battor Catholic Hospital situated in the North Tongu District of the Volta Region of Ghana. Battor Catholic Hospital is the only referral health facility in Tongu district. Mental health, medical, surgical and obstetrics and gynaecological services are provided at the hospital. It also runs antenatal clinics and offers preventive health services. The hospital has two obstetrician gynaecologists. The common diseases that are presented to the hospital are malaria, respiratory tract infection and accidents. The gynaecological clinic does not provide services to only women living within the District but women from other regions, especially the Greater Accra, Eastern and other neighbouring regions due to the hospitals location and its proximity to these areas.

Cervical cancer is the commonest gynaecological cancer reported at the gynaecological clinic of the hospital. Cervical cancer screening began in the 1970's at the hospital. In a screening program from January 1988 to July 1992, 4053 women aged 20 years and above had been screened using the Papanicolaou method and done by the hospital based approach. Since 2010, the hospital has been undertaking community based gynaecological cancer public education and screening clinics.

Recently, as part of their screening services, they have introduced HPV testing as primary screening for women aged 30 years and above and the pap smear used for triaging such women who are positive. The pap smear on the other hand, is being used for women between the ages of 21-29 years.

3.3 Study Design

The study employed cross-sectional study design using qualitative data collection techniques of in-depth interviews (IDIs) and focus group discussions (FGDs). This study design help explore the knowledge and beliefs of gynaecological cancer among women visiting the gynaecological centre and also women who have suffered from gynaecological cancer.

3.4 Study Population

The study population was women visiting the gynaecological unit of Battor Catholic Hospital.. On the main clinic days which is Mondays, Tuesdays and Thursdays, averagely about 90 women visit the gynaecological unit of the hospital daily. Women come from all areas of lives and have different socio demographical characteristics. And women between the ages of 18 and 65 were enrolled in the study.

3.5 Sampling Methodology

Recruitment of participants for the FGDs and IDIs was done purposively in the Battor Catholic Hospital. In addition, the lists of women who came to the health facilities was obtained from the Health Officers and followed up.

3.6 Data Collection Technique

Four (4) focus group discussions were held among women visiting the gynaecological department of the hospital. The socio demographical characteristics of the women were recorded. About eight (8) women constituted one focus group. A set of guidelines was generated to serve as a guide for the discussions on knowledge and beliefs of women about gynaecological cancers.

In depth interviews were held with women who have suffered gynaecological cancer. This helped to ascertain their knowledge about gynaecological cancer and how they were coping with the condition and perception from others. Five (5) women were interviewed separately at the hospital using an interview guideline.

In order to encourage all women to participate fully during focus group discussions, women aged 18 to 30 were constituted in one group while women aged 31 and above were in another group. Two {2} focus group discussions were held women 18 to 30 while the other group also had two focus group discussion. There was a total of 10 participant in each of the three 3 group, And 8 in 1 group.

Recording was done using a tape recorder as well as note writing during all the process of data collection. Women in each focus group discussion were numbered in order to aid identification during transcription and discussion.

3.6.1 Training

Data collectors were recruited and trained to collect the data. The training of data collectors highlight on the following; ethical issues pertaining to the study, interviewing techniques e.g. probing, identification and selection of appropriate study participants, translating and practicing the study tools (FGD and IDI guides).

During the training, data collectors practiced the study tools on each other and ensured that they understood the questions and responses. The study tools were translated from English to the local language and then were back translated to ensure accuracy of translation.

3.6.2 Piloting and pre-test of study tool

Pretested provided an opportunity to identify any problem with the study tools and validate the assumptions made. The tools were pretested to ensure that illogical or missing steps are identified and corrected before starting the study.

3.7 Data Processing and Analysis Plan

3.7.1 Data Processing

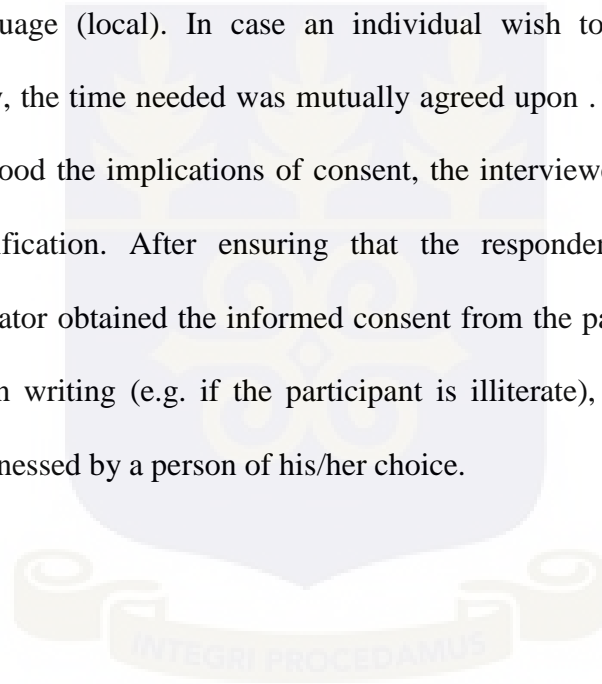
The IDIs and FGDs were recorded digitally and audio files were labelled appropriately for easy retrieval. Word for word transcription was made in the language in which the interview was conducted (and later translated from local language to English where necessary) by the interviewers. Descriptive aspects of these group and individual interview sessions (i.e. setting, characteristics of participants, non-verbal communication, etc.) were recorded by handwritten notes and expanded into daily field notes documents at the end of each day. Study team members then met at the end of each day to review daily findings and identify key themes that emerged in the data collected.

The researchers validated the transcripts by listening to a sample of the tapes to check accuracy of content and translation quality. Completed translations of interviews, group discussions, and expanded field notes were conducted by study personnel and entered into Microsoft Word. The transcriptions were then coded and inductive content analysis was done.

3.8 Ethical Consideration

Approval for the study was sought from the Battor Catholic Hospital. A proposal was sent to the Ghana Health Service ethical Review Committee for ethical clearance. And ethical clearance was approved with the code GHS-ERC: 140/02/17

Respondents were informed in their mother tongue about the purpose of the study by trained field workers. Information about the study was provided both orally and in written form. The written study information and informed consent criteria were read out to the potential participant in the appropriate language (local). In case an individual wish to have time to consider participation in the study, the time needed was mutually agreed upon . To ascertain whether the individual really understood the implications of consent, the interviewer allowed individuals to ask questions for clarification. After ensuring that the respondents had understood the information, the investigator obtained the informed consent from the participants. If the consent could not be obtained in writing (e.g. if the participant is illiterate), then the thumb print of participant taken and witnessed by a person of his/her choice.



CHAPTER FOUR

4.0 RESULTS

4.1 Introduction

This chapter presents results of the study on knowledge and beliefs of gynaecological cancer among women visiting the Battor Catholic Hospital

4.2 Demographic characteristics of participants

The women who participated in the FGDs were aged between 18 to 60 years. They were women who visited the gynaecology unit for general gynaecological and obstetric treatment. The 38 selected participants were residents of different localities; 10.5% were from Sogakope, 21% from Sege, 26% were from Battor, 23 % were from Accra with 18% from other neighbouring communities.

Out of the 38 participants, 14 has no form of formal education, 13 had primary education, while 8 had secondary education and 3 had tertiary education. Also 28 of the women were married while the rest were single.

Women who participated in IDIs were those diagnosed with gynaecological cancers. They were between 28 to 55 years old. They were all married with children and two had some form of formal education while the three were not educated.

4.3 Knowledge on Gynaecological Cancer

This theme revealed women's knowledge and awareness regarding description, signs and symptoms, risk factors and preventive strategies that women visiting the Hospital are using against gynaecological cancer.

4.3.1 Description of Gynaecological Cancer

Almost all participants had heard about some types of gynaecological cancers mostly from the media with the rest getting information from health workers at health facilities and a few from family and friends. However, knowledge about what gynaecological cancer is really about was poor, and several misconceptions existed among participants. Many participants across the study consistently stated that gynaecological cancer resulted from wounds which do not heal. Some participants stated that:

“it is a bad sore and it affect anybody especially women. This wound can be very painful and it takes a long time to die. When it doesn’t die then it turns in to cancer” (FDG2, P 4)

“It’s a wound that never dies. Resp6: also gotten through eating food from the microwave and inserting things into ones vagina” (FGD 1, P 2,)

“It’s a genetic disease and is also through our food due to use of chemicals. A lot of our food of late is grown with lot of chemicals which then later on hurt us by giving us cancer”(FGD 4, P 7)

Some participants also said they knew gynaecological cancers are caused by diet. Some women said it is caused when people don’t eat on time and also when women eat lot of acidic food. Some participant said it is caused by chemicals in food .These chemicals, participant said were causing lots of changes in the body and making it difficult for the body to fight gynaecological cancers;

“Cancer can affect people who don’t eat on time.my sister has some and she says she gets it when she doesn’t eat.” (FGD 1.P6)

“The fertilizer is a big cause. the use of fertilizer in growing our food should be stopped .this is because our grandmothers use to eat healthy diet and never suffered any of this problems but now everything is fertilizer so there are many cancers around.”(FGD4, P 4)

This statement was further confirmed during the IDI, where some women also linked gynaecological cancer to food and nutrition which is quoted below;

“I was then later hearing that microwave might be the cause of my cancer. If really that is the cause of cancer, then why do they keep selling them? (.IDI,p 2)

Cancer was also attributed to spirituality; they perceived gynaecological cancer as a punishment to a woman who has many sexual partners or as a punishment to a woman who was cheating on her husband. A participant said;

“It affects women who like plenty men, some women are so bad of late and go around chasing many men for money. After some time, they then start suffering from all this women related cancers.”(FGD 2,participant 6,)

Other respondents also thought of cancer as communicable and can be acquired through using the same washrooms. Participants said that;

“When you get into contact with the fluid from an infected person. Then you can get cancer. That is why it is not good to sleep around as it causes lot of diseases.”(FGD2,participant 3)

“If someone uses the washroom and does not flush it away and you also go”(FGD2, P 8).

4.3.2 Symptoms of Gynaecological Cancers

Knowledge of signs and symptoms of gynaecological cancer was very poor and participants continuously stressed that they needed to be educated more to understand how the disease manifest.

“Madam please we don’t now unless you teach us. This is why the government needs to send a lot of doctors and nurses so they can help us know more about all this diseases” (FGD1, P 4)

“We have no idea, Can you please give us information” (FGD4,P 1)

The few who knew some signs and symptoms of gynaecological cancers had either have a personal experience with the disease or with those affected by it. The major symptoms they listed were vaginal bleeding, excessive discharges, backache and abdominal pain. A woman had this to say;

“lot of times people with gynaecological cancer has plenty discharge and this discharges also smell very badly. Some of them even need to be catheterized in order to be able to urinate”.(FGD,4participant)

There were a few misconceptions about the signs and symptoms associated with gynaecological cancer, and some participants believed their gynaecological cancer was due to fibroids.

“ I also know that prolonged fibroid can also lead to cancer.my sister suffered from that .she has fibroids and after 3 years it turned into cervical cancer. We took her to the Hospital but it was too late and she died” (.IDI participant,49years).

4.3.3 Risk factors for gynaecological cancer

Knowledge about risk factors for gynaecological cancer was varied as many participants noted that having; many sexual partners, sexually transmitted infections and family history of cancer would increase one's risk.

Some women also mentioned the use of various chemicals and items to tighten the vagina as a risk factors.they also believed when the female genitals are not washed well, this can caused gynaecological cancers

“Gynaecological cancer can be gotten through when you don't take care of you self and vagina well and then you allow fungus to grow in your vagina and then they can get very sick. Like not changing your pad regularly”(FGD3,P 7).

“Also stop all this inserting of things to make the vagina tight that we do.as this can all lead to gynaecological cancer.”(FDG4,participant 9).

“I know one woman who is always taking drugs to tighten her vagina but now she is always discharging plenty and has to use pad always even though she has been to Hospital for a while but still....”(FGD1participant 3).

Some respondents also mentioned the use of second hand clothing and underwear as a risk factor associated with gynaecological cancer.

“Our use of second hand underwear. We should try and at least wash it well or use hot water to kill the germs from the previous user. You might not know what the previous user has (FGD3,P 6)

4.3.4 Preventive Strategies

Most of the respondents had varied ways they use to prevent gynaecological cancers. They also had a lot of suggestions on what one needed to do to prevent acquiring gynaecological cancer and these were mainly personal and spiritual strategy. Some women mentioned the need for the intervention of God in preventing themselves from being affected with any of the gynaecological cancers.

“God created us and he can protect us always but we also need to be cautious like during use of washroom we shouldn’t sit on it but squat or put toilet paper on the seat before. Prevention is better than cure” (FGD4, P 8)

Some of the women also mentioned that they need to take care of themselves and stop douching, as this could cause lots of problem and bring about cancer. Some also mentioned that the use of tight clothing and under garments made breathing difficult thus reducing all these practices may help to prevent gynaecological cancer. This is shown as stated by these women

“We need to stop douching and also take good care of ourselves. (FGD1, participant 10)”
“Reduce all the tight clothing, which causes problems. Because our body doesn’t get to breath.” (IDI participant 4)

A few participants made mention of screening for the various gynaecological cancer as a strategy. These participants stated that being screened regularly was the only way to know if you had gynaecological cancer and this could help with treatment early.

“ we need to demonstrate to all women and then get everyone involved. Because looks like these cancer are a big issue, doing this will help make lot of women come and get screened .because me I know that is the only way to prevent and protect yourself” (FGD 3, respondent 2).

4.4 Beliefs Associated with Gynaecological Cancer

This theme encompasses both cultural and spiritual beliefs associated with gynaecological cancer among women that were visiting the Battor Catholic Hospital.

Most participants had varied spiritual beliefs associated with gynaecological cancer. Most of the respondents believed that cancer was a disease associated with spiritual and curses. Some of the participants had a lot of misconceptions and negative beliefs about gynaecological cancers

“Cancer is when you suffer from witchcraft. That is why those women who suffer from gynaecological cancer are mostly sent to prayer houses for deliverance.(FGD4,P 8).”

“People in my vicinity always say cancer is not a disease of the Hospital. They always attach it to juju and believe it is spiritual.so women who suffer from cancer are sometimes sent to the herbal homes for treatment.”(FGD2, P 6)

Some beliefs associated with gynaecological cancer also have to do with women suffering from curses due to something that they did wrong to their husbands or relatives. Some of the participants said that in their community it was believed that such cases always need prayers

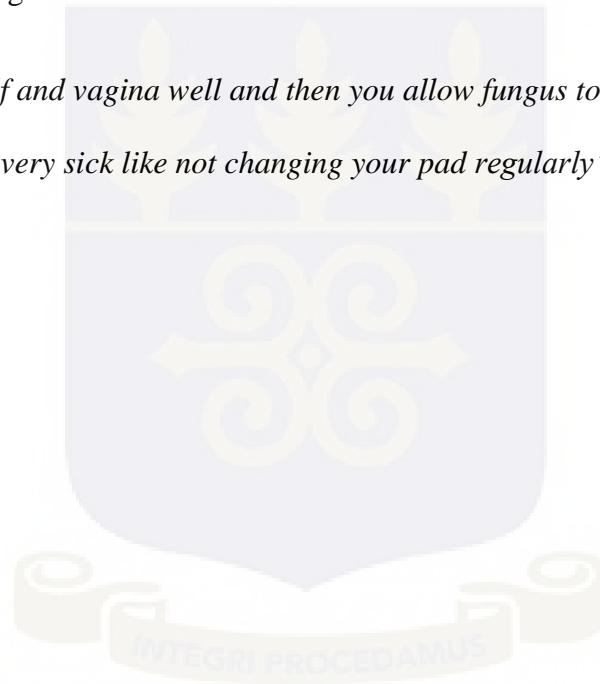
“I believe some of it is through spiritual means. When someone wants to punish you, they can put a curse on you that can make you to suffer from these cancers. One lady also suffered from cancer after she made her husband suffer. She run away when he didn't have money but she came back and we heard she came back with cancer.so we all prayed that we shouldn't go through anything like that.”(FGD2, P 6)

Some participants also believed that cancer had nothing to do with spirits and that early treatment was the key and cited some examples of other family members who reported for screening and were diagnosed and treated early.

“My relative also was told she had cancer when she came here for screening and she seek for treatment early and she was treated and she is now alive” (FGD2, P1)

Others also stated that poor personal hygiene causes organisms to grow and then causes problems in the female organ.

“Care of yourself and vagina well and then you allow fungus to grow In your vagina and then they can get very sick like not changing your pad regularly” (FGD 3, P 7).



CHAPTER FIVE

5.0 DISCUSSION

This study set out to explore the knowledge and beliefs of gynaecological cancer among women visiting the Battor Catholic Hospital using focus group discussions and in-depth interviews.

5.1 Knowledge on Gynaecological Cancer among Women.

The knowledge about gynaecological cancer among the women was shallow and with a lots of misconceptions. Most of the women who visited the Hospital were not educated formally, so making access to information about gynaecological cancer difficult. Most women said they have heard about gynaecological cancer but did not really know what constituted it. Therefore making the description difficult. Most women did not know about the different gynaecological cancers, it was stated by Ebu, et al in, (2015) that, most women got information about gynaecological from family and friends' .which was mostly misinformation. In a study by Edwin (2010), it was revealed that there were some knowledge gaps and misconceptions about gynaecological cancers such as misunderstanding of the purpose of Pap test, lack of familiarity with vaginal and vulvar cancers, and generally poor understanding of the female anatomy including the locations and names of reproductive organs and the possible ailments that affect those organs. These misconceptions can affect screening for early detection. Most women had varied information about symptoms that may suggest gynaecological cancer. Some of the symptoms mentioned had little to do with gynaecological cancer. This shows that the women had little information about it. Some women also mentioned that, they visited the hospital to get checked when they had symptoms that affected their normal daily activities. But mostly that is also the stage when the cancer has also progressed, making outcome of treatment not good. This was also mentioned in a

research done by Kebeke in 2012, which stated that, “if the symptom is more serious or alarming and includes a lump, bleeding or pain, then the risk of late presentation is typically abridged. Patients may fail to identify or appreciate atypical or vague symptoms, which may facilitate delayed presentation”.

5.2 Risk factors associated with gynaecological cancer.

Some risk factors associated with gynaecological cancers mentioned were, having several sexual intercourse, having several sexual partners. These behaviours expose women to contracting the human papillomavirus, which is the most common sexually transmitted infection worldwide Adjololo et al.,(2010), There are many factors associated with the development of cervical cancer, some of which include early sexual intercourse, high parity, multiple sexual partners, smoking, and co-infection with human immunodeficiency virus (HIV) Adjololo et al.,(2010)). However, the known primary underlying cause is the Human Papilloma Virus (HPV), which is the most common sexually transmitted infection worldwide, and it is estimated that 50% to 80% of sexually active women are infected at least once in their lifetime (Adjorlolo, et al., 2010)

The most important means of reducing infection therefore has to do with preventing HPV infections and also early screening in order to help with early detection and treatment. Patients always report to the Hospital when symptoms are far advanced. This is because most of the symptoms that are seen at the preliminary stages are not so serious. Most of the women mentioned that they only reported when they experienced excessive bleeding such as reported by Macloed et al., (2009) if the symptom is more serious or alarming and includes a lump, bleeding or pain, then the risk of delayed presentation is typically reduced. Patients may fail to recognize or appreciate atypical or vague symptoms, which may mediate delayed presentation. In cases

where symptoms are understood and thought to be serious, there is a reduced time to presentation to the hospital(Edwin,2010)

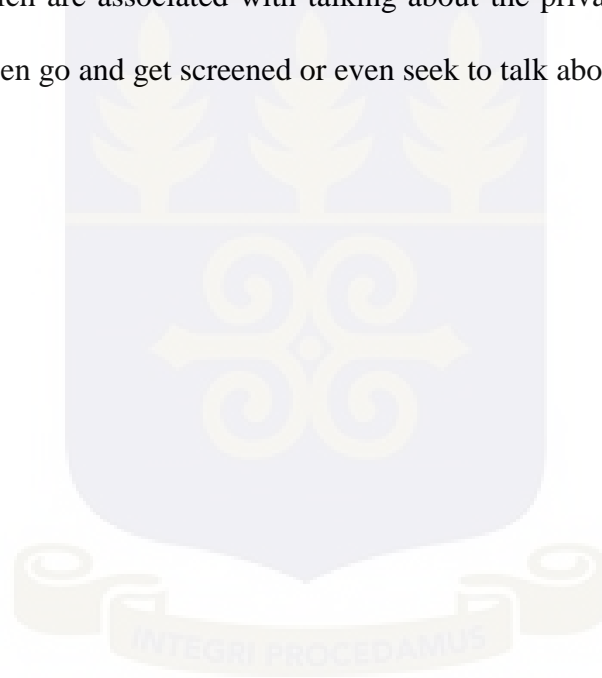
Whatever the cancer site, the facilitator for presentation to a nearby clinic and Hospital is often when a symptom becomes devastating or impacts on normal activities, rather than the presence of the symptoms alone. (Jugal et al.,2015)

5.3 Beliefs on Gynaecological Cancer

Beliefs of women have a great effect on how they deal with issues. Most rural women are affected by what happens around them and the beliefs of people around them. In this study, it was found that cultural and spiritual beliefs affect what people think about gynaecological cancer and how they approach it as written by Jugal et al.,(2011) “Cultural beliefs affect both the risk factors for cancer in addition to the meaning of the disease by initiating customs of behaviour and providing guidance for its members to respond emotionally, cognitively, and socially to this disease”. These mostly lead to “delay in seeking medical treatment, thereby prolonging the interval between the first appearance of symptoms and the first visit to doctor” (Jugal et al., 2015).

Women thought cancer was a punishment for something that was done wrong, such as having multiple sex partners, cheating on one’s spouse and being a witch, this was also presented during a research by Morris (2012) which reported that “most people with cancer are of the belief that, nothing can be done to prevent cancer and that cancer is always fatal” It may be seen as a punishment so the stigma and fear of being labelled can even prevent women from seeking early screening in order to be diagnosed and treated.

Furthermore most women suffering from gynaecological cancer are stigmatised. In most traditional settings the body parts involved in gynaecological cancer are the parts that are not supposed to be mentioned. It is difficult for patients to report symptoms to their doctors at the initial stages for further investigations to be carried out. They tend to report the symptoms, if becoming life debilitating and life threatening. The location of the symptoms tends to make women reluctant to disclose to their doctors, and may be less willing to undergo the necessary physical examinations to investigate the cause of such symptoms (Ling and Phelan, 2014). Some cultures have taboos which are associated with talking about the private parts of the making it difficult for women to even go and get screened or even seek to talk about certain symptoms.



CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

There was little knowledge about gynaecological cancer with a lot of misconceptions about the descriptions, symptoms and preventive strategies among women visiting the Battor Catholic Hospital. Most women didn't have knowledge about screening as a preventive strategy.

Women had varied beliefs associated with gynaecological cancer. Most believed that gynaecological cancer was a spiritual disease and also a form of punishment.

6.2 Recommendations

Based on the findings of this study, the following recommendations are suggested;

1. Health education about gynaecological cancer at the health facility should be intensified in order for women to know about the seriousness of gynaecological cancer, to aid in early reporting of cases leading to early treatment.
2. Women should be educated on the risk factors associated with gynaecological cancer as well as preventive strategies such as regular screening to prevent gynaecological cancer. They should be made to know the importance of screening services
3. Community health professionals should educate women on gynaecological cancers in order to curb the misconceptions about gynaecological cancer in the society and to manage the stigma associated with gynaecological cancers
4. Health insurance should be made to cover screening of gynaecological cancers in order to help with early detection and treatment to save lives.
5. Community leaders should be involved in educating women during gatherings in order to help manage stigma and also facilitate understanding of gynaecological cancers.

6. Further studies is required to know the knowledge of women in the communities .this will help in to equip the media with various programs to educate women on gyneacological studies



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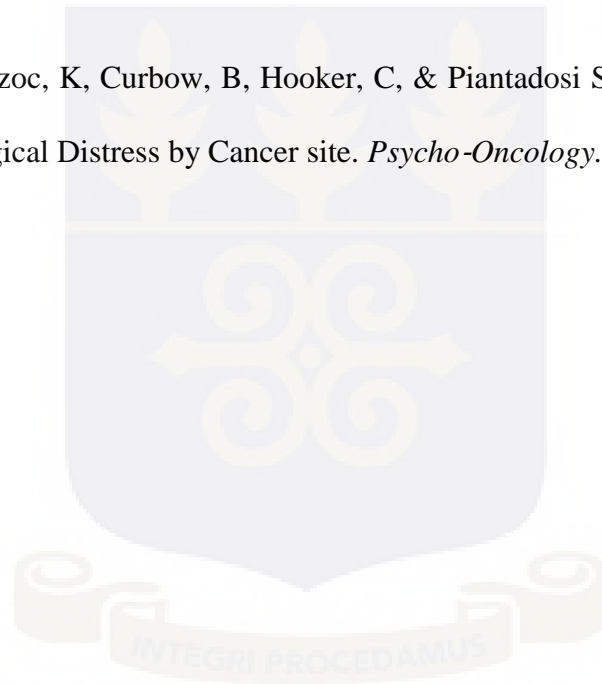
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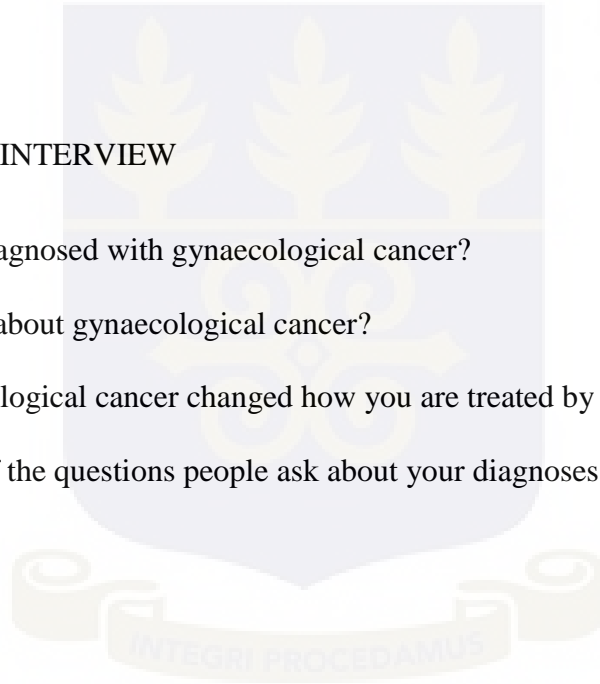
APPENDICES

Appendix A: Guide for Focus Group Discussions

1. What do you know about gynaecological cancer?
2. How did you hear about gynaecological cancers?
3. What are your beliefs about the causes of gynaecological cancer?
4. How do you think one can prevent gynaecological cancer?
5. What do you think are the signs of gynaecological problems that suggest gynaecological cancer?

GUIDE FOR INDEPTH INTERVIEW

1. How were you diagnosed with gynaecological cancer?
2. What do u know about gynaecological cancer?
3. How has gynaecological cancer changed how you are treated by family and friends?
4. What are some of the questions people ask about your diagnoses?



Appendix B: Ethical Clearance

