

UNIVERSITY OF CAPE COAST

EXPLORING THE SOCIO-CULTURAL INTERPRETATIONS OF BREAST  
CANCER AND THE COPING STRATEGIES OF PATIENTS AT THE CAPE  
COAST TEACHING HOSPITAL, GHANA

NANA AFIA KARIKARI

FEBRUARY 2018

UNIVERSITY OF CAPE COAST

EXPLORING THE SOCIO-CULTURAL INTERPRETATIONS OF BREAST  
CANCER AND THE COPING STRATEGIES OF PATIENTS AT THE CAPE  
COAST TEACHING HOSPITAL, GHANA

BY

NANA AFIA KARIKARI

Thesis submitted to the Department of Sociology and Anthropology of the  
Faculty of Social Sciences, College of Humanities and Legal studies, University  
of Cape Coast, in partial fulfilment of the requirements for the award of Master of  
Philosophy degree in Sociology

FEBRUARY 2018

## DECLARATION

### **Candidate's declaration**

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's signature..... Date.....

Name: Nana Afia Karikari

### **Supervisors' declaration**

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal supervisor's signature..... Date.....

Name: Dr. William Boateng

Co-supervisor's signature..... Date.....

Name: Dr. (Mrs.) Georgina Yaa Oduro

## ABSTRACT

Breast cancer is considered as a global public health problem. Many lives are lost to it because of late diagnosis, where treatment of the disease is almost impossible. Factors such as socio-cultural interpretations of the disease have been attributed to this delay. This study therefore sought to examine some socio-cultural interpretations of breast cancer and the coping strategies adopted by patients in Cape Coast Teaching Hospital. Qualitative research design informed the orientation of the study. In-depth interviews were conducted to elicit information from twenty-five participants who were involved in the study. The data were validated through observation. The social constructionism theory and the ABC-X model informed the study. The study revealed that the interpretations linked with the disease did not only determine the time patients reported to the hospital but also permeated their entire health seeking behaviours. Those who believed the illness was a spiritual condition were much more inclined to seek spiritual help from their deities and vice versa. In addition, patients either absconding or continuing orthodox treatment was influenced by their socio-demographic characteristics. Furthermore, the extent of appearance concerns of patients were dependent on the stage of the disease, age and marital status of patients. It was discovered that patients adopted In-group support as a means of coping with the illness. It is recommended, among other things, that hospitals should spearhead the formation of informal breast cancer advisor groups to help educate and support patients.

KEY WORDS

Breast cancer

Chemotherapy

Coping strategies

Mastectomy

Socio-cultural interpretations

Treatment choices

## ACKNOWLEDGEMENTS

My deepest appreciation goes to my family especially my Dad and Mum for their great support, and encouragement.

I am extremely thankful to my supervisors, Dr. William Boateng and Dr. (Mrs.) Georgina Yaa Oduro for their guidance which enabled me to successfully complete this study. Also I am grateful to Dr. Brempong Osei-Tutu for his support.

I wish to thank the Head of the Breast Clinic at the Cape Coast Teaching Hospital, Dr. Morna for his assistance.

My gratitude goes to all the study participants, who in sharing their personal experiences provided me with rich data for my thesis.

Lastly, I would like to acknowledge all those who supported me especially Elijah Tukwariba Yin, Aikins Amoako Asiamah, and Michael Owusu Akomeah.

DEDICATION

I dedicate this work to my parents, Kofi Karikari and Agnes Achiaa Karikari.

## TABLE OF CONTENTS

Content	Page
DECLARATION	ii
ABSTRACT	iii
KEY WORDS	iv
ACKNOWLEDGEMENTS	v
DEDICATION	vi
LIST OF TABLES	xiii
LIST OF FIGURES	xiv
CHAPTER ONE: INTRODUCTION	1
Background to the Study	1
Statement of the Problem	6
Research Objectives	7
Research Questions	8
Significance of the Study	8
Operational Definition of Terms	9
Delimitation	10
Organization of the Study	10
CHAPTER TWO: LITERATURE REVIEW	11
Introduction	11

Breast Cancer	11
Participation in Breast Cancer Examinations	16
Socio-cultural Environment and Health	19
Socio-cultural Interpretations of Breast Cancer	21
Other Socio-cultural Dynamics and Breast Cancer	24
Socio-demographic Factors as Determinants of Breast Cancer Screening	
Intentions and Time Patients Report for Diagnosis	27
Effects of Breast Cancer	34
Coping Strategies of Patients	37
Theoretical Framework	41
Social Constructionism	42
Relevance of the theory	43
ABC-X Model	45
Application of the theory	48
Conceptual Framework	49
CHAPTER THREE: METHODOLOGY	52
Introduction	52
The Research Design	52
Philosophical Justification	53
Study Setting	55

Population	56
Sample	56
Sampling Procedure	57
Recruitment procedure of participants	58
Data Collection Instrument	59
The interview procedure	60
Observation procedure	62
Reliability and Validity	65
Pre-test	65
Sources of Information for the Study	67
Data Analysis and Interpretation	67
Ethical Principles and Procedures	69
Field Experience and Practical Challenges	70
Limitations to Data Collection	72
CHAPTER FOUR: ANALYSIS AND DISCUSSION	74
Introduction	74
Profile of Patients	74
Age	76
Marital Status	76
Formal Education	77

Occupation	77
Religion	77
Ethnicity	78
Period of Breast Feeding	78
Stage of the Disease	79
Link with other Diseases	79
Lifestyle pattern of patients	79
Time Patients Presented the Disease to the Hospital	80
Location of patients: The contextual world of the women	81
Knowledge about the Disease	83
Socio-cultural Interpretations Attached to the Illness	85
Reactions of Patients	87
Shock of Diagnosis	88
Body Image: The Two Polarized Fears	89
Socio-cultural Interpretations and Health Seeking Behaviours of Patients (Treatment Choices of Patients)	92
Patients who Believed in Medical Causes	94
Supernatural Believers: Searching for Answers	94
Perceived Potency of Treatment	96
Socio-Demographic Characteristics and Health Seeking Behaviours of Patients	97

Effects of the Illness on Patients	104
Financial Drain	104
Decline in Businesses	107
Domestic Sphere	109
Decline in Social Relationship	110
Coping Strategies	113
Individual Capital	113
Concealing the evidence of the illness as a coping mechanism	113
The feeling of hope and self-reassurance	114
Social Capital	115
Family Support	116
Support from Generalized Others	118
In-group Support as a Coping Mechanism	121
Religion as a Soothing Therapy	121
CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	125
Introduction	125
Summary of the Research Process	126
Key Findings	126
Conclusions	128

Recommendations	130
Suggestions for Further Research	132
References	134
APPENDICES	145
APPENDIX A: INTERVIEW GUIDE	145
APPENDIX B: INTERVIEW GUIDE FOR HEALTH WORKERS	151
APPENDIX C: OBSERVATION GUIDE	153
APPENDIX D: INFORMED CONSENT	154

## LIST OF TABLES

<b>Table</b>	<b>Page</b>
1 Biodata of Patients	74

## LIST OF FIGURES

<b>Figure</b>	<b>Page</b>
1- A Conceptual framework showing the Dynamics of Health Seeking Behaviours of Patients	51

## CHAPTER ONE

### INTRODUCTION

#### **Background to the Study**

Breast cancer is the erratic growth and proliferation of cells that originate in the breast tissue due to mutation (Sharma, Dave, Sanadya, Sharma & Sharma, 2010). Schettler (2013) stated that breast cancer is an ancient disease, which was first recorded between 3000-2500 BCE in Egypt. The aetiology of breast cancer is complex and may be caused by numerous factors. According to Ghartey (2013), the actual cause of the illness is not known but some of the triggers identified by medical scientists are genetics, diet and environmental factors like exposure to chemicals, smoking, radiation, viruses and bacteria. Schettler elucidated that largely, cancer of the breast is an ecological disease as much as it is a disease of abnormal cell growth. This is because there are numerous environmental factors that interact with the biology of the human breast. These environmental elements arise from the early to the late life of an individual. Nutrition, exercise and stress levels, exposure to chemicals and radiation, collectively either make an individual susceptible to the disease or not. Kawar (2012) intimated that in spite of improved diagnostic skills and scientific break-through in effective treatment, cancer of the breast continues to be the leading cause of cancer deaths among women worldwide.

According to Patel-Kerai, Harcourt, Rumsey and Nagvi (2015), global estimates suggest that on an annual basis, there are more than 1,050,000 reported new cases of breast cancer. They stated for example, that in the United Kingdom a

total number of 49,936 women were diagnosed with the disease in 2011 while in 2012, 53,000 new cases were reported. In developing countries, Balekouzou et al., (2016) reported that about 324,000 women died of breast cancer representing 14.3 percent of all deaths. In sub-Saharan Africa, for the year 2012, it was estimated that 94,000 women developed breast cancer out of which 48,000 died (Brinton et al., 2014).

Geographically, the data above somehow shows variation in the disease and its associated mortality cases. Banning, Hafeez, Hassan, Faisal and Zafar (2009) espoused that high income countries often record high incidence rate but low mortality (80 percent survival rate for at least 5 years); whereas the opposite is true for low income countries, especially in Africa. Beiki, Hall, Ekstrom and Moradi (2012) added that more than two-thirds of all breast cancer mortality occur in Africa. Africa has a high degree of mortality rate due to late diagnosis, and lack of modern cancer equipment (Segni, Tadesse, Amdemichael & Demissie, 2016).

Late presentation of the disease for diagnosis is the most common cause of poor survival rate in Africa (Sarfo, Awuah-Peasah, Acheampong & Asamoah, 2013). In sub-Saharan Africa, 90 percent of breast cancer patients present the disease for diagnosis either at the III or IV stage. It has been shown that most patients delay in seeking medical help, and as a result, the disease easily advances to its optimal state. When this happens, patients benefit less from the use of western therapy (Ohene-Yeboah, Adofo & Akpaloo, 2013).

As part of the problem of early diagnosis, Schettler (2013) pointed out that the time between earliest tumour detection and clinical diagnosis is often decades long. Khazaee-Pool et al., (2014) also revealed that women mostly detect these symptoms by chance, in some cases, while having a shower, getting dressed or during breastfeeding. This means that most women are usually unaware of the early stages of the disease. Others may be privy to their condition as breast cancer patients but may be adamant in seeking treatment. Notwithstanding this, some women also detect it through active breast self-examination. Available literature proposes that prevention and early detection are vital means of reducing breast cancer mortality (Errico & Rowden, 2006; Martei, 2011).

The intention of women to either go for screening or seek early medical treatment is mostly influenced by their socio-cultural beliefs. Socio-cultural beliefs provide the lens through which people frame their attitudes toward a particular disease or health care services. Karbani et al., (2011) and Helman (2000) asserted that women's beliefs and interpretations about breast cancer are socio-culturally patterned, and these beliefs inform their perceptions of risk and the strategies to adopt in order to mitigate the effects. It can therefore be inferred that, socio-cultural concepts are important factors that either restrict or facilitate women's decisions regarding breast cancer and its treatment.

In the advent of a crisis, it is imperative to adopt coping strategies to help alleviate the impact of the predicament on an individual. Coping strategies are complex and multidimensional and vary because of differences in contextual factors. In relation to health, Suh (2013) espoused that, coping strategies are

cushioning agents and the lack of these intervening agents can be detrimental to one's health. Ahmadian and Samah (2012) asserted that along with other interventions, strong social support can substantially help ameliorate the stress response and improve outcomes in women with breast cancer. Social support has both structural and functional dimensions. Structural support refers to the size and complexity of the network of reciprocal relationships that an individual has with friends, relatives, and co-workers. The functional component has to do with what the network actually provides, such as emotional support, information regarding medical care options, financial assistance.

Summarizing the various coping strategies, Bardwell, Ancoli-Israel and Dimsdale (2001) argued that there are five ways of coping with stress or an unwelcomed event. They stated that individuals either choose a type or adopt more than one strategy to lessen the impact of an event on them. These coping mechanisms according to Bardwell et al., are:

Seeking Social Support: This describes efforts to seek informational support, tangible support, and emotional support outside of the individual.

Positive Reappraisal: this coping mechanism describes efforts to create positive meaning by focusing on personal growth. This often has a religious dimension.

Self-Controlling efforts to regulate one's feelings and actions.

Accepting Responsibility: acknowledges one's own role in the problem with an effort of trying to put things right.

Escape-Avoidance: describes wishful thinking and behavioural efforts to escape or avoid the problem.

Ghana is not immune to this public health issue. Most patients (50 to 70 percent) present the illness at the advanced stage (III and IV) after first noticing a change in their breasts (Clegg-Lampsey, Dakubo & Attobra, 2009; Ohene – Yeboah & Agyei, 2012; Sarfo et al., 2013; Ghartey, 2013). Ohene-Yeboah et al., (2013) emphasized that this pattern, aside being the most resource intensive to treat, can be so advanced that even optimal western therapy may offer minimal survival benefits for patients. Dei (2013) argued that breast cancer screening behaviours in Ghana have been shown to be influenced by several socio-cultural factors, especially the interpretations attached to the disease and the socio-cultural value of the female breasts. Buttressing Dei’s assertion in relation to the latter, Oduro (2013) opined that the breast is esteemed as providing Ghanaian women with a source of pride and a form of cultural femininity, identity and beauty. Consequently, many women are not willing to lose their breast or think of anything happening to it. Furthermore, Martei (2011) pointed out that some women consider touching and exposing breasts to strangers (which in this case are health personnel) as morally embarrassing. Some interpretations that mastectomy would lead to death or diminish sexuality; and the disease is caused by spiritual forces are some justifications for late presentation of the illness. The thought of all these interpretations often deter women from reporting early, for medical attention changes in their breasts but wait till their condition gets out of hand.

### **Statement of the Problem**

Breast cancer is a precarious phenomenon that causes fear and anxiety. It raises concerns about recovery, quality of health and chances of survival of the individual suffering from the illness. According to Ghana Cancer Plan (2012), Ghana is not exempted from the problem of breast cancer. It is recorded as one of the leading causes of cancer deaths among women in Ghana. It forms 15 percent of all cancers and 40 percent of all female cancers. Jemal, Bray, Center, Ferlay, Ward and Forman (2011) added that about 2,000 breast cancer cases and 1,137 related deaths are recorded annually among Ghanaian women. The study further indicated that the five-year survival rate is below 50 percent, with a relatively greater proportion of the disease being reported in women below the age of 50 years (Ohene-Yeboah & Agyei, 2012). The incidence mortality ratio of the disease in Ghana is 0.68 (Ohene -Yeboah et al., 2013). The statistics on the disease raises eyebrows and cannot be swept under the carpet.

Despite the earth shattering statistics, women suffering from the disease have their own socio-cultural interpretations to the causes and treatment of the illness. Some women interpret touching and exposing the breasts to health professionals as morally embarrassing. For others it is about spiritual forces so it is not a case for the hospital. Furthermore, some view the breast as a source of femininity and beauty (Oduro, 2013), thus most women are skeptical in seeking medical help for the fear that, breast cancer may cause mutilation of the breasts that may lead to loss of body attraction as well as deplete some gender roles (Dei, 2013; Martei, 2011). All these interpretations lead to low and late presentation for

diagnosis. Clegg-Lamptey et al., (2009) and Dei (2013) reiterated the fact that it appears that these socio-cultural interpretations are worsening the situation of breast cancer in Ghana and unfortunately, not much exploration and investigation have been done on this issue.

Aside the worsening situation, breast cancer patients face multiple challenges, which include the following: stigmatization, financial drain and emotional turmoil. In the mist of all these challenges, it is however unclear the coping strategies women affected by the disease adopt to alleviate their predicament. It is against this background that this study (as echoed by Clegg-Lamptey et al., 2009; Dei 2013) seeks to explore further the socio-cultural interpretations of the disease and the coping strategies of patients.

### **Research Objectives**

The general objective of this study was to explore the socio-cultural interpretations of breast cancer and the coping strategies adopted by patients at the Cape Coast Teaching Hospital.

Specifically, the study sought to:

- Explore the socio-cultural environment in which patients find themselves.
- Examine how socio-cultural interpretations influenced patients' health seeking behaviours.
- Investigate the influence of socio-demographic characteristics on patients' health seeking behaviours.

- Explore some coping strategies adopted by the patients in managing the impact of the illness on them.

### **Research Questions**

- What socio-cultural environments do breast cancer patients find themselves?
- How do socio-cultural interpretations inform patients' treatment choices?
- How do socio-demographic characteristics influence patients' treatment choices?
- What are the coping strategies adopted in mitigating the impact of the illness on patients?

### **Significance of the Study**

Available literature on the experiences of women suffering from breast cancer in Africa and Ghana, in particular, is limited. Many accounts of breast cancer largely represent experiences of women in Western cultures. Consequently, it would be inappropriate to generalize these findings in the Ghanaian setting, particularly as the healthcare systems, culture and lifestyles are not entirely comparable. Therefore, a study of this nature is vital to provide a contextual picture of the phenomenon and add to scholarship on breast cancer. Furthermore, breast cancer is occurring more commonly in Ghana. There is however, poor knowledge and understanding of the phenomenon. Therefore, this study is expected to contribute to our understanding of breast cancer from a socio-

cultural perspective. Such an understanding, will serve as a basis in developing appropriate strategies and interventions to help minimize the incidence of the disease in the Country and support for patients.

### **Operational Definition of Terms**

*Cancer*: a disease where cells in the body grow out of control.

*Breast self-examination*: the consistent and repetitive monthly examination of the breast to detect any abnormalities. This involves the woman looking and touching each breast for possible lumps, distortions, swellings, discoloration and any other changes for early detection and prompt medical attention.

*Mammography*: the use of advanced screening tools and procedures in detecting breast cancer. It has been established as the most effective screening procedure in detecting cancer. The role of mammography is to detect tumours, thus minimizing the diagnosis of breast cancer at an advanced stage.

*Clinical breast examination*: a visual inspection and palpation of the breast by a trained health worker.

*Mastectomy*: the surgical removal of the diseased breast. This can be a partial or full removal of the breast depending on the stage of the cancer.

*Socio-cultural Interpretations*: the shared overarching models, perspectives through which members of a particular social setting understand and construct their realities.

*Coping Strategies*: has been conceptualized as the internal and external measures patients adopt in alleviating the impact of their predicament.

### **Delimitation**

The study focused on the Cape Coast Teaching Hospital. Though there are other hospitals in the metropolis, Cape Coast Teaching Hospital was selected because it is the only referral hospital in the region with modern cancer equipment. The study covered the socio-cultural interpretations associated with breast cancer and patients' coping strategies. This study however, did not examine the socio-economic factors that determine the time patients report to the hospital. This is because the focus of the study was pitched on socio-cultural interpretations of breast cancer and some coping strategies of patients.

### **Organization of the Study**

The study is organized into five chapters. Background to the study, statement of the problem, objectives, research questions, significance of the study, operational definition of terms and delimitation make up Chapter One. Chapter Two is the literature review. The literature review focuses on other related works, theoretical underpinnings and conceptual framework. Chapter Three covers the methodology. Chapter Four is the analysis and discussion of data. Chapter Five encompasses the summary, conclusions and recommendations.

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

This chapter encompasses review of relevant works, theoretical underpinning of the study and the conceptual framework. The chapter is divided into two key sections. The first section looks at the review on; breast cancer, participation of breast cancer examinations, socio-cultural environment and health, socio-cultural interpretations of breast cancer, socio-demographic determinants of health seeking behaviours, effects of breast cancer and, finally coping strategies of patients. The second section looks at the Social Constructionism Theory and the ABC-X model as the theoretical underpinnings of the study and, lastly the conceptual framework.

#### Breast Cancer

The female breast is often seen as a medium that connects women to their socio-cultural roles as mothers and wives, and it is arguably one of women's valuable features of the body and a strong sign of femininity (Frederick, Peplau & Lever, 2008). Swami and Tovee (2013) intimated that across cultures, physical appearance is important to humans and certain features are appealing. One such feature is the female breast. It is deemed as one of the eye-catching organs of a woman. It usually forms the basis among other features of judging the attractiveness of a woman.

This important organ is susceptible to cancer and women often suffer breast cancer than men. It is regarded as the most common aggressive cancer among women and highly destructive of women in their prime life (Sarfo et al., 2013). According to Schmauss, Machens and Harder (2016), the global figure in 2012 revealed that breast cancer is both the most common cancer and the leading cause of cancer-related deaths with 1.7 million new diagnoses and 521,900 deaths. For Ghartey (2013), it is a disease has affected populations stemming from urban and rural, wealthy and poor, old and young. That is, the disease is not restricted by one's culture, ethnic affiliation, race, social status, or religious beliefs.

The specific causes of the disease are not known despite vigorous scientific research. However, some scholars have attributed the causes to multiple factors such as; unhealthy environment, radiation, chemicals, smoke, poor diet, advancement in age. Explaining this assertion further, Schettler (2013) indicated that breast cancer like other complex diseases, such as diabetes, hypertension is a "design problem". By a design problem, he posited that, breast cancer is much more common in industrialized countries where people adopt western styles of eating, sedentary lifestyle, consumption of alcohol and tobacco, making and using consumer products. These, he intimated, significantly contribute to the rising incidence of the disease.

The assertion by Schettler (2013) strongly suggests that as people make choices about lifestyles, they are designing that patterns that might trigger breast cancer. In the context of Africa, de-Graft, Boynton and Atanga (2010) explained

that chronic diseases like breast cancer have been strongly attributed to changing behavioural patterns (e.g. sedentary lifestyles and diets high in saturated fat, salt and sugar), which are linked to structural factors such as industrialization, urbanization and increasing food market globalization. Beiki et al., (2012) also espoused that family members (especially female members) of a breast cancer patient have an increased risk of developing breast cancer. Likewise, a woman who had breast cancer has an increased risk of getting breast cancer in the other breast. From the above explanations, in as much as breast cancer can be caused by biological factors like hereditary it is also more of an ecological disease as most of the triggers emanate from the environment.

Thorntona and Pillarisetti (2008) enumerated some general alerting features of breast cancer as swelling or lump in the breast, swelling in the armpit, nipple discharge (clear or bloody), pain in the nipple, inverted nipple, scaly or pitted skin on nipple, persistent tenderness of the breast, and unusual breast pain or discomfort. They added that in an advanced stage of the disease other symptoms such as bone pain, shortness of breath, drop in appetite, unintentional weight loss, headaches, neurological pain or weakness are experienced.

It has been suggested that the appropriate method for breast cancer prevention and early detection is to observe some preventive behaviours. These include lifestyle modification and screening behaviours (i.e. mammography, clinical breast examination and breast self-examination). Lifestyle modification can help reduce risk of breast cancer to a large extent. Studies have demonstrated that lifestyle interventions such as changing dietary habits, performing adequate

physical activity, reduction in smoking and alcohol intake may prevent breast cancer and decrease the risk. The awareness level of the causes, signs and frequent examining of the breast (breast self-examination, clinical breast examination and mammography) for possible changes and prompt presentation have been proven to increase the survival chances of women. Studies have shown that women in developing countries often present the disease for diagnosis at the “eleventh hour”, thus reducing their chances of survival (Segni et al., 2016; Suh, 2013)

The awareness of breast cancer, the types of screening methods available and the effectiveness of these screening methods influence breast cancer screening intentions and the time women report to the hospital for diagnosis. Othman et al., (2012) argued that women who believe that mammography screening is effective in detecting breast cancer have been found to have positive intentions towards screening uptake. Similarly, women who know that regular screening can potentially improve survival of breast cancer are most likely to undergo screening. According to Opoku, Benwell and Yarney (2012), many women in Ghana unfortunately have limited knowledge about breast cancer and its screening procedures. This in turn, adversely affect their screening intentions and the time they report for diagnosis.

A successful management of breast cancer largely depends on the level/stage of the cancer growth. The stage of the cancer is ascertained through medical examination. According to Ghartey (2013), when doctors are investigating the level of cancer growth, they look out for some traits under the

microscope. Among the traits doctors look for are a large number of irregularly shaped dividing cells, variation in cell size and shape, loss of specialized cell features, loss of normal tissue organization, and a poorly defined tumour boundary. The microscopic examination further provides information regarding the likely behaviour of a tumour and its responsiveness to treatment. Schmauss et al., (2016) revealed that cancer with highly abnormal cell appearance and large numbers of dividing cells tend to grow more quickly, spread to other organs more frequently, and are less responsive to therapy than cancer whose cells have a more normal appearance. Based on these differences in microscopic appearance, doctors assign a numerical “grade” to most cancers.

In this grading system, Sharma et al., (2010) indicated that after a diagnosis has been made, doctors ask the following three questions to determine how far the disease has progressed: How large the tumour is, and how deeply has it invaded surrounding tissues? Has the cancer cell spread to regional lymph nodes? Has the cancer spread to other regions of the body? Based on the answers to these questions, the cancer is assigned a “stage.” A low number grade or stage (I and II) refers to cancers with fewer cell abnormalities than those with higher numbers (III and IV). A patient’s chances for survival are better when cancer is detected at a lower stage. The stage helps doctors determine the most appropriate treatment and management procedures to adopt.

Although there is no cure for breast cancer, there are means of managing the disease. Breast cancer is usually treated by surgical removal of lump detected by mammogram or by palpitation (Sharma et al., 2010). Early detection of breast

cancer and appropriate treatment can affect the outcome of the disease. Depending on the stage and type of the cancer, lumpectomy (removal of the lump only), or surgical removal of the entire breast (mastectomy) is performed.

Radiation therapy is another cancer management procedure (Khakbazan et al., 2014). It involves using high-energy X-rays or gamma rays that target a tumour or post-surgery tumour site. These radiations are very effective in killing cancer cells that may remain after surgery or recur where the tumour was removed. Radiation therapy for breast cancer is usually performed after surgery and is an integral component of breast-conserving therapy. The dose of radiation is often strong enough to ensure the elimination of cancer cells.

In addition, Costa et al., (2014) elucidated that chemotherapy is the use of anti-cancer drugs to treat cancerous cells. Specific treatment for the breast cancer is based on; overall health, medical history, type and stage of the cancer, tolerance for specific medications, procedures et cetera. Chemotherapy treatments are often given in cycles; a treatment for a period of time, followed by a recovery period, then another treatment. Chemotherapy is usually given before surgery to shrink the tumour and sometimes make breast conserving surgery possible rather than a mastectomy.

### **Participation in Breast Cancer Examinations**

For breast cancer examinations, Petro-Nustas et al., (2002) revealed that Jordanian women often present the disease for diagnosis at an advanced stage. They intimated that 70 percent of all newly diagnosed breast cancer cases are

within stages III and IV. To Petro-Nustas et al., what makes it a worrying trend is that unlike their counterparts in Sweden, where 70 percent of women aged 25-80 years examined their breasts on a regular basis, for young Jordanian women between the ages of 30-39, only 16 percent reported performing breast self-examination regularly. Additionally, Ahmadian, and Samah (2012) indicated that among Malaysian women, only 3.8 percent carried out mammography; and there is a significant difference in screening rates between urban and rural areas (50.6 percent versus 42.3 percent respectively).

Evidence from other studies have shown low uptake of breast cancer screening among women in Africa. For instance, Krombein and De Villiers (2006) investigated breast cancer screening practices among women in Bonteheuwel, a white-dominated community in Western Cape, South Africa. In spite of majority of women having a family history of breast cancer, screening uptake was low. Only 11 percent of women were found to have undergone mammography screening once in their lifetime. Of these women, only about 3 percent reported having received such screening in the previous two years. However, the clinical breast examination practices of the women were somewhat encouraging, as about 62 percent reported ever receiving clinical breast examination, with 29 percent reporting having been checked in the previous year. In addition, 65 percent of women reported ever practicing breast self-examination, whereas 44 percent reported having performed breast self-examination during the previous year, and 24 percent performed breast self-examination on a regular basis as recommended. In general, women who practiced breast self-examination

on a regular basis also reported regular uptake of clinical breast examination and mammography screening.

In Nigeria, Oche, Ayodele, and Umar (2012) espoused that breast screening participation is very low. For example, the study found that mammography screening practices of female health care professionals was low and about 9 percent of the respondents had undergone mammography screening during the previous year. The further study added that women who had been taught how to perform breast self-examination by health care professionals were more likely than those who had not been taught to comply with screening recommendations and practice it on a regular basis.

According to Sarfo et al., (2013), approximately 70 percent of women who are diagnosed with breast cancer in Ghana were in the advanced stages of the disease with a low uptake of breast cancer screening. Opoku et al., (2012) also explored the breast cancer screening behaviours of 474 Ghanaian women aged 40 to 70 years in two urban areas in southern Ghana and reported that overall, the uptake was generally low. Only 2 percent of the women stated ever undergoing mammography screening in their lifetime, while 12 percent reported having been examined by a health care professional once in their lifetime. About 32 percent of women reported ever practicing breast self-examination in their lifetime. However, none of the women reported adhering to recommended screening guidelines for any of the methods chosen. While these findings may reflect breast cancer screening practices among women in Ghana, there is a greater likelihood that breast cancer screening uptake is even lower among women living in other

parts of the country (especially in the rural areas) than those reported by the authors. This may be because women residing in urban settings have somewhat easier access to mammography and clinical breast services, compared to those who live in the rural areas.

The evidence presented thus far demonstrates that breast cancer screening uptake among women in Ghana and other African countries is generally low. Studies have shown that breast cancer patients in developing countries and especially in sub-Saharan Africa report late for diagnosis of their ailment. This results in a relatively high rate of mortality. Early detection and diagnosis greatly increase chances for successful treatment. The causes of this delay are multifactorial. Examples include but limited to socio-cultural issues, socio-cultural interpretations attached to the illness and socio-demography. The discussion below therefore examines some social determinants of screening intentions and early reporting for diagnosis particularly among Ghanaian women. These include socio-cultural environment and health, socio-cultural interpretations of breast cancer, other socio-cultural dynamics of breast cancer, and socio-demographic characteristics.

### **Socio-cultural Environment and Health**

This aspect of the review discusses the importance of the social environment in the discourse of health and illness.

The World Health Organization (WHO) defined health as “a complete state of physical, mental and social well-being and not merely the absence of

disease or infirmity” (WHO, 2009). This definition according to Uskul (2009), calls for attention to the complexity and multidimensionality of the concept of health. The social well-being component of the definition opened the way to conceptualizing the individual as a social being, part of bigger entity than his/her own body. Thus, the World Health Organization recognizes the role socio-cultural factors play in issues related to health. The import of this recognition suggests that for a holistic analysis of health and wellbeing of individuals, emphasis should not be placed only on medical/biological factors but these factors must be analyzed concurrently with other equally important factors like socio-cultural issues, which affect the functioning of an individual.

Joffe (2002) concurred that understanding of an illness is influenced by the ideological currents that exist in a particular society. Suh (2013) also asserted that practices, perceptions and understanding of health differ from one society to the other. These social dimensions ultimately exert impact on the wellbeing of the people. It was stated that, different lifestyles and perceptions adopted by people are generally influenced by the community’s socio-cultural factors. Chin and Noor (2014) defined socio-cultural models as the shared perspectives through which members of a particular culture understand and interpret their realities. People who share identical cultural models tend to construct their realities and interpret them in similar ways. Interpreting cultural models thus offers a profound understanding of human motives and behaviours.

The socio-cultural milieu provides people with a way of transmitting and assimilating ideologies through socialization, which serves as a foundation for

social interactions. Even though socio-cultural framework is viewed as a social structure, it is seen within the lives of the people. As emphasized by Uskul (2009), the individual is increasingly viewed as part of a larger network of forces significantly influenced by the socio-cultural environment. Socio-cultural elements do not only present the framework within which people understand and make sense of the world, also they shape the psychology regarding health and illness. Socio-cultural factors inform how people think of, feel about, and act upon their physical wellbeing. People in different cultures and social groups explain the causes of illness differently. In addition, the treatment people seek is often influenced by their beliefs and perceptions of what is causing their illness and how best to treat the disease (Helman, 2000).

### **Socio-cultural Interpretations of Breast Cancer**

In the advent of an illness, people look for explanations. Meanings attributed to an illness vary considerably over time and across social groups. Illness is an incomprehensible event and as Currer and Stacey(1993) argued, illness always give rise to the questioning and interpretation because, it is often sought in a way which goes further than medical explanations. Weitz (2013) also indicated that people typically seek explanations for why illness occurs and why it strikes some rather than others. Weitz further added that most of these explanations would then define the illness as being deserved punishment for sinful behaviour or blame the individual for their own illness. Young (1993) reiterated that these given interpretations persist because people find them useful

and convincing. These interpretations reinforce existing social arrangements and help justify the tendency to accept, reject, mistreat or simply ignore those who have illnesses.

Karbani et al., (2011) opined that women's beliefs and explanations about cancer are socio-culturally patterned, and these beliefs inform their perceptions of risk and the type of action taken to minimize risk of breast cancer. Socio-cultural concepts have been identified as significant factors that either hinder or facilitate women's decisions regarding breast cancer diagnosis and treatment. These concepts according to Hwang et al., (2015) frame women's attitudes towards concepts of health and illness. There are some perceived socio-cultural beliefs and interpretations of breast cancer and these, according to Banning et al., (2009) create barriers for prompt diagnosis and treatment of the illness.

Post (2014) argued that these beliefs and interpretations are invariable misconceptions and they influence women's views and decisions surrounding testing and treatment. She indicated that superstition and spirituality surround the word "cancer" and that breast cancer stigmatizes a woman. She explained that some people interpret the disease as caused by the devil and this has led to yielding to God as the only source of power to fight the cancer rather than acceptance of biomedical treatment. Likewise, most women avoid mentioning the words breast cancer, fearing that just stating the word would result in getting the disease. The study further added that women with breast cancer are often stigmatized and treated as outcasts as some believe that mingling with affected women will cause the cancer to spread to them.

Guidry, Matthews-Juarez, and Copeland (2003) also added that there are socio-culturally driven notions about breast cancer and its screening. He explained that if a woman participates in breast cancer screening, people would jump to conclusion that she has breast cancer and this creates a negative reflection of her. Also not exploring the “unknown,” that is, they believe that what is not known will not happen or will eventually disappear hence no need to examine the breast. Again, some believe that “if your body has no pain, it means that there is no injury”; “if a lump is not causing pain you should not bother it, it will probably go away.” If you talk about cancer, it comes into your house”; “if you go to the doctor to be examined for breast cancer, you end up with breast cancer, if you do not go, you will not get breast cancer”. These as intimated by Guidry et al are some superstitious interpretations surrounding the disease and these cause ignoring early signs of breast cancer by most women.

Others also interpret the disease as bad genes. The woman is made to feel guilty that she has brought “bad genes” into the family. She keeps her disease under wraps just to avoid social rejection and social isolation. In some extreme cases she is isolated from her family members, whereby her dining utensils are separated, fearing that she will spread the disease to the rest of the family members. This negative attitude of society toward breast cancer can be a greater killer than the disease itself (Lui et al., 2009).

Furthermore, Karbani et al., (2011) asserted that a common interpretation of breast cancer is that the illness is a punishment to the victim because of an ancestor’s misconduct. They strongly believe that if the ancestor had misbehaved,

the descendants would suffer from their ancestors' immoral acts by having bad luck or suffering from incurable diseases such as breast cancer. Some relate the interpretations to karma, fate, and believed they had to endure the illness to make amends for bad deeds from their past lives.

Some other commonly held interpretations are that when a woman is unable to breastfeed after giving birth, she gets swollen breast (a boil in the breast). Thus, the disease is understood to be a result of an accumulation of excess breast milk. Therefore, a breast cancer patient is viewed as someone who could not breastfed. Again, women who suffer from breast cancer in some social contexts are perceived as witches. They are believed to have used their breasts for ritual purposes. Furthermore, breast cancer patients are viewed as women who kept money in their brassiere and did not observe personal hygiene (Asobayire & Barley, 2014; Martei, 2011).

### **Other Socio-cultural Dynamics and Breast Cancer**

Aside the socio-cultural interpretations of the disease, there are other socio-cultural dynamics, which determine the time patients report to the hospital either for screening or for treatment. Khazae-Poo et al., (2014) indicated that some socio-cultural norms such as modesty and concealment of sexuality as virtuous qualities of women and the expected role of women heavily regulate gender relationships even in health care setting. Studies show that female members of some cultural groups are reluctant to be examined by male physicians and even the anticipation of this happening contribute to delays in or complete

avoidance of health care seeking. Ham (2005) reiterated that despite the availability of healthcare services, these cultural beliefs on illnesses influence low utilization of healthcare services of certain cultural groups. For example, in the case of breast cancer, health services like screening facilities maybe underutilized when people's cultural beliefs conflict with the healthcare knowledge passed to them.

In a study on modesty by Donkor et al., (2016), findings from the study implied that Asian, Hispanic, Muslim, and Jewish females value modesty as a way of protecting them from the wider world. These cultures that have strict rules of modesty on the underutilization of their healthcare services. The study further revealed that, few Israeli women participated in breast screening programs. This was due to the reason that the procedure is thought to violate their orthodox rules on modesty by requiring a woman to disrobe and have physical contact with a health professional (which in most cases are males). This however is not peculiar to women in the named groups, as Post (2014) and Hwang et al., (2015) have all cited that modesty is one main issue when it comes to uptake of breast cancer screening and reporting for diagnosis. This is because most cultures regard modesty as a sacred value, which must be adhered to. Therefore, exposure and touching of any part of the body especially the female breast is something which is considered “wrong and a taboo”.

Another socio-cultural issue is the gender relation dynamics. Although the dynamics may differ from one context to the other, the point remains that there exist inequalities between women and men in some social settings. Most social

settings are deeply rooted in the patriarchal system, which gives men the opportunity to be decision makers, providers of household resources with women being at the backstage, the supposed “receivers” of laws made, and resources provided. According to Kwarar (2012), some cultures even forbid women from being assertive and require them to be submissive. The above shows how power and health issues are negotiated between men and women. Men continue to exercise enormous authority over women. Women also feel obliged to respect the views of men. In a marital context, insubordination on the part of the woman can warrant a divorce and this is seen as a sign of failure and disgrace not only to the woman involved but also to her entire extended family (Asobayire & Barley, 2014; Hwang et al., 2015).

Suh (2013) reiterated that a twist to socio-cultural issues is that the breast connotes beauty, femininity and connects women to their gendered roles as mothers and wives. Women thus are concerned about maintaining these socio-cultural attributes, consequently in seeking for medical help, women are conscious of the repercussions the treatment will have on these attributes.

Furthermore, the attitudes of people towards health and illness are linked to supernatural attributes. When the socio-cultural beliefs and interpretations suggest that the disease is caused by supernatural forces, people ordinarily seek spiritual help. The display of heavy reliance on God or any form of deity of their faith, for protection from the disease, as well as on divine intervention and healing give an inkling of how pervasive supernatural attributes are in matters of health and illness. In cases where the cause of the disease is unknown, one is tempted to

believe that it is due to some spiritual cause and curses. Nothing happens without a cause and since nobody knows the cause of the disease in question, people attribute it to supernatural forces (Banning et al., 2009; Post, 2014; Uskul, 2009).

Socio-cultural norms on preventive lifestyle may influence peoples' perceptions about preventive health care and hence their attitudes towards the uptake of preventive health services like healthy lifestyle and breast cancer screening (Carroll et al., 2007). In settings where people have imbibed preventive lifestyle, they are more likely to patronize preventive health services than those who do not have the culture of prevention. In Ghana for example, Opoku et al., (2012) revealed that the concept of preventive care is generally unfamiliar to many individuals. For example, in the absence of severe symptoms of breast problems, some Ghanaian women do not seek breast health care. This attitude may have a potential effect on women's intentions to have clinical breast screening and mammography, and on the performance of breast self-examination.

### **Socio-demographic Factors as Determinants of Breast Cancer Screening Intentions and Time Patients Report for Diagnosis**

Women's intentions to undergo either breast cancer screening or report early for diagnosis have been explained basically as a function of multifactorial reasons (Soskolne, Marie, & Manor, 2007). One of such factors is formal education. It has been found to be a great influence on women's decisions about breast cancer screening. Studies have shown that higher education level increases the level of screening participation and early reporting for diagnosis (Ham, 2005;

Othman et al.,). According to Lynch and Kaplan (2000), one's level of education is an indicator of better jobs and higher incomes. Thus, the higher the level of education the better the job and higher income level which in effect give the individual the ability to subscribe to health-enhancing goods and services, such as hospital services and healthier foods. Similarly, Remennick (2006) asserted that a higher level of education has been associated with greater patronage of breast cancer screening.

Elsie et al., (2010) found that in Uganda, there was high rates of mammography screening uptake among women with higher education attainment. The study revealed that women who had completed primary education or higher were more likely than those without any education to be screened. Women with low level of education were also more hesitant to seek information about breast cancer screening than educated women.

In a related study by Agarwal and Dalal (1996) also found that in India, Malaysia and Hong Kong, women with higher levels of education, which had brought them higher levels of salary, were more likely to have their disease diagnosed in its earliest stages. MacLean et al., (2004) argued that generally, educated women have better access to healthcare and ultimately, better breast cancer survival compared to women with the lowest educational level, irrespective of country. This can be attributed to the fact that, lack of education adversely affect women's ability to comprehend and understand recommended screening guidelines and other related issues such as breast cancer symptoms and risk factors

Opoku et al., (2012) found that highly educated Ghanaian women were more likely than their uneducated counterparts to have mammography screening, clinical breast examination and or perform breast self-examination. In addition, compliance with breast screening recommendations were greater among women with high level of education than it was among the less educated. For example, Ohene-Yeboah and Agyei (2012) revealed that majority of women who reported practicing breast self-examination on a regular basis had completed secondary school or higher. He added that highly educated women showed greater knowledge of screening procedure, breast cancer risk factors and symptoms than their counterparts.

Another socio-demographic determinant that is measured closely with one's education, is occupation and income. Remennick, (2006) observed that unemployed people are more likely to have poorer health than professionals. The argument lies in the fact that professionals are more resourceful in getting better access to healthcare such as buying better drugs, getting better services, and even undergoing better surgeries. These are because most professionals achieved higher levels of education and have, in general, secured better jobs and hence higher income levels, which then enable them to enjoy better healthcare services.

Elsie et al., (2010) again indicated that employed Ugandan women were more likely to undergo mammography. This is mainly because the employed women had higher incomes, which enabled easier access to mammography screening services. In addition, they stand the chance of benefitting from counselling and health promotion on cancer screening and care at the work place.

In Nigeria, Ndikom and Ofi (2012) reported that the uptake of screening especially mammography was not encouraging among low income women. This they attributed to the numerous competing health and social needs. Furthermore, Oche et al., (2012) reported a similar finding from a study of female health care professionals in Nigeria and found that low paid professionals rarely undergo mammography screening, while highly paid professionals reported greater interest in screening and complied with recommendations.

McFarland (2003) cited cost as a major barrier to cancer screening. The study showed that women with low income were the least likely to undergo cancer screening, compared to women with high incomes. In Ghana, low income women have been found less likely to undergo mammography screening than those with higher income status (Clegg-Lamptey et al., 2009; Ohene –Yeboah & Agyei, 2012). The authors stressed that high costs of mammography screening services prevent many women from undergoing screening.

A number of studies have shown age as a contributor to breast cancer screening intentions. Higher screening intention has been consistently associated with older age (Ham, 2005; Othman et al., 2012; Soskolne et al., 2007), with highest rates in the 50 to 60 year group. Both after and before this age, screening intentions were lower among women in many populations. For example, Othman et al., found that Jordanian women above age 50 years were more likely than those below that age to have mammography screening. This high rate of screening intention often found in older women could be explained by the fact that breast

cancer risk increases concurrently with age, especially in women above 40 years and the need for them to undertake annual screening (Jemal et al., 2011).

Uskul (2009) argued that women's status/ gender roles in the society can shape their health-seeking behaviour by determining their priorities. For example, many are concerned about how they should fulfil their responsibilities towards their families, and how they should maintain their status in the society. If their priority is satisfying the needs of their families (that is performing the roles as mothers and wives) than their own health, they are less likely to seek medical help.

Christou and Thompson (2012) argued that few studies have found a relationship between marital status and screening intentions of women. According to them findings on the influence of marital status on screening intentions are mixed. These mixed arguments are evident from the discussion following:

Ohene-Yeboah et al., (2013) in their study revealed that single women are more likely to patronize screening; while the findings of (Dei, 2013; Clegg-Lamptey et al., 2009) however, proved otherwise as married women were more likely to patronize breast cancer screening.

Another dimension to this discussion is where marriage has the tendency to impede breast cancer screening, as elucidated in the study conducted by Kawar (2012). It was reported that in Jordan many husbands do not allow their wives to visit or consult physicians or to even read articles related to breast cancer. Furthermore, many husbands require their women to wear the hijab (a veil) to cover their faces and do not allow women to uncover their bodies for physician

examination and/or forbid them to get treatment. Therefore, the women's freedom to make decisions regarding their own health are curtailed. Thus, any woman who wishes to seek medical help must seek a male's approval before she can proceed. Family structure interference is applied through the collective nature of their culture, where extended male family members have powerful influence on a woman's health and participation in breast cancer screening. The study reported that women suffer injustice in every aspect of life, including health care and that they live under tremendous pressure and restrictions from family (nuclear and extended). Unfortunately, when a woman gets breast cancer the man will frequently be advised by his family to leave her and find another woman to marry, implying that she is now defective. This makes women reluctant to be screened for any type of cancer.

Augmenting this finding by Kwar, Asobayire and Barley (2014) in their study in Northern Ghana revealed that women in the Kasina Nankana District of Navorongo, consult their husbands and other male heads in the family before they pursue any medical help such as breast cancer screening. They explained that the family system is highly patriarchal and the customary marriage system bestows upon the man the responsibility for the economic, social and general welfare of his wife and her children. Since families hold morality and chastity in marriage in high esteem, married women are required to inform and seek authorization from their husbands whenever they need to visit a health facility. Visiting a hospital to disrobe and be examined by a male medical officer (which is the case in the district) is an uncomfortable and a complicated situation for the women. As

expressed by the women, they cannot allow another man to touch their breasts, accusation would be levelled against them of being adulterous if found in such a compromising position and the fear of being divorced, which will bring disgrace upon her family thus they are reluctant to go for medical screening.

Christou and Thompson (2012) are therefore right by indicating that the influence of marital status on screening intentions is diffused. This is because from the foregoing discussions on marital status, going for breast cancer screening services or not is underpinned by multiple factors like patriarchy, liberal cultural setting, and whether or not the woman is single.

Pei and Rodriguez (2006) asserted that the habitat of an individual is a crucial determinant of screening intentions. They argued that people living in urban areas have a higher tendency of having intentions for screening as compared to those in the rural areas. This is often due to the availability of modern health facilities. Supporting this argument, a study by Ohene Yeboah et al., (2013) showed that women in the urban areas patronized breast screening exercise in the hospitals than women in the peri-urban and rural areas.

Another determinant of breast cancer screening intentions is a family history of breast cancer. Evidence suggests that women with a family history of breast cancer are more likely than women without any history of the disease to initiate screening intentions at an earlier age and undergo screening on a regular basis (Othman et al., 2012). In terms of screening preferences, women with a family history of breast cancer are more likely to undergo mammography than clinical breast examination and breast self-examination (Price et al., 2010). It is

believed that regular screening could potentially reduce their chances of developing the disease (Othman et al., 2012).

O'Malley et al., (2001) also added that women with a history of breast health problems such as swelling and pain were found to patronize screening regularly as compared to those without such health challenges.

### **Effects of Breast Cancer**

Breast cancer diagnosis is often perceived as a crisis for both patients and their families and profoundly changes the lives of women and their families. Weitz (2013) indicated that, the disease changes women's life irrevocably making it a nightmare to the extent that they struggle to make difficult treatment-related decisions. Lives of women are described as "being in suspense" when they are told that they have breast cancer. Even after surgical, chemotherapy and radiation treatments, there is the constant fear of recurrence and uncertainty.

One main challenge women suffering from breast cancer deal with is appearance-related issues. The physical deformation caused by the side effects of treatment, is often regarded as a depletion of the body image and sexuality of patients. Vieira, Santos, Santos and Giami (2014) reiterated that fear of loss of sexual attractiveness and rejection from the partner, generate anxiety for women who consider such representations to be important. Karbani et al., (2011) also added that women are always competing with each other for the attention of a man. For this reason, it is necessary that a woman is always well "presented" and "physically attractive" since there would be strong competition in the affective-

sexual market. Thus, there is the tendency for most women suffering from the disease to entertain fear of being out of the “race”. These psycho-emotional problems can subsequently increase the physical problems of the women. Body image concerns even span across creed. For example, Suh (2013) revealed that even in Muslim cultures such as Iran where women are expected to cover their body; disfiguring of the breast, which leads to changes in body image, can result in problems in relation to their spouses. For this reason, when a woman feels that she is not sexually attractive to her spouse, and receives negative reactions from the spouse due physical deformation, the woman’s self-esteem and confidence are affected adversely.

From the arguments made by Weitz, Vieira et al., Karbani et al., and Suh, it can be inferred that, breast cancer distorts women’s unique sexual appearance hence creates terrifying jolt to their body image. This loss of body image creates an identity crisis for most women and this is likely to dwindle the faith these women have in their bodies.

Charmaz and Rosenfield (2010) espoused that illnesses are most likely to result in stigma when they cause visible disfigurements or loss of bodily functions. Also diseases which defy human understanding in terms of causes etcetera also tend to elicit stigma and fear. One such illness is breast cancer. It has the propensity to cause social stigma and self- stigmatization. Due to some negative misconceptions and interpretations attributed to the causes of the illness, patients whose medical status are overt in the community are often discriminated against. People more often than not isolate themselves from these patients with

the assumption that they may be infected if they get closer. Weiss and Lonquist (2015) further pointed out that some patients discriminate against themselves by keeping their distance from others. These women feel that they have lost an important part of their body, and no longer feel balanced or whole, which result in not feeling feminine enough. They become more conscious of their bodies, especially when going out in public and, as a result, limit their social activities. Furthermore, there is a feeling of burdening friends and family and as such, coil into their shells and become less sociable.

The costly nature of treatment of breast cancer has been identified by many women as a major challenge and a barrier to breast cancer care. Patients are required to make out of-pocket payments to either pay a significant part of the cost of screening, diagnosis and treatment or incur the full costs (depending on a buffer like health insurance scheme). According to Opoku et al., (2012) health insurance schemes exist in many countries, however not all women are privileged to have access to the scheme. Thus, those who are not on the scheme would have to bear the full expensive cost of treatment. The financial burden of living with breast cancer as argued by de-Graft et al., (2010) exacerbates the psychosocial burden of patients and families, which leads to family disruption, depletion of family resources and diminished family support.

Suh (2013) asserted that breast cancer patients more often than not experience changes in lifestyle and daily routine, following a long period of treatment. Their everyday life is full of uncertainties regarding their gendered roles. Ahmadian and Samah (2012) added most women are not able to perform

their domestic duties so have to rely on others for assistance. As they undergo treatment, their inability to perform previous routines creates emotional turmoil, as most of the women are not able to perform their expected social roles.

Using the analogy of the marriage vow, Weiss and Lonquist (2015) explained that the effect of breast cancer on patients is just like the marriage vow; is for better, for worse. This is because the disease can either pull friends and families to the patient or push them away. They argued that when a woman is diagnosed with breast cancer it comes with associated problems such as depending on others for emotional support, financial assistance, domestic assistance and so on. Some friends and family empathize with the patients due to the excruciating pains and discomforts they experience by offering their help and resources to patients. Others on the other hand are overwhelmed by the level of dependency and the rate at which resources are being depleted and so distant themselves from patients.

### **Coping Strategies of Patients**

Illness is an inevitable phenomenon, experienced at one point in life. As such, there is the need to map out strategies to cope with the illness when it strikes. Absence of intervening strategies can be detrimental to one's health, as an individual may react with feelings of hopelessness. Thus, it is imperative to adopt coping strategies as cushioning agents. Weitz (2013) espoused that, coping strategies are counteracting actions undertaken by people whose survival and livelihood are threatened by an event. Coping strategies available to women

suffering from breast cancer are often influenced by factors such as how women view their illness, socio-cultural interpretations of the disease and its symptoms; the physical and emotional demands of the illness, social networks, age, gender among others.

There are numerous ways of coping with diseases. One such strategy is treatment preference. People in different cultures and social groups explain the causes of illness differently. The treatment people seek to alleviate the pain of an illness is often influenced by their beliefs and interpretations of what is causing their illness. Helman (2000) posited that classification of disease as either caused by biological factors or supernatural forces influence the treatment preference of patients. The study added that the choice of a treatment process over another gives an inkling of the interpretations attached to the disease. A particular treatment process is preferred if it is considered to be effective to ease the suffering of the individual. Twumasi (2005), espoused that treatment of illness is not the exclusive right of scientific medical practitioners but also alternative treatments. He maintained that the use of alternative treatment has grown rapidly due to the perceived efficacy to cure chronic diseases.

Joulaee, Joolae, Kadivar and Hajibabae (2012) revealed that some patients interpret and cope with the disease from the religious approach (accepting the disease as God's will or a spiritual battle), thereby resorting to spiritual help as a means of comforting themselves. Meneses and Yarbrow (2007) also revealed that, generally several women use alternative methods such as herbs, traditional medications, sorcery, and amulets to treat their breast cancer. This is due to the

interpretation given to it as caused by mystical forces. In addition, Arevian, Nouredine and Abboud, (2011) indicated that when women say the word “breast cancer”, they frequently say religious phrases to follow the word such as: “God/Allah please protect us”. These quotations according to Arevian et al., reflect the tendency to call on a higher being to protect them, keep them cancer free and healthy. In Ghana, Asobayire and Barley (2014) indicated that due to historical and cultural factors, Ghana’s contemporary culture is a complex duality of old and new, indigenous and foreign and this is no different in terms of health practices. As such, the health service system of Ghana has complex mixture of orthodox and alternative health providers. Although the orthodox service system has catch up with the people and is considered superior to the other alternatives (because of its scientific investigations), nonetheless the patronage of the other categories which comprise of Traditional healers (those who use herbal concoction or magic or both) and the Faith-based spiritualists (those who give cosmic explanations to the disease) is high. de-Graft et al., (2010) stated that most Ghanaians are oblivious of the causes of some chronic/terminal diseases like breast cancer, epilepsy, asthma, among others. They believe that they are caused by supernatural forces as such address them as “Sumsum yare /Obosam yare” which literally means spiritual ailment/ devil’s ailment, which is beyond the scope of orthodox medical services. Due to the supernatural explanation given to cancer in some cases, traditional healers, herbalists and spiritualists have become important health care outlets in Ghana offering help to breast cancer patients in a form of treatment. Furthermore, Martei (2011) stated that in Ghana religion plays

a pivotal role in the provision of emotional and spiritual support during breast cancer diagnosis and management.

Social network is another medium through which affected patients cope. Khakbazan, et al., (2014) stated that social network including employers, colleagues in the workplace, family, and friends, generally show a favourable impact on the maintenance of health and coping with stress and illness. In a study, which investigated the social support of Chinese women with ovarian cancer during chemotherapy, Banning et al., (2009) found that social support from patients' family members and friends such as emotional and financial support, frequent visits et cetera were considered as major resources for the women during their treatment. It is considered one of the most important factors to increase the hope level of patients. Patients who obtained higher amount of love from family members and friends were found more cooperative with their doctors and nurses. The women obtained information about the disease and this considerably increased their strength to fight the disease. Ahmadian and Samah (2012) also added that healthcare professional sometimes provide support, with nurses providing women with emotional support, reassurance and encouragement throughout the cancer journey.

Furthermore, Guidry et al., (2003) revealed that many women of African descent share positive attitudes about strong kinship bonds, flexibility of roles in the family, and connectivity to religion, education, and work. These attitudes and beliefs could be traced back to African culture in which the communalism and survival of the tribe were viewed as primary and shared by all. The bond of

kinship was the center of tribal life and sense of survival of a collective unity. Reliance on a kinship network or extended family system remains a major way of coping with interpersonal matters and external environmental pressures. Extended family bonds provide significant financial and emotional support. The extended family comprised of a large number of uncles, aunts, boyfriends, girlfriends, older brothers and sisters, deacons, preachers, and others. The bonds of the extended family are often critical to these women when confronted with making personal health decisions, including cancer screening, diagnosis, and treatment. Augmenting Guidry et al's assertion, Dei (2013) opined that Ghanaians share strong social bond hence, the potential effect of social support on women's intentions toward breast cancer screening cannot be overemphasized. In most cases, when Ghanaian women have problems with their health, they first seek non-medical support from their family and friends.

Denial is a common coping strategy adopted by patients and according to Schettler (2013), denial may provide short-term benefits but is often ultimately detrimental. It is normally called "false consciousness". This is where patients refuse to accept the reality and live under disguise just to forget about the existence of the ailment.

In conclusion, evidence presented thus far showed that breast cancer is a dreadful disease. Meanwhile, the participation in screening methods and seeking early treatment are faced with obstacles. These obstacles are mainly attributed to socio-cultural issues. Furthermore, the literature suggests that women alleviate their predicament by adopting some mechanisms to cope with the illness.

## **Theoretical Framework**

The study is underpinned by Social Constructionism and Reuben Hill's ABC-X model. These theories were chosen because of their practicability to the study. The social constructionism explains how individuals imbibe meanings in a particular social setting. The ABC-X also discusses how individuals adapt in the advent of a predicament.

## **Social Constructionism**

This is a micro sociological perspective popularized by Berger and Luckman (1967) in their landmark study "The social construction of reality". They were interested in how reality, knowledge, thought, fact, and even the self is generated and institutionalized. The conclusion made was that reality, knowledge, thought, fact, and even the self, emanate from the social realm (community generated) and maintained through linguistic entities (verbal and nonverbal constructs). The major focus of this theory is to uncover the ways in which individuals and groups participate in the creation of their perceived social reality. It involves looking at ways social phenomena are created, institutionalized, and made into tradition by humans. Reality is socially constructed and it is seen as an ongoing, dynamic process which is generally accepted. The theory posits that most social interactions involve some acceptance of what reality is.

The theory espouses that reality originates from human activity. Thus, members of a society together invent the knowledge, beliefs, and ideologies.

Knowledge is a human product, which is constructed socially and culturally, as such individuals' realities are shaped through the experiences and the interactions with others. For example, how we were raised and what we were raised to believe affect how we present ourselves, how we perceive others, and how others perceive us. In short, our beliefs and backgrounds (social setting) colour our perceptions of reality. Understandings are not developed separately within a person. Instead, a person develops understandings/ internal models/perceptions/ knowledge by using experiences and interactions with other people. This makes each person's reality unique. Construction can thus be seen as a social process whereby constructs (reality) emerge from ongoing conversations and interactions.

### **Relevance of the theory**

This theory essentially embraces the ideology that knowledge, beliefs and perceptions are interpretive nets woven by individuals and groups in a society (socially constructed). In relation to health and illness, the theory focuses on the way people make sense of their bodies and body disturbances through socially constructed ideas and beliefs. Therefore, the theory suggests that interpretations of illness is socially constructed. Social forces like the shared norms, ideologies, beliefs and interpretations shape the understanding and actions of people towards health, illness and healing. That is to say, these forces shape peoples' understanding of the disease, the experiences of the illness, decision regarding treatment and the outcome of the problem. The theory is therefore relevant to this

study because it gives the opportunity to acknowledge the diverse attributions and interpretations people/patients attach to breast cancer within their social contexts.

Putting the theory in the perspective of interpretations that people/patients may attach to breast cancer, it can be argued that, the interpretations, beliefs, understanding and experiences of the illness are often inextricably tied to the social attributions. Patients' realities about the illness especially the causes, treatment, and coping strategies often stem from broader social perceptions about breast cancer and interactions with significant and general others. It is worth noting that patients' choices of care are not based solely on medical criteria, but on other factors such as the perceived interpretations, family responsibilities, perceived stigma among others. For example, if the perceived cause of the illness is attributed to spiritual, the health seeking behaviour of the patient most likely would be from a spiritual perspective.

Thus, from the perspective of the social constructionism it can be argued that ideas, constructs and interpretations of breast cancer are socially motivated. The interpretations (realities) attached to the illness by the patients are not intrinsically determined, but they are the expressions and experiences of others, their personal experiences which are informed by their environment and the larger social milieu.

In conclusion, what patients hear, know and understand, are the perceived realities from their environment, which they decipher to inform their judgments and interpretations of the disease, with corresponding health seeking behaviours, and coping mechanisms.

### **ABC-X Model**

The ABC-X model emanated from Reuben Hill's 1949 study on how families adapt to various stressors/ problems. Although the model originally concentrated on the family as a group, researchers over the years have incorporated the individual as a unit of analysis in the model and have applied the model in other fields other than Family Studies. For example, the model has been used in the field of Medical Sociology to explain illness as a stressor and how individuals and their families cope with the predicament.

In as much as human beings try to avoid stress/problems the fact remains that we are not immune to it. ABC-X is therefore a model that describes and explains the processes individuals and their families adopt to successfully or unsuccessfully buffer their stress. The model suggests that, there are two protective factors (resources and perceptions) which are adopted to buffer the impact of a stressor on an individual or family. These two factors relate together to predict family or individual crises. Hill adopted alphabets to explain the processes. A (the event/stressor/problem) interacting with B (the family's stressor and the mitigating resources) which interacts with C (the definition or perceptions the family makes of the event) to produce or avoid X (the crisis).

*The "A" variable: (the stressor)*

The A variable is defined as stressor or a life event impacting on the individual or family which produces, or has the potential of producing changes in

the life of the individual and the family social system. Hill conceptualized stressors as both expected over the course of life, and sudden and unexpected. The stressor is expected to produce crisis. However, the level of crises is dependent on variables B and C.

*The “B” variable: (the resources)*

The B variable refers to the internal and external individual or family resources and social support available to the family and the individual, which are used to lessen the impact of the stressor by preventing the stressor from escalating into a crisis. Resources then become part of the individual’s and family’s capabilities and strengths, which enable them to deal with the stress and avoid crisis. The resources can be examined at three levels. The first level is personal resources, which can be high self-esteem, financial stability, skills and so on. The second level is the family resources; strong cohesion, family adaptability (like role swap), fluid communication, emotional support, affection, and a sense of economic interdependence. The last level is the social support; assistance from people outside the family like friends, colleagues among others. Hill theorized that social isolation would significantly increase the impact of the stress on the individual or family functioning; in contrast, positive social supports would minimize the impact.

*The “C” variable: (perception of the stressor)*

The C variable is the individual's and family's subjective meanings of the stressor and its seriousness and how they are affected by it. This component of the model illustrates individual and family perceptions held about the stressor. The C variable reflects the individual and family values and previous experiences in dealing with stressors. The extent to which the family or the individual perceives the stressor can vary from seeing stressors as life challenges which must be overcome, or interpreting stressors as disasters which can lead to the break of the individual and the family. Hill intimated that some families have positive appraisals, which increase their ability to accept their circumstances and vice versa.

*The "X" variable: (crisis/outcome)*

The X variable is the outcome of the "ABC" process. That is, the stressor, individual/family resources and definition given to the stressor are hypothesized to interact to determine if a crisis (X) will result and, if so, the extent of the crisis. Crisis is conceptualized as a continuous variable, which creates an amount of disruptiveness, disorganization, tension, destabilization among others within the individual and family as a social system. Crisis differs from stress, in that the stress is a demanding event, while crisis is characterized by the individual's or family's inability to restore equilibrium. In other words, stress may never reach crisis if the family or the individual is able to use existing resources and define the situation to avoid crisis and maintain stability. If there are deficiencies in

resources and definition given to the stress, crisis can result as continuous pressure on the individual and family.

### **Application of the theory**

In the field of health and illness, Hill's ABC-X model remains a useful tool for identifying how individuals and families cope with stress and some explanations of how families and individuals vary in their responses to stressor, which in this case is illness. This model helps us to understand that making decisions, solving problems, and taking actions are intertwined and complicated which often present a state of dilemma for families and individuals.

In relation to breast cancer, at that material moment the patient is diagnosed with cancer, the illness immediately becomes a stressor for the individual and the family. The aftermath depends greatly on the strength of the resources of the individual and the family and a positive appraisal of the stressor (positive perceptions). The patient being diagnosed with breast cancer means changes in physical appearance, changes in routine activities, high expenditure among others. Therefore, there is the need for adjustment and adaptability. The strength of resources then becomes powerful tool for the family and the individual to deal with the stress and avoid crisis. The resources can be high self-esteem of the individual, financial stability, strong cohesion within the family, smooth adaptations to new activities, emotional support, and economic interdependence. Furthermore, support from friends significantly increase the individual or family functioning; in contrast, worries about high expenditure, and loss of income due

to missed work, stigmatization and neglects, which are weak resources will minimize the individual/family functioning. For the C variable, a good appraisal of the illness as an ordinary life challenge which needs all the necessary adjustment will help mitigate the effect of the illness, but when the diagnosis is seen as a threat to for example, marriage, parenting role, future plans, dreams, and goals that might not happen, then the reverse is true. These factors (B and C) combine to paint a picture of the outcome, that is X or the crisis. If both the individual and the family do not have strong resources (B) and good appraisal of the illness, then the stressor will certainly result in a crisis. Therefore, we can conclude by indicating that both “B and C” variables are the coping mechanisms patients together with their families adopt. They are the means to reducing the impact of the stressor from escalating into a crisis.

### **Conceptual Framework**

The conceptual framework has been developed from the concepts and theories underpinning the study. It shows an interplay of the theories and the concepts and how they are linked together. The main concepts informing the work are socio-cultural interpretations, coping strategies, socio-demographic characteristics, time for presenting the illness to hospital, treatment choices, and survival. The ABC-X Model and the Social Constructionism Theory explain how the concepts informed each other, by showing their associations.

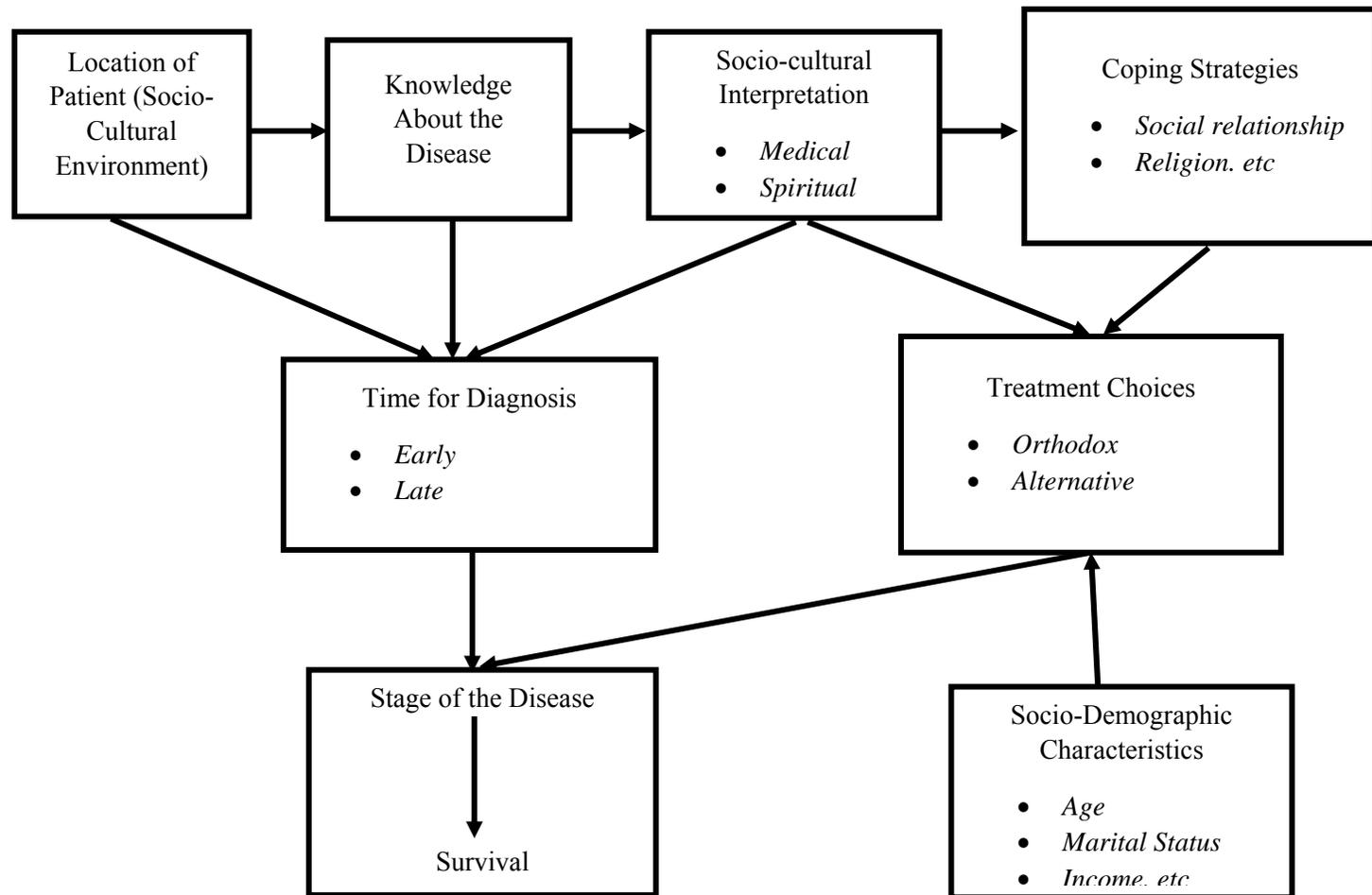
The arguments made thus far show that the uptake of breast cancer screening, early reporting of the disease for diagnosis and treatment choices by

women are greatly influenced by the socio-interpretations attributed to the disease. These interpretations emanate from established social constructs. These social constructs are often complex and intertwined worldviews, which individuals inherit as members of a particular society through socialization. These worldviews inform people on how to view the world, how to experience it emotionally, and how to behave in relation to other people, to supernatural forces and to the natural environment. Thus, the social construct within a particular social setting/ social environment informs women's interpretations of the disease, which further influence their intentions to screen their breasts and the type of treatment to seek which have rippling effects on the chances of survival. It is important to note that, the socio-cultural environment (location) does not only play a significant role in the interpretations people attribute to the disease but also the level of awareness of breast cancer.

Furthermore, as Guidry et al., (2002) indicated, socio-cultural interpretations feature prominently in the coping strategies of patients. The meanings that an individual and the family attach to an event or their appraisal of stressors influence their perceptions, which in turn determine the kinds of strategies to adopt to buffer the stressor, which is breast cancer. This brings in the ABC-X model, which suggests that, the interpretations an individual and family have, become crucial in deciding on not only the coping mechanisms to adopt but also the treatment choices. In addition, socio-demographic characteristics often influence intentions to screen for breast cancer and treatment choices.

The import of the above discussion is that, for the survival rate to increase there is the need for early presentation of the disease for prompt diagnosis. Socio-cultural interpretations have been chiefly attributed to the late presentation of the disease. Interpretations do not exist in a vacuum, they emanate from the social environment (location) which strongly influences our understandings and the meanings we attribute to things. These interpretations determine the time patients report to the hospital for diagnosis and treatment choices. Also, socio-demographic factors play a vital role with regard to the urgency with which women screen their breast and the type of treatment choices they adopt.

Below is the graphical representation of the conceptual framework



**Figure 1:** A Conceptual Framework showing the Dynamics of Health Seeking Behaviours of Patients  
Source: adapted from Concepts in the Literature, Social Constructionism Theory and ABC-X Model.

## CHAPTER THREE

### METHODOLOGY

#### Introduction

The methodology section consists of the research design, study setting, population, sample, sampling technique, data collection instrument, pilot study, data collection procedure as well as data analysis. It further discusses issues on ethics, reliability and validity, field experience and challenges and limitations of the study.

#### The Research Design

A qualitative research design was used in this study. According to Creswell (2013), qualitative research design is a form of systematic empirical inquiry grounded in understanding how people make sense of their experiences. Bryman (2012) also indicated that qualitative research emphasizes the dynamic, holistic and individual aspects of human experiences, and attempts to capture these experiences in their entirety, within the context of those experiencing them. Furthermore, it is used to explore sensitive issues which are not in the mainstream.

This design was adopted to explore the experiences of breast cancer patients. Detailed information on the experiences of patients and the role socio-cultural interpretations, together with other social factors play in breast cancer as a phenomenon were solicited.



### **Philosophical Justification**

The views on how research should be conducted, whether to choose positivism, interpretivism or a blend of the two have been the dilemma of social researchers especially those in the field of sociology. It is often propagated and expected that social phenomena should be investigated just like the natural sciences where a hypothesis is formulated and then tested using precise measurement techniques. This was the cry of early sociologists like Comte and Durkheim. This research strategy, according to Bryman (2012) definitely exists, but the view that this is how research should be done is by no means shared universally. In addition, Buchanan (1998), observed that positivism is a powerful ideology but it is not the only method for gaining valid knowledge, thus the concentration on testing and measuring of variables may account for the limited success of the positivist methodology in explaining human behaviour, especially in health studies.

On the other hand, sociologists like Weber, Mead and Schutz favoured an approach which eschewed positivistic method, arguing that people and their social institutions are very different from the subject matter of the natural sciences. As such, there is the need to have an approach known as interpretivism which is more sensitive to the special qualities of people and their social institutions. Interpretivism unlike positivism rejects the notion that reality is fixed and measurable. On the contrary the experiences and perspectives of individuals are socially constructed, historically embedded and construed in different ways (Greig, Taylor, & Mackay, 2007). The aim of the qualitative approach is not to

predict, control or change anyone, but to deepen our understanding of the human life.

Qualitative design was found to be most suitable for this study because it adopts the ontology of interpretivism which is based on the fact that social phenomena can be understood through interpretations of individuals' subjective experiences. Taking into consideration the research objectives which sought to get the inner experiences of patients, patients' interpretations of the disease, how these interpretations informed their choices and actions, problems they encountered and how they are coping with the illness, the qualitative approach was considered an effective strategy in exploring these objectives. The approach was more effective in revealing salient insights into socio-cultural and contextual issues and how these greatly influenced late breast cancer presentation by the patients.

Buttressing the justification for the use of the qualitative approach further, Holloway and Wheeler (2009) argued that breast cancer related issues, to a large extent, have been studied by the use of the quantitative design. They further intimated that there have been difficulties in implementing the results in cancer care and one reason for this is that, quantitative tools have difficulties in capturing what is unique in patients' experiences and exploring deep layers of human feelings. They added that quantitative approach has the tendency to omit important issues that patients may have expressed in a study with a qualitative approach.

## Study Setting

The study setting was Cape Coast Teaching Hospital. The hospital was formerly known as the Central Regional Hospital. It was the first of a series of regional hospitals established by the Ministry of Health. The hospital started full operation on 12<sup>th</sup> August 1998. In 2003, it was adjudged the best regional hospital in the country. It was upgraded to a teaching hospital with the inception of the School of Medical Sciences in the University of Cape Coast. It is a referral hospital with 400 bed capacity and provides specialist services including the following: Obstetrics and Gynaecology, Surgery, Orthopaedics, Medicine, Child Health, Pathology, Ear Nose Throat (ENT), Endoscopy, Neurosurgery, Intensive Care Unit, Psychiatry, Dentistry, Eye unit and so on ([www.capecoastteachinghospital.org](http://www.capecoastteachinghospital.org), Accessed on 24<sup>th</sup> Feb., 2017).

The Breast Clinic receives patients from all over the country. It is staffed with a team of surgeons, radiation oncologists and nurses. The clinic receives patients on Wednesdays and Fridays for regular review and for chemotherapy respectively.

Cape Coast Teaching Hospital was selected as the study site because it is a referral hospital with the state of the art equipment. Furthermore, the hospital receives quite a number of breast cancer patients annually. Statistics from the biostatistics department of the hospital indicates that the number of breast cancer patients received in 2015 was thirty-seven. A year later (that is 2016), the figure soared to one hundred and seventy.

According to Walford (2001), gaining access to a research site is a process which involves both formal and informal negotiation skills. The researcher used both formal and informal means to gain access to the hospital. The researcher first engaged and dialogued with the doctor in charge of the Breast Clinic to find out if it was feasible to conduct the study at his unit. The idea and asked the researcher to write officially to the hospital administration. An introductory letter from the Department of Sociology and Anthropology was given to the Medical Director for consideration. The researcher was given the go ahead after completing ethical procedures.

### **Population**

All females diagnosed with breast cancer and who were undergoing treatment at the Cape Coast Teaching Hospital were the targeted population for this study. Females were selected because the focus of this study is on women suffering from breast cancer.

### **Sample**

The study had twenty-five participants as its sample size. Twenty female breast cancer patients were recruited because they were readily available for the study. Five health workers were selected, specifically three from the Breast Clinic and two from the Female Surgical Ward. This sample selection and size permitted the exploration of the diverse views of women and health workers on the phenomenon under investigation. In addition, data saturation was reached, as participants gave no new information.

As intimated by Teddlie and Yu (2007) for qualitative design, sample size is typically small and this helps the researcher to learn the most from the participants. Walliman (2006) also buttressed the above assertion that at least a sample size of 30 or less is an appreciable number for any kind of qualitative study.

### **Sampling Procedure**

Sampling is a process or technique of choosing a sub-group from a population to participate in a study. The non-probability technique was used in this study. Creswell (2013) argued that the use of non-probability sampling is most appropriate where the research aims at providing an in-depth understanding of the world as seen through the eyes of the people being studied. It is a technique for obtaining in-depth responses about what people think and how they feel about a phenomenon. Furthermore, Teddlie and Yu (2007) reiterated the fact that, non-probability sampling is a good method to use when attempting to study a sensitive phenomenon.

Convenient and purposive sampling techniques were used to select patients for this study. Convenient sampling is where participants are readily available and agree to participate in a study (Latham, 2007). The convenient sampling technique was adopted due to the nature of participants and setting of the study. Breast cancer is a chronic disease and it is difficult getting patients in a “pool” at once. This is because, there is a stipulated day in the week where patients go for diagnosis and treatment. Furthermore, patients have been schedule

for specific days and time for diagnosis and treatment. As such, selection was based on the readiness of the available patients to participate in the study.

Purposive sampling according to Latham (2007) is choosing a sample based on personal knowledge of the population, its elements, and the nature of the research aims. That is the population is non-randomly selected based on certain characteristics. The individual characteristics are carefully chosen to respond to essential questions about a certain matter or product. The researcher is then able to select participants based on the prior knowledge of the said characteristics. Furthermore, Oppong (2013) argued that purposive sampling technique is extensively used particularly in the context of qualitative research. This is because, it offers the researcher the opportunity to involve subjects who have experience or knowledge of the issue/s being addressed in the study. He noted that the use of purposive sampling entails categorizing subjects in accordance with known criteria centered on the research problem.

### **Recruitment procedure of participants**

As indicated earlier, patients were conveniently and purposively selected for the study. Patients aside being available and ready to participate in the study were selected based on some criteria/ characteristics. The inclusion criteria for this study were patients who have been diagnosed and tested as having breast cancer and were going for routine follow-up appointment at the hospital. Patients who were yet to receive confirmation of having breast cancer were excluded from the study. This is because the study was interested in those diagnosed with the disease. In effect, patients who were receiving chemotherapy treatment and those

at the mastectomy stage were involved in the study. This was done to ensure that participants were selected based on the fact that they are living with the disease and they can give a vivid account of the knowledge and experiences of breast cancer. The doctors and nurses aided the selection of patients. They identified patients who had been diagnosed with the disease from those who were yet to be confirmed.

Five health workers were purposively selected to participate in the study. They included a breast surgeon, one junior doctor, a nurse at the consulting room and two other nurses at the Female Surgical Ward. The five health workers were found to be appropriate to give rich and valuable information regarding their experiences with patients during diagnosis and treatment in the clinical setting. For example, the doctors deal directly with patients through diagnosing and treatment, the consulting room nurse ushers the patients in to the consulting room, assist the doctor in examining the patients and has the opportunity to observe the demeanour of patients as they are being given treatment. Finally, the ward nurses administer medication to both pre and post-surgery patients, assist patients and doctors during chemotherapy and see to the well-being of patients at the surgical ward. As such, interviewing these five individuals augmented the accounts given by the patients.

### **Data Collection Instrument**

In-depth interviews and observation guides were the data collection instruments found most appropriate for this study. The observation was done to

augment the in-depth interview to give a fuller picture. An in-depth interview, according to Oppong (2013) is regarded as the best way for exploring and gathering an experiential narrative phenomenon. In-depth interview is most appropriate where detailed insights are required from individual participants (Teddlie & Yu, 2007). In-depth interview provided participants the opportunity to describe their experiences as patients living with breast cancer. They gave account of their own stories in their own words. Bryman (2012) further added that, in an in-depth interview, the interviewer is interested in the context and content of the interview, thus this approach allowed much more space for interviewees to answer on their own terms than structured interviews. This yielded rich data, as participants were able to give an in-depth experiential narration of how socio-cultural interpretations and contextual factors manifested in their predicament as breast cancer patients and the strategies they adopted in mitigating their condition. The instrument allowed the researcher to probe answers to ensure consistency in responses given. The interview was done on a one on one basis. A digital audio recorder was used to record the interviews. However, permission was sought from the participants before recording.

### **The interview procedure**

The study had two venues for the interviews. These were the Out Patient Department (OPD) and the Female Surgical Ward. Seven patients (7) were interviewed at the OPD and thirteen (13) patients were interviewed at the Female Surgical Ward. All interviews were done on a one-on-one basis. There was no separate note-taker or translator. As stated by Robson (2002) one-on-one

interviews offer the possibility of modifying one's line of enquiry, following up interesting responses and investigating the underlying interpretations of events. The interview procedure started by establishing good relationship with participants. Before the start of any interview, the researcher took time to establish rapport, gain their trust and open up lines of communication with participants. In some cases, the researcher had to visit some participants at the ward a few times, spent few hours with them before the researcher scheduled dates for the interviews.

Aside the five health workers who were interviewed in English, every interaction throughout the fieldwork was through the Akan language. This was particularly so because patients preferred this medium of interaction since it enabled them to express themselves well and thoroughly. Also, the use of their own language made it possible for the researcher to explain issues to their understanding. Questions on lifestyle patterns, knowledge of breast cancer, treatment choices, socio-cultural influences, coping strategies, among others were asked. As intimated by Silverman (2006) open-ended questions allow for more flexibility in delving more into the perceptions and feelings of participants. Follow-up questions were asked as a form of probes and prompts.

Using the in-depth interview gave the participants the opportunity to talk about their worries to the researcher. Silverman (2006) indicated that, in-depth interviews have been particularly attractive to researchers who want to explore voices and experiences which are not in the mainstream discussions. The challenge with this method was that some of the participants answered questions

by talking for a long period, telling the whole of their life story (they digressed) and as Bryman (2012) observed, when this happens interviewers usually face the problem of deciding when to return to the interview guide.

The duration of the interviews and breaks varied between patients, so the pace with which each patient was comfortable set the length of time for the interviews. The interviews lasted between 20 and 80 minutes depending on the intensity of the conversation and the environment. Interviews with participants at the Female Surgical Ward were very intense. Comparatively, they talked at length and in more detail about their experiences than those who were at the OPD. This could be attributed to their physical and emotional state after either surgery or chemotherapy thus going through emotional turmoil unlike their counterparts at the OPD who were mostly patients who have undergone mastectomy or about finishing their chemotherapy who have been scheduled for review. As such, the researcher varied the style of questioning according to the type of patient being interviewed. The interviews lasted forty-four days (in April and May).

### **Observation procedure**

Observation, according to Flick (2009) is a vital tool in exploring and understanding issues. It enables the researcher to find out how something factually works or occurs. The observation was carried out to capture the ordinary activities of patients at the hospital. The researcher wanted to know about the lives of patients at the hospital. The researcher spent four hours (7am to 11am) on Wednesdays, Fridays and Saturdays in the field. A structured observation was used as the observation technique. The researcher observed the following: How

friendly/receptive patients were with one another, If there were groups (informal groups/ associations), the category of people who followed patients to the hospital for treatment and after surgery, how well patients associated with health professionals, general demeanour of patients, availability of support systems (counselling unit).

According to Bryman (2012), structured observation employs explicitly formulated rules for the observation and recording of behaviour. The rules inform the observer about what he/she should look for. These rules are articulated in what is usually referred to as an observation schedule. The aim of the observation schedule is to ensure that each participant's behaviour is systematically recorded so that it is possible to aggregate the behaviour of all those in the sample in respect of each type of behaviour being recorded.

The researcher was a non-participant observer. As Robson (2002) stated being a non-participant observer is where the researcher observes but does not participate in what is going on in the social setting. Structured observers are usually non-participants in that they are in the social setting observing but rarely participate in what is happening. Using the non-participant observer method enabled the researcher to concentrate on gathering naturally occurring data of patients since the researcher did not get involved in their activities to distort the natural flow of events.

For the risk of forgetting important observations, it was essential for the researcher to document things observed quickly because a lot of things took place. Bryman (2012) opined that due to the frailties of human memory, researchers

have to record activities in the field. Therefore, the researcher had a field notebook in which all observations were recorded. At the top of each record in the field book, the researcher wrote the date, the time and the setting followed by what was observed. The writings during the observations in the settings were brief. Later in the day, the short records were expanded by writing a full field note that included the people and situations involved; what the main issues were, which research question did the observation bear most centrally on and some reflections of the researcher.

The verbal, non-verbalised and situational details gathered from the observations proved to be an appropriate technique for getting an insight into real life situations of patients. Staying in their settings for hours in a day, watching and listening to the chat they had with friends, enabled the researcher to understand how they try to survive in everyday life. For example, how they spoke about their understanding of their predicament to one another and the expression of pain. The observations complemented the interviews and served as a backup evidence for patients' narratives.

It must be noted that observations were conducted twenty-one days before the start of the interviews. This helped the researcher to familiarize herself with the context and environment of the participants. It also helped the researcher to do a second observation whenever information obtained from the interview did not confirm earlier observations.

### **Reliability and Validity**

Reliability refers to the consistency of a measure of a concept. It is a matter of whether a particular technique, applied repeatedly to the same object, yields the same results each time (Creswell, 2013). Validity, on the other hand, is when the instrument accurately/actually measures concepts it seeks to measure. A pilot study was conducted to test the instrument to check for reliability and validity.

Also, Bryman (2012) argued that establishment of validity and reliability of a qualitative research is about the trustworthiness of the data. Qualitative research is trustworthy, when it accurately represents the experience of the study participants.

The following were observed to ascertain the trustworthiness of the research:

- All participants were taken through the same main themes.
- The researcher interviewed the participants to the point of data saturation (No new information was raised).
- The interviews were tape-recorded and played to participants to ascertain the information given.

Additionally, data was collected from two key sources, which is from patients and some medical staff while two different methods (interviews and observations) were used in gathering the data for the study.

### **Pre-test**

This was done to ascertain the efficacy of the instrument. The essence of a pre-test is to obtain information for improving the study or assessing its feasibility. Furthermore, it is to tailor the questions to address the research

objectives. The pre-test was done in Ridge Hospital in Accra. It was done to test the effectiveness of the instrument and address any ambiguities. In addition, the pre-test presented an opportunity to check consistency of questions and to detect errors in cross-cultural language differences. It further examined how best concepts in the study have been explained; the reactions and understanding level of participants and identified any issue(s) which were overlooked in the drafting of the questions. It gave a fair picture of what the actual data collection was going to be.

The pre-test had ten participants. Participants were taken through the same themes. Overall, participants did not have difficulties answering the questions. Notwithstanding this, there was the need for rephrasing of some questions and changing of terms. For example, under lifestyle pattern of patients, there was an item about contraceptive use, which needed revision. Per their demeanour, it was realised that the term contraceptive was quite technical for most of the participants as they sought further explanation. Thus, the researcher changed the word contraceptive to family planning, which the participants understood and could relate well with the new word. Interestingly, because the characteristics of the participants were not too different from the actual study participants, it gave the researcher first-hand experience of dealing with study participants of that nature. That is to say, the attitudes, behaviour and expressions of the actual study participants were not too distinct from the pre-test participants, hence the researcher knew when to ask a question, how to probe, when there was a need for

a pause, among others. Furthermore, the pre-test, gave the researcher an inkling of the duration of the interviews.

### **Sources of Information for the Study**

Information for the study was derived from primary and secondary sources. For the primary source, data was obtained from the field by the use of in-depth interviews and observation while the secondary information was obtained from related literature and relevant reports and information from published text such as: academic periodicals, research journals and government publications, published and unpublished dissertations.

### **Data Analysis and Interpretation**

A digital audio recorder was used to record interviews. Interviews recorded in the Akan language were transcribed and translated verbatim into English. Conducting the interviews and their transcription went concurrently to avoid the dangers of procrastination. Conducting the interviews, transcribing and translating brought the researcher closer to the data. The researcher became conversant with the stories of the women, thus identified key issues and became aware of the similarities and differences in their accounts. The researcher developed the themes manually. Working manually allowed the researcher to delve much more into the data and be familiar with the emerging themes. The thematic analysis approach was adopted.

The researcher adopted Braun and Clarke (2006) thematic analysis approach. The approach has six phases namely, familiarising with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and lastly producing the write up from the data.

The themes and subthemes were the product of a thorough reading and rereading of the transcripts and field notes that make up the data. After the fieldwork, all the transcripts and field notes were read through thoroughly. Key themes that ran through all the transcripts and the field notes recorded concerning each research question were identified. The themes were consistent. Developing these themes and their subthemes enhanced the researcher's understanding of the data. The data was organised around the key themes identified. These key themes were classified as analytical categories (that is the main theme under which other sub themes or issues emerged).

These analytical categories were assigned a particular colour, which in this case was green. For example, treatment preference which was an analytical theme was coloured with green. The researcher then went back to each transcript and coloured green what the participants said concerning this theme. As the key themes were picked, sub themes and other striking issues were being identified. These sub themes and striking issues were coloured with red. Colouring was done on the computer screen not on hard copy. A word document was opened for each key theme, where statements (which were coloured with purple) addressing the themes were placed. The analysis was more data driven, therefore, inductively

inclined. Analysis of the data therefore involved reading the transcripts to identify frequently occurring issues to allow patterns and themes to surface.

### **Ethical Principles and Procedures**

Ethical principles are a set of moral rules, which are adhered to in order to prevent harming, or wronging others especially in the field of research. Due to the sensitive nature of this study, ethical principles such as confidentiality and informed consent were strongly observed. Prior to the commencement of data collection, ethical clearance was secured from the Institutional Review Boards of the University of Cape Coast and Cape Coast Teaching Hospital. The hospital being an autonomous institution makes authorities prioritize the welfare of patients together with health workers and so are very cautious regarding the flow of sensitive and confidential information to the public. As a result, the researcher was taken through rigorous ethical procedures. Firstly, the researcher was taken to the Research Unit of the hospital where clarifications were sought on the objectives, sample size and sampling technique, the data collection procedure and the duration for the collection of data. Furthermore, the researcher was quizzed on the practical ways of ensuring confidentiality and privacy of patients due to the sensitive nature of the research. Finally, the Head of the Research Unit vetted the research instrument. The researcher was then directed to the Biostatistician where the research instrument and the informed consent forms were again vetted. The above procedures took twenty-one days after which the researcher was given the green light to start with the data collection.

The consent of participants was sought before the start of any interview. Participants were informed about the study and its objectives. Participants gave oral consent to the researcher. This strategy specifically ensured that participation was fully voluntary and informed, based on an understanding of what the study is about, what its risks and benefits were, how the results will be used and the fact that participants could withdraw from it at any time. Furthermore, given the sensitive nature of the study, confidentiality was strictly adhered to. Information given by participants was managed as private communication.

Participants' actual names and any other identifiable characteristics were delinked from the data. Participants were encouraged to use pseudonyms to protect their identities. Although there were no anticipated risks associated with this study, several steps were taken by the researcher to minimize any potential harmful effects of the study on the participants. For example, when emotions were heightened the researcher paused the recorder and gave the participants time to recover. Taking a cue from the reactions of participants to questions asked previously, some questions were rephrased to suit their current mood.

### **Field Experience and Practical Challenges**

Experience from the field was a mixed feeling (happy at the same time anxious about the hospital environment). It was motivating interacting with participants who were ready to share their experiences. It created an avenue for establishing rapport with health workers and patients. Interactions with the participants provided good records regarding the data collected. The non-

verbalised and situational details gathered through the interviews and observations gave me insight into the experiences and lifestyles of women living with breast cancer. Doing a qualitative research of this nature can be emotionally challenging. My emotional experiences were quite overwhelming especially, feelings of sorrow and loss of appetite. Such experiences were expected as a number of authors have stated that researchers can be negatively affected emotionally and physically by researching sensitive issues. Some of the negative outcomes include gastrointestinal problems (Dunn, 1991), insomnia and nightmares (Dunn; Etherington, 1996), headaches (Dunn,), exhaustion and depression (Ridge, Hee, & Arent, 1999) and threats to physical safety (Langford, 2000; Lee & Renzetti 1995). As Langford (2000) indicated, it is imperative for researchers to consider the above named effects when investigating sensitive issues.

The researcher also experienced physical challenges as characteristic of any study. Some of the challenges encountered were; firstly, all the patients were interviewed in the local language specifically the Akan. The Akan language however has different dialects including Twi, Fanti, and Akuapem. Although there are some similarities among these dialects, the fact remains that there are differences in pronunciations and meanings, thus getting the exact local equivalent of some English words was challenging. Furthermore, the pronunciation of words like lump in Twi is not the same in Fanti as such there was the need to use gestures, situations and descriptions to explain some words/concepts.

In addition, there were periodic interruptions like phone calls, taking patients out for X-ray, administering of drugs to patients by nurses and families visiting. Researching in the hospital environment was also a challenge. Securing suitable venue on Fridays (Chemotherapy day) was problematic so the researcher had to conduct the interviews at the ward. The ward was not favourable due to exposure to infections but the researcher had to endure and the necessary precautions were taken.

Lastly, the researcher had a hard time recruiting participants. Some targeted participants refused to take part in the study because they saw it to be a form of media reportage. Others, after consenting and scheduling a date with the researcher, changed their minds at the eleventh hour.

### **Limitations to Data Collection**

Although, the main focus of the study was to explore the experiences of women living with breast cancer, nonetheless, a limitation to this work was the inability of the researcher to have significant others of patients participate in this study. This would have given a holistic view of the phenomenon, taking into consideration the accounts from the women, health workers and close family relations (significant others).

In addition, though the study employed one-on-one in-depth interviews which facilitated an open and candid experiential accounts and the development of some novel themes; it is important to acknowledge that a qualitative study comes with its own challenges. One of such limitations is the sampling techniques

adopted which in this case were purposive and convenient. The adoption of these two techniques to specifically identify women who informed the research questions presented a level of subjective selection bias. Additionally, given the relatively small size of the sample, generalization of the findings to the general population of Ghana may pose a challenge. The research nonetheless, is credible as most of the findings in this study corroborates those of other studies on breast cancer done in Ghana.

## CHAPTER FOUR

### ANALYSIS AND DISCUSSION

#### **Introduction**

The analysis and discussion is the presentation of the findings from the data collected. This chapter focuses on answering the research questions guiding the study. They are based on emerging themes from the in-depth interviews and observations conducted. In all, six main analytic recurrent themes were identified from the data. These major analytic themes examined the time patients presented the disease to the hospital, reactions of patients to the disease, socio-demographic influence and breast cancer, treatment preference, effects of the disease and coping strategies of patients. Some of these analytic themes have sub-themes. This chapter however begins with the profile of patients.

#### **Profile of Patients**

This profile gives a descriptive picture of patients in terms of their biodata, general characteristics and their lifestyle patterns.

**Table 1; Biodata of Patients**

Pennames	Age	Education	Occupation	Marital status	No. of children	Duration of B.F	Residence of patients	Ethnicity	Religion	Stage of the disease
Aunty Esi (D)	60	None	Retailer	Widow	Five	18 months	Takoradi	Akan	Muslim	CT
Juliet	30	Diploma	Teacher	Married	Two	18 months	Kotokuraba	Akan	Christian	M
Monica	21	SHS graduate	None	Single	None	None	Drobo	Akan	Christian	CT
Salah (BP)	45	None	Farmer	Married	Three	18 months	Twifo Hemang	Akan	Christian	M
Sister Yankee (D)	45	Middle School Cert.	Retailer	Married	Three	18 months	Takoradi	Dagomba	Muslim	CT
Sarah	29	JHS graduate	Housewife	Married	Two	9 months	Abura	Akan	Christian	CT
Yaa Ruth(D)	68	Middle School Cert.	Retired nurse	Divorced	None	None	Mankessim	Akan	Hindu	M
Money Matter (D)	50	None	Fish monger	Married	Four	six months	Elmina	Akan	Christian	M
Vero	32	Primary	Retailer	Married	One	24 months	Shama	Ga	Christian	CT
Araba	60	None	Farmer	Married	Six	8 months	Gomoa Fete	Akan	African Traditionalist	CT

**Table 1 continued**

Pennames	Age	Education	Occupation	Marital status	No. of children	Duration of B.F	Residence of patients	Ethnicity	Religion	Stage of the disease
Mama Lucy	50	None	Fish monger	Married	Three	12 months	Daabiso	Frafra	Muslim	CT
Mansah	42	NVTI graduate	Seamstress	Widow	Four	8 months	Wenchi	Akan	No affiliation	M
Bruwaa (BP)	55	None	Fish seller	Divorced	Two	12 months	Elmina	Akan	Christian	M
Lebencee	40	Primary	Baker	Married	One	9 months	Assin Fosu	Ewe	Christian	M
Sophia (BP)	31	JHS	Retailer	Single	One	24 months	Komenda	Ga	Christian	CT
Adama	35	NVTI graduate	Caterer	Married	Two	10 months	Lapaz	Ga	Christian	CT
Comfort (BP)	50	Middle School Leaving Cert.	Pastor	Married	Two	12 months	Takoradi	Ewe	Christian	M
Vim Mama (D)	55	None	Retailer	Widow	Two	18 months	Fadama (Accra)	Akan	No affiliation	M
Rukky	48	None	Porridge seller	Married	Two	9 months	Abura	Grushie	Muslim	CT
Aunty Sam	42	None	Hair dresser	Married	Three	8 months	Kakumdo	Ga	Christian	CT

(D- patients who had diabetes before breast cancer; BP- patients who had High Blood Pressure before breast cancer; B.F- breast feeding; CT- Chemotherapy; M- Mastectomy)

## **Age**

With reference to age, three out of the twenty participants were within the age bracket of 21-30 years, four participants were within the age group of 31-40 years, eight participants were within the age cohort of 41-50 years, four participants were within the age range of 51-60 years and one participant was above 61 years. It is evident from the data that the majority of the patients fall within the 41-50 age cohort. Though it is unclear why the majority of the participants fell within that age group, it is pertinent to mention that, this finding is akin to Ohene-Yeboah's and Agyei's (2012) study where most of the study participants fell within the same age bracket. Although the literature suggests that breast cancer mostly affects women at their post-menopausal age, the age distribution of breast cancer patients in this study however shows that women in their premenopausal and menopausal periods were more affected by the disease. Figures for the 21-30; 31-40; and 41-50 age categories cumulatively constituted 19 out of 20 patients. It could be implied that breast cancer is no longer "a disease for the old" as women as young as twenty years are being diagnosed with it. It is imperative therefore to investigate further, the possible reasons for this outcome.

## **Marital Status**

For marital status, the majority of the patients (thirteen) were married, two were single, two were divorced, and three were widowed. Putting together the figures of the married, widowed and the divorced patients, which is indicative that they have had relationship with a man or baby, constitute eighteen out of twenty patients which is alarming. Even in the case of the two single patients, one had a

child which presupposes that she also had an interaction with a man and a baby. It could well be that interaction with a man, a baby or both could induce breast cancer.

### **Formal Education**

On the subject of formal education, nine patients out of the twenty had no formal education, two were primary school leavers, three were Middle School Leaving Certificate holders, two had Junior High School Certificate, two others were graduates from Vocational Institutions, one was a Senior High School graduate and lastly one had a Diploma Certificate. The limited knowledge of breast cancer and its early warning signs exhibited by the patients is clear indication of the low level of formal education.

### **Occupation**

In the case of occupation, five of the patients were into the retail business. In this study, the retail business is a generic term for women who were into buying and selling of commodities. From the data it was realized that there is no over preponderance of one occupation over the others, as could be said that it is prone to developing breast cancer.

### **Religion**

Most of the patients (twelve) were Christians. Christianity in this study encompasses all the various denominations found in the religion. Muslims were the next populous group with four in number. One patient was a believer in the

African Traditional religion, one Hindu, and two others who belonged to none of the faiths. According to the 2010 population census by the Ghana Statistical Service, 71.2 percent of Ghanaians are Christians, 17.6 percent Muslims, 5.3 percent non-affiliates and 5.2 percent, African Traditional believers. This data agrees with the Ghana Statistical Service figures that is the more statistical figures of the religion the more breast cancer cases reported and vice versa. It could therefore be inferred that no of the religions are actively educating their members on breast cancer because if that is the case figures obtained in this study will not follow the statistical service figures.

### **Ethnicity**

For ethnicity, most of the patients (eleven) were Akans with few from other ethnic groups. Akans are the predominant ethnic group in Ghana, concentrated at the southern sector of the country. Taking the location of Cape Coast Teaching Hospital into consideration, there is a higher chance of getting more Akans.

### **Period of Breast Feeding**

With regard to breast feeding, from the above table, it was realized that the length of time a child was breastfed was not a factor in inducing breast cancer.

### **Stage of the Disease**

For stage of the disease, patients presented advanced stages of the illness to hospital. Eleven patients were undergoing chemotherapy treatment while nine had either undergone mastectomy or were about to undergo surgery which are the advance stages of the treatment protocol.

### **Link with other Diseases**

Although the interview guide did not have a question on linkage of other diseases with breast cancer; probing further into the health status of patients, it was revealed that, nine out of the twenty patients had either diabetes or high blood pressure before being diagnosed with the disease. There is a likelihood that these two disease conditions either on their own or due to drugs being taken, trigger the development of breast cancer. There might be the need for further investigations into the effects of medicines used for the treatment of diabetes and hypertension.

### **Lifestyle pattern of patients**

Under lifestyle patterns, the study sought to find out the activities of patients to identify some common trends that could induce breast cancer. It aimed at finding out if patients drink alcohol, smoke, use contraceptives, take balanced diet, and do regular exercise.

The data showed that fifteen out of twenty patients had taken alcohol from the locally brewed to foreign alcoholic beverages. For some patients it was a lifestyle (frequent intake) and for others it was taken once in a while especially at

occasions like wedding, funeral and other social gatherings. However, they all indicated that due to their current condition, they no more consume alcohol.

On diet, the majority (nineteen) preferred carbohydrates to fruits and vegetables. Patients gave reasons as carbohydrates giving them more energy and tasting better than fruits and vegetables.

Seven patients used contraceptives, specifically the injectable which were administered close to the armpit.

On the question of smoking, all the patients answered in the negative. On probing further into the activities of the patients, it became known that most of the participants use charcoal and firewood (seventeen) with a few (three) used Liquefied petroleum gas (LPG) for cooking. The charcoal and firewood emit smoke which may have similar effects like tobacco smoking which is known to cause cancer.

On the issue of exercise, patients interpreted it to mean cooking and walking to work without any conscious effort to do regular and vigorous exercise. These lifestyle patterns of the patients tend to confirm existing literature, that such lifestyles trigger the development of breast cancer.

### **Time Patients Presented the Disease to the Hospital**

Location of patients, knowledge about breast cancer and the socio-cultural interpretations of it, were the three main factors that influenced the time patients reported to the hospital for diagnosis.

### **Location of patients: The contextual world of the women**

One of the main tenets of this study is to describe the socio-cultural milieu of patients and how their environment impedes or facilitates the time they presented the disease to the hospital. It is important to consider the socio-cultural background of patients if we are to understand fully how they view and understand their illness. Breast cancer patients in this study were not homogenous. Their experiences varied in terms of geographical location. As Helman (2000) stated, the socio-cultural environment of individuals creates unique patterns of beliefs that inform their attitudes towards prevention and treatment of disease. The socio-cultural environment of patients provided them with a way of assimilating the interpretations of the illness through socialization.

The location of patients had a direct link with the time they reported the disease to the hospital. This is because the community an individual lives in has a role on how information flows, the sort of information that is circulated, the meaning and interpretation people in that community attach to the information, socio-cultural dynamics, the kind of social interaction and power relations. Regarding the time patients reported to the hospital, they indicated that the sort of information they received from their community either prompted them to go to hospital early or otherwise. In a collectivistic community where there are expressive ties between people (as typical of rural areas) patients more often than not, delayed in going to hospital. This is because in such communities there is often an easy flow of information/interaction, thus patients were afraid to seek treatment for the fear of their health status getting into the public domain. They

concealed the illness until it got out of hand, before seeking medical help. Women from the rural and peri-urban areas (small closely knitted communities) intimated that women who had breast cancer in their communities died, and they were labeled as witches who had done evil and that the disease was their punishment. It will therefore be disastrous if they let people know about their condition for fear of stigmatization so they delayed in seeking medical help. For example, 50 year old Mama Lucy indicated:

*This disease is so bad. When people get to know that you have it they spread all sort of falsehood. Let me tell you, there was this beautiful lady in my vicinity. She had the disease and people gave her all sort of names. Some called her a witch who tried to kill someone and the person she was trying to kill prayed and that is the result of her action. Others said she is promiscuous. When I had the disease I was very afraid to tell people. Even my family it took a while before I told them, because I did not know how they will behave towards me. So myself together with my daughter were applying herbs secretly on the breast till my sister from Accra came and advised me to go to the hospital in Cape Coast instead and non will know about it.*

This sentiment by the women could be explained by de-Graft et al.'s, (2010) assertion that most Ghanaians are oblivious of the causes of some chronic/terminal diseases like breast cancer, epilepsy, asthma. They believe that they are caused by supernatural forces and as such address them as “Sumsum yare /Obonsam yare” (spiritual/ demonic condition), which is beyond the scope of orthodox medical services. Due to the supernatural explanation given to cancer in some cases and the perceived belief that is beyond orthodox treatment, most women are adamant to seek early treatment.

Other patients stated that women in their communities who had breast cancer and went to the hospital had their breasts removed and died. Therefore, going to the hospital meant that they will suffer the same fate hence the delay. For example, Salah, 45 years old indicated:

*“Oooh I did not come early to the hospital because I feared that if I come the doctors will ask me to go for surgery and I might die. People in my community say if you have breast cancer and they remove your breast you will never be the same and you will die. I believed it initially because two women in my community who had the disease and went to the hospital for surgery died. I came to the hospital only after I got to know that those women died because the disease had reached a bad state, I mean their breasts were decaying. So I said to myself that I have to rush to the hospital before I get to their state and die.”*

The urbanized patients also reported late. Though they did not give explicit reasons for the delay. It could be inferred that there were multiplicities of factors such low knowledge level, disbelieve in orthodox treatment, misconception about the disease.

### **Knowledge about the Disease**

On the knowledge about the disease, patients were asked about the causes, symptoms and signs, screening methods and treatment procedures and below were some of the responses given.

*“My lady [referring to the interviewer] I had no idea what breast cancer was. I experienced excruciating pains in my breast, it became more tender and I had lumps as well. I always thought it was a kind of rash on the skin especially around the breast. I did*

*not know there was anything like chemo and the likes". (Araba, 60 years)*

*"I experienced pains in my breast especially the left one, also my nipple started discolouring and I had lumps too. Well I never knew about screening methods and treatment choices until I came to the hospital. Initially I never suspected that my symptoms were signs of breast cancer. I thought they were signs of menopause."*  
(Comfort, 50 years)

*"Hmmm they sometimes talk about it on radio, but the truth is I never paid attention to it. Now I have it and I don't even know much about it". (Bruwaa, 55 years)*

*"first I did not know. Now I know is breast disease. For me I though the lump was the ordinary lumps in the breast because they were not painful. However, as time went on it was paining me and the pain became severe so I decided to come to the hospital".*  
(Sister Yankee, 45 years)

Although the women exhibited some general alerting features of breast cancer like lump in the breast, swelling in the armpit, nipple discharge and unusual breast pain or discomfort, they were to a large extent, ignorant of the disease and lacked accurate knowledge of the causes, symptoms, screening methods and treatment procedures. Though some indicated having heard of the condition through the media, breast cancer was partially understood by them.

Patients further indicated that, unlike other chronic diseases such as hypertension and diabetes, the discussion on breast cancer in the public domain was not very common. They stated that it is not openly talked about like diabetes and hypertension. This assertion by patients is probably because of the stigma

attached to the illness, where sufferers keep it to themselves and possibly with close relatives instead of the community.

The inadequate knowledge of the disease by the women could be further attributed to some factors like low level of awareness of it and low formal education. According to Othman et al., (2012), women who have knowledge about the disease usually have positive intentions towards screening uptake and reporting early to the hospital and this significantly improves survival chances.

### **Socio-cultural Interpretations Attached to the Illness**

Patients gave varied interpretations to the illness. Out of the twenty patients, thirteen indicated that the disease is caused by supernatural forces. Some of them intimated as follows:

*For me it is spiritual. How can you be given treatment and your hair falls out, your nails get discoloured? [side effects of chemotherapy] this is not so with other diseases". (Mansah, 45 years)*

*"for me I believe it is spiritual. How can you be there and all of a sudden you get this dreadful disease?" (Mama Lucy, 50 years)*

*"The disease is caused by witches. They use our breasts for rituals. That is why when you get the disease you die within a short period because they have already killed you in the spiritual realm. So it is a matter of time for it to be manifested in the physical"*  
(Sarah, 29 years)

Several of the patients gave a spiritual interpretation to the disease, others indicated that breast cancer is just a medical condition like any other disease. They argued:

*“Oooh for me I don’t regard it as spiritual. It is medical. I think as you grow you are susceptible to a lot of sicknesses and breast cancer is one. You know things change within your system”.*  
(Juliet, 30 years)

*“It is a medical condition. I don’t believe this is a spiritual disease. It is a disease that is becoming common and I think it is a purely medical condition.”* (Sophia, 31 years)

Some had mixed interpretations to the disease. They expressed the following views:

*“All they say is that it is a disease that kills. It is like HIV/AIDS, once you get it you will surely die”.* (Aunty Sam, 42 years).

*“The general perception is that it is a disease that kills. Especially when your breast is removed” When someone gets it she dies. Others believe that when you don’t observe personal hygiene and dirt accumulates around the breast you will get it.”* (Salah, 45 years)

When asked about the interpretations patients attribute to breast cancer, a senior doctor intimated:

*“It is interesting the kind of interpretations patients attribute to breast cancer. Most of the patients that we receive in this hospital attribute the disease to spiritual causes. Some say their rivals cursed them with the disease, others are of the view that because they are not spiritual [prayerful in this sense] “Obonsam” [devil or malevolent spirits] have inflicted them with the disease. There are few who regard the disease as medical or caused by other factors other than spiritual. Breast cancer is not a spiritual disease; it is a purely medical condition so I do not understand where people get these*

*interpretations that it is spiritual. How can a witch cause your cells to outgrow? Well let me leave that to the pastors, maybe they can tell me more about that possibility [sighs deeply and laughs]". (Doctor E.M)*

From, the above narrations, socio-cultural interpretations given to the illness ranged from medical reasons, supernatural attributions, poor personal hygiene to promiscuity. These interpretations about the illness influenced the time women reported for diagnosis. The interpretations especially the perceived fatality associated with the illness increased apprehension amongst women and caused a considerable amount of fear, tension and worry regarding the illness. Many of the women kept the symptoms for a considerable number of time, only to later require treatment for advanced stage of the illness. This feature of the data concurs with previous published works by Banning et al., (2009), Hwang et al., (2015) and Post (2014) that the perceived interpretations of breast cancer, which mostly are misconceptions, frame women's attitudes towards health and often create barriers for prompt diagnosis and treatment of the illness.

### **Reactions of Patients**

Patients' reactions toward the disease ranged from shock of the diagnosis, fear of losing body image, to fear of death.

### **Shock of Diagnosis**

All studied patients expressed shock at their diagnosis. It was inconceivable to them in the sense that what had initially started as painless breast

lumps turned out to be breast cancer. For some, that was the first time of hearing about the disease. As health workers explained the disease and its treatment procedures, patients expressed feelings of shock, disbelief and emotional upset. Most of the patients were therefore terrified to break the news to their families because of the perceived risk of the treatment procedures and the stigma attached to the illness. Below are some accounts given by the study participants:

*“When I was diagnosed with the disease I cried. I could not believe what the doctor said. So I remember asking the doctor if they had not mistaken my medical records for someone”.*  
(Juliet, 30 years)

*“It was like my world had crushed. Breast cancer? I thought of how the disease was going to affect the family and me. I heard it is a disease that kills even after treatment so there and then I knew I was close to my grave. As I talk to you I can die anytime”.* [She sobs] (Bruwaa, 55 years)

*“I was in doubt when the doctor indicated I had the disease. I thought it was just breast pain until I realized the thing was getting out of hand. Up till now I still don’t understand how I got the disease. It is a blow. When I was diagnosed, I could not tell my family members immediately. It took like a month or two before I told them. I could no longer hide the pain and the stress I was going through”.* (Rukky, 48 years)

A nurse added:

*“Oooh yes when patients are diagnosed with the disease the atmosphere becomes tense and uncomfortable for us. Some burst out in tears crying like they have lost a relative. Some ask*

*too many questions after answering and explaining what they need to know, they ask the same questions again. For others too it is normal. All they ask is what they should do next and that is it. But I would say generally they get sad. It is a dangerous disease and so if I were to be in their shoes certainly I will do same or even worse". Hmmm [sighs deeply] (Nurse Hajia)*

Surmising the above narration, it is clear that cancer development is upsetting for women. The issue of breast cancer is an emotional one that elicits numerous reactions from women. Many women are uncertain about the future, feel depressed, scared and terrified at the thought of having to undergo treatment and the related insecurity associated with the condition. This aspect of the study's findings is supported by Vieira et al's (2014) assertion that breast cancer diagnosis is often perceived as a crisis for both patients and their families and profoundly changes the lives of women and their families. Their everyday life is full of uncertainties regarding their gendered roles and sexuality as well as future functionality.

### **Body Image: The Two Polarized Fears**

The extent and nature of appearance-related concerns of patients in this study were dependent on the stage of the illness, age and marital status. Several of the patients had reached advanced stage of the disease. The side effects of the treatment were visible. Even though patients indicated that being alive was the most important thing, nonetheless issue about body image was a major concern especially for the young, single and the married. They indicated that changes in their appearance made them feel that they had lost an important part of their body.

They no longer felt balanced or ‘whole’, which resulted in not feeling feminine enough. Below are some accounts of the patients:

*“I am not married. Am due for surgery meaning my breast is going to be removed. How would I get a husband? It means that I will not give birth, because I do not think any man will be interested in a half breasted girl like me. So if I don’t marry and give birth it means I have failed as a woman and I can’t be compared to my mates because what they have I don’t. As for death we will all die but when you die what will people remember you for” [she cries uncontrollably]. (Monica, 21 years)*

*“My main concerns were one; they were going to remove my breast. Something that has been with me for ages now am going to lose it. Secondly, how would I feel as a woman without breast, although am not breastfeeding now, the breast is very important. It gives you a sense of femininity. So breast cancer is really problematic”. (Lebenee, 40 years)*

*“This disease affects your self-esteem as a woman. The fear of losing your breast is not easy. You feel that something valuable is missing. When you get intimate with your husband, it is an issue because you feel pains in the breast. Although he might say it is okay, it is never okay. When it comes to such things it is quite disturbing”. (Adama, 35 years)*

Patients who were fifty years and above, and either divorced or widowed were not particularly concerned by the changes in their appearance. Instead, they placed greater emphasis on their health and being alive and the surgical pains they

would endure after surgery. To them, due to their age and marital status, appearance issues were not so important. They expressed the “I am not bothered about my breast” demeanour. They were less bothered by the changes than younger women were. Furthermore, they intimated that younger women are the ones who invest more in their appearance and not them. Below are some expressions by the patients:

*“I am not worried. Look at me, I am old. What do I need this [pointing to the infected breast] for? I have five children; my husband is dead. At my age am I now going to marry? [laughs loudly] for me if they say removing this thing [referring to the breast] will save me why not. After all I am not using it for anything. If I am to go out I just pad my bra and I am good to go. After all the thing is like a leaf now [laughs again]. But what concerns me is about my health. I am diabetic so sometimes I get adverse reactions from the drugs I take. Now I am not able to move my legs as I should, I have severe waist pains. These are the things am worried about. Because of my immobility I am not able to play with my grandchildren as before and I am sad”.*  
(Aunty Esi, 60 years)

*“Young ladies like you [referring to the interviewer] are the ones who get worried and cry as if they have been told they are going to hell. After all, their health is important than the breasts they cry over. If the doctors do not remove and you die, then what do you get. As for me when the doctors told me that they have to remove the breast, I just asked them to go ahead. Now I have done the surgery and am living. My sister do I look ugly?”*  
(Yaa Ruth, 68 years)

Sentiments by the young, single and married are expected taking into consideration their age and marital status. The female breast is seen as a medium that connects women to their socio-gendered roles. A deformation of the breast alters their social roles of being mothers and wives. This situation creates a feeling of failure and disengages them from the social expectation of looking “normal” like other healthy women. As Karbani et al., (2011) indicated, women are always competing with each other for the attention of a man. For this reason, it is necessary that the woman is always well “presented” and physically attractive since there would be strong competition in the affective-sexual market. If Karbani et al., assertion is anything to go by, then it stands to reason that the young, single and married women, unlike their counterparts, are concerned over the loss of their former roles, especially because of their husbands and husbands-to-be. A woman’s perception of the lost breast signifies that she is no longer able to fulfil her reproductive and erotic functions.

### **Socio-cultural Interpretations and Health Seeking Behaviours of Patients (Treatment Choices of Patients)**

In a medically pluralistic society like Ghana, people suffering from ailment have a number of ways of seeking treatment. As Twumasi (2005) indicated, the treatment of sick people is not the exclusive rights of scientific medical practitioners (orthodox treatment) but also the prophets, mallams, traditional healers among others. The preference of one choice over the others is greatly influenced by the meanings and interpretations people attach to the illness.

The interpretations an individual give to an event are largely derived from the experiences and the interactions with others in a given socio-cultural context. These social constructs shape the realities of an individual.

As the social constructionist theory posits, reality is socially constructed and it is seen as an ongoing dynamic process which is generally accepted. The existing knowledge, beliefs and perceptions are interpretive nets, woven by individuals and groups in a society. The beliefs and interpretations shape the understanding and actions of people. In relation to health, illness and healing, socio-cultural constructs shape peoples' understanding of illness, their experiences of it and decisions regarding treatment. Thus, the patients' perceptions of the causes of breast cancer were socially embedded and these social interpretations influenced the actions they took in seeking relief for the ailment.

Finding from this study shows that interpretations given to breast cancer influence the type of treatment sought. Thus those who perceived the disease to be unnatural were adamant in seeking medical help but rather resorted to other treatments like herbal or spiritual treatment or both (alternative treatment), and vice versa. For patients in this study, orthodox medicine and alternative medicine offered different solutions to their problems. Therefore, the choice of one over the other or both was informed by what they believed to be the ultimate cause of the illness.

### **Patients who Believed in Medical Causes**

Some patients indicated that breast cancer is caused by malfunctioning of their organs, unhealthy lifestyle, and other pathological reasons as narrated below:

*“I see this sickness as common because I know four people who are also suffering from this condition. So I see this as an ordinary disease, I don’t think it is spiritual”.* (Juliet, 30 years)

*“For me I don’t regard it as spiritual. It is medical. I think as you grow you are susceptible to a lot of sickness and breast cancer is one”.* (Mansah, 45 years)

*“I believe this is a purely medical condition. I think it is the food we eat. you know it may also be as a result of our lifestyle during our youthful days. I hate to attribute things to the supernatural.”*  
(Aunty Sam, 42 years)

### **Supernatural Believers: Searching for Answers**

Some patients attributed their illness to acts of malevolent people in the society. Breast cancer was not regarded by some patients as something only to be cured but there was a quest to understand it. It was no longer a matter of biological or pathological explanations but understanding the “why this happened to me”. According to the patients who viewed the disease from the supernatural angle, malicious spirits inflict diseases that are disruptive on an individual. They stated that, the human environment is a setting where people are potential targets of anger, jealousy, rivalry and greed. Consequently, the illness is a spell cast to

bring shame to an individual. Below are some sentiments expressed by some patients:

*“I had two dreams. In the first dream, I saw myself eating. In the second one I saw myself eating again and I felt a sharp pain in my right breast. A month later, I felt a lump close to my armpit. After some months when I went to the hospital, the doctor told me I have breast cancer. Is this normal? It is strange. I dreamt eating and had pains in my right breast, after some months the doctor tells me I have breast cancer. Surprisingly not in the left but the right breast, I dreamt about. so though I come to the hospital, there is this man who says he is a herbalist whom I go to. He told me my case is purely spiritual. He even gave me a clue as the person responsible for my condition”. (Vero, 32 years)*

Some women also discussed their diagnosis in relation to “karma” (what goes round comes around), as they believed they had to endure the illness to make amends for bad deeds from their past lives (the belief of supernatural sanction).

Some of such beliefs were:

*“For me I sometimes believe that this disease is as a result of something I did in the past and now am suffering for it. I cannot really come up with one but sometimes I reflect and I suspect my past has a role. You know when you are young you do so many things that you regret. I always pray to God to heal me because the load is heavy for me to bear.” [sighs and sobs gently]*  
(Mama Lucy, 50 years)

In addition, one patient indicated that it was a test of faith in God and everything that is happening in her life is for a purpose.

*“I believe I had this disease for a reason. It is to test my faith in the Lord. I always talk about faith and having hope in God. Therefore, this is to test if I can practice what I preach and stand the test of time so for me my faith is in God. He alone can heal me. For the hospital it is a formality. My healing comes from above.” (Comfort, 50 years)*

It can be inferred from the above narratives that some patients sought dual treatment because to them, things do not just happen and the knowledge of an illness goes beyond the physical interpretations that the medical service can give. Hence, there was the need to seek further explanations to the illness. This resonates with the dominant argument evident in the literature (Arevian et al., 2011; Meneses & Yarbrow, 2007) that people often associate breast cancer with spiritual causes and these spiritual causal ideologies inform their engagement with alternative healing systems.

### **Perceived Potency of Treatment**

In the middle of the two determinants of treatment choices (medical and supernatural causes) is the perceived efficacy of treatment. When a treatment option is perceived to be more potent, it influences the patronage of particular treatment over others. As opined by Martei (2011), the preference could be from personal experience, advice from friends and close relations given about the efficacy of that particular choice. Some patients intimated that:

*“When my breast got swollen, I stayed home for three months and a man was treating me with herbs. So after the third month I requested that I wanted to go the hospital because I was not*

*seeing any improvement .Now I use the drugs prescribed to me by the doctors. I have stopped the herbal treatment because the doctors advised me to stop herbal medicine because it will not help me. Indeed, after the surgery I have realized that my health is getting better.” (Sarah, 29 years)*

*“When I was diagnosed with the disease I didn’t come back to the hospital. I resorted to herbs and concoctions that I prepared. When I realized that the affected breast was deteriorating and the pain was becoming too much, I said to myself “let me go back to these people [hospital] maybe I will get better. That is why you see me here.” (Araba, 60 years)*

*“I was advised by my family to come to this hospital because the doctors here are very good and they are experienced.” (Aunty Esi,60 years)*

### **Socio-demographic Characteristics and Health Seeking Behaviours of Patients**

The study sought to explore how socio-demographic characteristics influence patients’ health seeking behaviours. To this end, eight socio-demographic categories namely age, marital status, education level, occupation, income, residence, religion and hereditary of patients were explored. It was gathered from this study that, socio-demographic characteristics of patients did not influence the time they sought medical help as suggested in literature. Contrary to the popular argument in literature like Elsie et al., (2010); Othman et al., (2012), Opoku et al., (2012) where it was indicated that socio-demographic characteristics influence the time patients reported to the hospital for either

screening or treatment; it was realized from this study that with the exception of residence (as discussed earlier in the work), the other socio-demographic characteristics did not influence the time patients presented the illness for diagnosis. Rather socio-demographic characteristics of patients played a role in patients either absconding or continuing treatment. It is important to note that, socio-demographic characteristics of patients and they, either absconding or continuing treatment varied. For example, patients' age, marital status influenced their willingness to continue or stop treatment, while hereditary of patients did not inform their health seeking behaviours. The main trends are summarized below.

With regard to age, the findings showed that younger patients were more likely to abscond treatment than their older counterparts. This is quite intriguing in the sense that, all things being equal, young persons are more likely than their older counterparts to prefer the modern way of treatment. It is assumed that the young ones will better appreciate orthodox medicine than the older ones who are believed to have been exposed to traditional outlook, thus, are more likely to shun modern medical treatment. However, this was not the case in this study. Younger patients were more "adventurous" in the pursuit of their health. They indicated that, it is important to explore other options so that the most effective will be identified. Older patients, on the other hand were not ready to "gamble" with their lives. They were skeptical in seeking alternative health because to them the orthodox treatment is more effective than the others hence there is no need to explore alternatives. This dichotomous preference can be attributed to the fact that

young patients are much more concerned about their appearance (as discussed under body image issues). As such, they are ready to explore all avenues so as to get well and, most importantly, save their breasts.

Marital status was influential with either the continuity of treatment or otherwise. While the widowed and the divorced continued with the treatment, the single and the married often absconded orthodox treatment and patronized alternative treatment. They feared losing their breasts and the consequent negative effects on their intimate relationship as the main reason for sometimes absconding medical treatment and seeking alternative treatment. There was a perceived knowledge among patients that if a woman continues with orthodox treatment, loss of the breast is inevitable. Therefore, for the single and the married there is no need to take chances with the orthodox treatment but explore the alternative treatments which more often promises a once and for all treatment without any loss of breasts. Ironically, the widowed and the divorced were adamant in patronizing alternative health products. To them there was no need seeking health care from other sources.

Religion of patients had a role in patients either abounding orthodox treatment or continuing with treatment. For those whose beliefs resided in the fact that misfortunes do not happen in the vacuum but are caused by unforeseen forces, they did not resort to orthodox treatment when they were first diagnosed and vice versa. They resorted to faith-based healing when they were first diagnosed with the disease but came back to the hospital when they realized things were getting out of hand (that is they were not getting better but

deteriorating). They relied on their spiritual heads for prayers, herbal treatments and other fortifications. Conversely, those whose religious beliefs were not in contradiction with seeking orthodox treatment, continued with treatment. They even received encouragement from members of their faith to seek orthodox treatment and discard any other forms of treatment. Below are some sentiments shared.

*“Oooh so is there a religion that prohibits their members from going to the hospital. [laughs] oooh well with my religion [Hindu] we are encouraged to go to the hospital. When I had the disease, I told one senior nurse [also a Hindu] about it. She counselled me and even recommended this doctor [the doctor in charge of the breast clinic]. So for my religion though we pray for healing, we believe in going to the hospital”. (Yaa Ruth, 68 years)*

*“You see nothing happens for no reason. All the physical occurrences have already happened in the spiritual. So it is important that in anything you do you seek spiritual guidance. Well going to the hospital is not bad but you still need guidance.” (Rukky, 48 years)*

*“I believe in herbs and other spiritual fortification. It is important that as a human being you fortify yourself against unforeseen attacks. When I was diagnosed, I felt I needed to fortify myself very well. Therefore, I was using herbs on the infected breast and I bathe with the herbs. Am in the hospital because my son forcibly brought me here. He says am getting worse so I have to come to the hospital. I do not see it so, this disease is a stubborn one and the forces behind it are strong so it*

*takes time for the healing to manifest for all to see. So I knew that I was getting better. What can I do, he is my son and I don't want to appear as a stubborn mother". (Vim Mama, 55 years)*

Education has the propensity to challenge the way people see the world and to question the status quo or the social order. It is assumed that all things remaining equal, formal education creates the avenue for people to become more objective and they require the scientific or empirical evidence to any explanation given and not to accept anything hook line sinker. Although the education level of patients was quite low, it was realized that even the few with relatively high formal education (JHS, SHS, NVTI and Diploma) did not only resort to orthodox treatment but patronized alternative treatments like herbal medicine and spiritual assistance. It was realized from the data that the age and marital status were very influential in the seeking of health by patients. As discussed earlier, for the young who were either single or married (they were relatively had formal education) it was about being healed and saving their breast. As such, any remedy, which promises a total healing, is sought after.

Occupation and income were intimately linked to patients either absconding or continuing with treatment. This is because one's occupation determined the income of the individual. The income level of patients affected the health seeking behaviours of patients. Those who had appreciable income were regular for treatments at the hospital. On the other hand, those with low income status either resorted to alternative treatment where cost of treatment could be paid in instalments unlike the orthodox treatment where patients have to make a

down payment before treatment commenced or stayed home till they got sufficient money to continue with treatment.

Another twist, which centered solely on occupation is that, some patients were more likely to abscond from orthodox treatment because of perceived spirituality associated with their occupation. This was very common among the retailers and farmers. The retailers reasoned that their trade is full of jealous business partners and shop neighbours as well as malevolent spirits waiting to cause havoc to prospering individuals. Being diagnosed with the illness, they concluded that they cannot get cured in the hospital because breast cancer is not natural and that its treatment goes beyond orthodox treatment. With regard to the farmers, they indicated that due to the nature of their occupation, they come into contact with many spiritual happenings which could contribute to contracting the disease. They expressed the following views:

*“For the job I do it is full of bad people. You see people are envious of my success. I remember two weeks before I developed the disease, I went to my shop and saw some particles in front of my shop. Initially I thought it was just an ordinary thing. A few hours after opening my shop, I started sweating profusely. I still thought the weather was just hot. Two weeks after this incident, I felt pains in my left breast. So now that I have been diagnosed with the disease, when I sit back and think through, I think someone may have sprinkled the particles and now am sick. I have been coming to the hospital for a year now but I am not getting better. Some of my friends [referring to other breast cancer patients] look far better than me. Meanwhile I came to the hospital before them. So I have decided that if there is no improvement in my health this year, I will stop coming because I*

*don't think they [referring to the health workers] can help."*

(Sister Yankee, 45 years)

*"My occupation [farming] is risky. You know how people fight over land. People do all sorts of things to own one. Even when the land is yours people want to take it from you. Some go to the extent of casting spells and incantations so that something bad will happen to you and then they will possess your land. You see I inherited the farm land from my grandmother, and ever since I inherited the farm land there have been clashes from my extended family. Some even go to the extent of threatening me physically, others invoke curses. So for me I think one of my family member "bought" [a curse placed on her] for me. Because sometimes when I go to my farm I see so many things like dug holes, pieces of cloth tied to my plantain suckers. All these are not normal."* (Salah, 45 years)

As indicated earlier, the location of patients was the only socio-demographic variable that had a direct link with the time patients reported the disease to the hospital and whether they continued with orthodox treatment or patronized other treatment choices. On the issue of patients, either continuing with orthodox treatment or seeking an alternative depended on factors like availability of diverse treatment options and proximity to a health facility. Availability of different treatment options in a locality can contribute to patients either continuing with or escaping orthodox treatment. When a patient resides in a locality where there are different treatment options, there is the tendency to choose more than one treatment.

Patients argued that all things being equal, closeness to a health facility motivates an individual to continue with orthodox treatment. They observed that the treatment is expensive and so adding transportation cost which is also quite expensive especially when the individual is coming from a distance is not motivating enough. As such if a patient is not determined to continue with the orthodox treatment, this situation can deter her from continuing treatment and seek medical attention from elsewhere.

From the findings, hereditary of patients did not have an influence with the time patients reported the illness for diagnosis neither did it have a link with patients avoiding treatment or continuing with treatment after diagnosis. This is because none of the patients indicated having such illness in their family.

### **Effects of the Illness on Patients**

This analytic theme had three sub-themes, which gave a clear picture of the impact of the illness on patients. These were financial drain, dependence on others and decline in social relationships.

### **Financial Drain**

The common sentiment shared by all patients regardless of age, marital status, occupation et cetera was that, the treatment and management of breast cancer was an enormous financial challenge and burden to them. All the patients alluded to the fact that the treatment and management, especially chemotherapy drugs, were too expensive. Although some of the women had subscribed to the National Health Insurance Scheme, the problem of affordability of treatment was

recognized by all. Insured women shared their frustrations indicating that the scheme only covered the “non-expensive” part of their treatment like laboratory tests and not chemotherapy which is crucial and very expensive. Many patients paid for the treatment themselves. Occasionally they received financial assistance from close family relations and religious affiliates. Patients however intimated that the treatment of the illness is still out of their reach. This sometimes creates a situation where some patients have to forgo treatment because of non-availability of money. The majority of the study patients were engaged in low-income jobs and they do not have adequate means to settle the bills and at times pushing some to pose as beggars to solicit for money from people. Some of their experiences are presented below:

*“The treatment is very expensive. The chemotherapy is very expensive, it costs two hundred and fifty Ghana cedis for a session. Am supposed to have chemotherapy for six months. So how am I going to pay for the rest of the months. I don’t have money to pay for it. Now there are other responsibilities that my husband and I have to consider. My children’s fees. We cannot spend all the money on me, hmmm”[sighs] (Juliet, 30 years)*

*“Breast cancer is bad illness. It has drained all my little savings I had. Now I rely on family members to help. The treatment is expensive. If you have chemo a day it is two hundred and fifty cedis, how much do I earn from my petty trade to be paying such an amount? (Sophia, 31 years)*

*“The government should come to our aid. The insurance is good but we need more help. Some of us have retired, others are*

*unemployed so at least if the insurance can cover the chemotherapy and the expensive drugs we will be happy. As for the labs we can afford. It costs like twenty-five Ghana cedis, and that is manageable but for the chemo, it is really draining us financially” (Yaa Ruth, 68 years)*

Speaking on the same issue a doctor intimated:

*“Indeed, patients do complain about the cost of treatment, especially chemotherapy, but the problem is cancer management and treatment are expensive, not only in Ghana. We share their sentiments but our hands are tied, we cannot do anything about it. Ours is to diagnose and treat them. So if the government can further subsidize treatment that will be great”. (Dr. OB)*

Aside chemotherapy being the main financial drain on patients, transportation and accommodation were also identified especially for non-Cape Coast residents, as another financial challenge. Sixteen of the study patients were non-residents of Cape Coast, as such, they have to make arrangements for accommodation and transportation to and within Cape Coast and back to their homes.

*“I come from Takoradi and anytime I come to Cape Coast for treatment I spend five hundred Ghana cedis on transportation alone. I pick a cab from Takoradi to Cape Coast and back to Takoradi. Any time I come with a relative I need to provide accommodation for that person”.(Comfort, 50 years)*

*“Any time I come for treatment I come with my husband. After my chemotherapy, I stay in the hospital ward while my husband*

*stays in a hotel. All these monies are being wasted. If I did not have this disease the money would have been channelled into something profitable like my business". (Vim Mama, 55 years)*

*"I come from Twifo Hemang to Cape Coast for treatment. The transportation is very high. The money I spend on transportation for a day's treatment is almost equal to the money I spend on feeding in my village. When I come, they (referring to health workers) are like buy this drug, do this and by the time I leave the hospital all your money is gone and I feel like crying."*  
(Salah, 45years)

This finding resonates with de-Graft et al., (2010) and Opoku et al., (2012) where they argued that, the financial burden of living with breast cancer exacerbates the psychosocial burden of patients and families, and often leads to family disruption, a depletion of family resources and diminished family support.

### **Decline in Businesses**

Almost all the women in this study were self-employed and therefore the disease had a significant impact on their ability to undertake the day-to-day activities of their businesses. Many of the women were unable to work effectively due to physical weakness because of side effects of chemotherapy and treatment drugs. Also, they spent most of their time in the hospital either for chemotherapy or for a review. Patients who have undergone chemotherapy are required to stay in the hospital wards for a period of two to four days for the purposes of monitoring for any adverse reactions. Similarly, patients coming for review spend hours of their time at the hospital. As a result, they hired the services of other

people to manage their businesses for them. Most of the women indicated a drop in revenue generated from their businesses because of their absence. Below are some sentiments shared by the women:

*“The illness has really affected my business. I have a guy whom I leave the shop with when I come to the hospital. My daily sales have reduced drastically but what can I say or do. At least it is better than closing the shop. Yes, I wish I was always available but my condition makes it difficult. Sometimes when I go to the shop am not able to do anything”. (Vero, 32 years)*

*“I own a bakery shop where I bake bread and other pastries. This job is labour intensive. Due to my condition, I do not normally visit my shop. On days that I visit, the accounts do not tally, some ingredients are missing. You ask the workers and none is ready to confess. Because am not there to supervise the business is going down. [sighs deeply] it is difficult; you think about your illness and at the same time think about your business collapsing. With all these, how can I be well?” (Lebenee, 40 years)*

*“On chemo days I get tired and weak so am not able to sell my wares. I leave the shop for my niece”. (Aunty Esi, 60 years)*

From the above, it is clear that the depending on others to manage patients' businesses has a devastating effect on their already low finances as such people siphoned money accruing from the businesses of the patients for their own use.

### Domestic Sphere

Majority of women in this study indicated that the disease had a significant impact on their domestic responsibilities, though they did their best to perform the domestic tasks. They relied mostly on husbands, daughters, sisters-in-law among others to assist with the daily chores because of their inability to work efficiently due to physical weakness (mostly because of chemotherapy). They explained that such a situation was a constant reminder of the illness. This finding concurs with the assertion made by Patel-Kerai et al., (2015), which indicated that patients often rely heavily on others especially on family members to provide practical support such as helping in household chores. Below are some of the experiences they shared with the researcher:

*“Some of the drugs are very strong and make you weak. Even the chemotherapy is not easy. Therefore, you are not able to go about your normal house duties as before”.*  
(Salah, 45 years)

*“My children are in school so we have hired the services of a house help. She now does most of the chores in the house. I am not comfortable at all with this arrangement but I don't have a choice because my health has failed me. Though I try to supervise, I wish I was the one doing all the chores as before. Seeing her assume those responsibilities makes it obvious that “the woman of the house” is sick [incapacitated]”.* (Sister Yankee, 45 years)

*“I find it difficult cooking and doing most of the house chores so friends and family members help”.* (Sarah, 29 years)

### **Decline in Social Relationship**

Another effect of breast cancer is a decline in social relationship. Under this sub-theme, it was realized that stigmatization was the main cause of the decline. The issue of stigmatization was very consistent in the accounts given by the patients. Generally, society stratifies its members according to a number of factors including illness. Illness creates social categorization, that is, distinguishes between the healthy and the unhealthy. Whenever a person is labelled ill, there is a perception that the person's actions, abilities and appearance do not meet the normal healthy expectations in a given context. Therefore, the person becomes undesirable and is seen less whole than those considered healthy. As Parsons (1951) reckoned, illness is a form of deviance. Deviance in the sense that it is a condition that is perceived by people within a particular socio-cultural setting to violate the “social expectations/ the perfect picture” which in this case is health. Thus, this is evident in the negative social sanctions like ridicule, stigmatization among others that are meted out to the sick person.

In relation to breast cancer, due to some negative misconceptions and interpretations, patients whose medical status is known in the community are often discriminated against. In this study, stigmatization took two forms; self - stigmatization (which manifested in most of the narratives) and covert stigmatization.

Self-stigmatization is a situation where due to the perceived belief of being discriminated against, an individual personally tries to avoid interactions with people. In this study, patients discriminated against themselves either due to the feeling that they were burdening their friends and family or they have lost their body image because of the deformation from treatment. With regard to loss of body image, patients expressed the dislike in meeting people and so reduced their participation of social gatherings like funerals, weddings, and parties. A probable explanation for this attitude may be the anxiety of patients that members of the community upon seeing them may ask or gossip about them which in turn is a constant reminder of their illness. They therefore prefer to stay indoors to avoid answering questions posed by people about changes in their bodies.

*“I am not able to go out. I am often indoors. When you go out people will start to talk and ask questions and I don’t like that. Some even discriminate. My social functions have reduced.”*  
(Lebensee, 40 years)

*“There are some social functions that I don’t attend. I used to be plump but because of the illness, I have lost weight. When I go out people, ask questions trying to know the root cause of my weight loss. You see am not comfortable telling people about my medical condition, so to avoid all these interrogations I stay home. I go out when it is necessary”.* (Mansah, 45 years)

*“People in my community are gossips. The least thing they hear or know about you everybody will hear. This disease is not a good one when you get it people say all sorts of things and they stay away from you. I even heard a lady who lives in the vicinity*

*had it. When people got to know they were not getting close to her because they said she was a witch. That lady died. So me I have advised myself. I will not allow people to know my status. So for me my motto is “operation don’t mingle with the gossips”. [laughs] (Adama, 35 years)*

The above narrations agree with the argument made by Weiss and Lonquist (2013), that most breast cancer patients often detached themselves from their usual world.

The covert stigmatization is where people reduce the level of interaction with patients in a subtle way. Contrary to the arguments made in literature (Charmaz & Rosenfield 2010; Kavar 2012) that discrimination against patients is done openly, the findings from this study revealed a different picture. Patients acknowledged that people isolated themselves from them with the assumption that they may get infected, yet the isolation took a low tone. Although, done in a subtle way, patients intimated a deterioration in the social ties they had with both significant others and general others.

*Ooo sister [referring to the interviewer], things have changed. They are not like how they were initially. I live in my family house. Before I contracted the disease, we all could eat from one bowl. Now we don’t eat from the same bowl when food is served.” (Salah, 45 years)*

The main probable rationale behind covert stigmatization is what Twumasi (2005) asserted that the Ghanaian society is a collectivistic one and thus it is incumbent on members to offer assistance to the sick. The view of Twumasi is amply demonstrated by Salah’s narration that her family felt obliged to interact

with her. This interaction however was under caution for fear of possible contraction of the disease. They therefore chose to interact with her not wholeheartedly but just to portray good standing with the patient, hence the issue of covert stigmatization.

## **Coping Strategies**

### **Individual Capital**

#### *Concealing the evidence of the illness as a coping mechanism*

Concealing evidence of the illness was an approach some patients adopted as their coping mechanism. Due to the social stigma attached to breast cancer, most of the patients indicated that they had ways and means of hiding the evidence of the illness from people. Some of the measures adopted included wearing of big brassiere, wearing of wig caps, painting of fingernails, increased intake of food to gain weight (especially those who have lost weight due to the treatment) among others. Below are some experiences of patients:

*“I hire the services of a ‘lawyer’ [referring to wig caps][laughs loudly]. Anytime I want to go out I wear them. I buy the nice ones that are difficult to detect that, it is not my natural hair. (Rukky, 48 years)*

*“Fortunately, my husband is from a particular ethnic group where their females normally go in for short hair. So with my short hair now, when people see me they normally would say you want everybody to know that you have married from that ethnic group. [She laughs] they don’t know what is happening in Jerusalem; am ill” [She laughs again] (Sophia, 31years)*

*“I wear artificial nails so that people will not see my discoloured nails” (Aunty Sam, 42 years)*

From the narrations of the women, adopting the above techniques as defence mechanism helps them to overcome their body image concerns and to regain their body shape. It also helps to reduce interrogations from people about changes in their bodies. It is clear that the women were conscious about the changes in their bodies especially when going out in public. Thus, as a way of coping with the reality, a virtual reality (enhancing their current physical appearance) was achieved.

### ***The feeling of hope and self-reassurance***

Another recurrent theme under coping strategies was the feeling of hope and self-reassurance. Most of the women positively dealt with the illness by convincing themselves that it is an occurrence that they need to embrace and fight on. Though they appreciated the fact that the illness has a negative toll on them, they had come to the realization that having the hope for survival will do them more good than brooding over the negative consequences of the illness. Some considered it as a temporary condition. For others, especially the married women with young children, staying alive gave them the mental strength to seek treatment to get better. With the issue of hope, time was a crucial determinant, as over time the women accepted their condition and had hope for survival. Initially when they were diagnosed with the disease, there was the feeling of uncertainty about losing their lives. However, as patients were treated from time to time

without any complications they had hope of staying alive. Some narrated their story:

*“I have the strong will to live. I always tell myself that God has a plan for my life that is why I am still alive”.* (Comfort, 50 years)

*“I was scared when I was diagnosed with the disease. But now I have accepted it. Whether I like it or not I have the illness.”*  
(Bruwaa, 55 years)

*“Personally, I felt that I will not die so I was very optimistic therefore, I never missed my appointment with my doctor. I purchased every drug prescribed. I want to survive and I know I will survive”* (Sister Yankee, 45 years)

### **Social Capital**

Aside the individual resources, social support was as a major strength for the women during their therapeutic process. Consequently, patients who obtained higher amount of love from family members and friends were found to be more fulfilled and it considerably increased their strength to fight the illness than their counterparts. As Ahmadian and Samah (2012), Banning et al.,(2009), Dei (2013)and Khakbazan et al., 2014) indicated, social support such as information regarding medical care options, financial assistance, transportation, along with the perception of being loved, valued, and cared for, are vital for their recuperating process. They improve the general wellbeing of the sick. Below are the sources of social support patients had:

## Family Support

For many women, family support was an essential coping mechanism that was offered both from immediate (nuclear) and close extended family members. The support, comfort and hope patients received aided them to overcome the treatment obstacles; both surgery and chemotherapy. Family members, particularly the nuclear family, were often named by the women as providing everyday support such as helping with household chores, emotional support, financial aid, taking them to interesting sites for fun among others. Below are some expressions by the women:

*“Support from my children. That is all! They are very supportive. They advised me to come to Cape Coast Teaching Hospital for treatment. They always encourage me”.* (Vim Mama, 55 years)

*“My family especially my mother and sister really support me. Also, my husband and children. From emotional to financial to helping out with my domestic responsibilities.”* (Mansah, 45 years)

*“My brother, my brother- in -law and my youngest child. They also encourage me”.* (Lebenee, 40 years)

The opposite reaction where families were reluctant to help was true in the cases of some women. Some patients stated as follows:

*“My family members are very busy with their own lives and they don’t really care about me. Imagine now I have high blood pressure. The doctors have advised me to stop thinking because it is not good for my health. Why would I not think. My family*

*has deserted me. When I call my daughter for assistance, she gives so many excuses and I get furious. I really think about this, am not a happy woman at all” (Araba, 60 years)*

*“The resource is from myself. There is no one helping. If I don’t have money it means that I will not come to the hospital and if I don’t come to the hospital, there would be negative consequences on my health”. (Aunty Sam, 42 years)*

*“I get money from the things I sell. I don’t get financial assistance from anywhere”. (Sophia, 31 years)*

From the two accounts given it is realized that, some patients are fortunate to have a supportive and understanding family, which saw to their needs and comfort. The reverse is however true. Weiss and Lonquist (2013), are therefore correct to say that when it comes to social support, living with breast cancer is for better or for worse. In that, it either pulls people to the patients; being sympathetic to the patient due to her condition or pushes people away from the patient due to some factors like fear of being infected, inadequate resources to help among others. Social support is very important as it helps speed up the recuperating process of the sick. As the women shared their experiences, it became evident that social support, particularly from their family members, was a buffer, which helped them get through their difficult situations. Those who did not get the needed support were in a state of distress and were gradually launching into other crisis (developing other medical condition).

### Support from Generalized Others

Support from generalized others like religious groups, friends, neighbours, and associations was available but very minimal. This was so because patients kept their medical status secret for the fear of stigmatization and “local gossip”. Consequently, patients did not receive much support from general others. Meanwhile, the few who knew about the condition of patients supported them with material things like foodstuffs (though patients preferred monetary support to offset their pending bills), emotional support and prayers. Some health workers encouraged patients especially when there was a need to take a medical decision and patients exhibited fear and anxiety.

*“I get assistance from a friend’s son.”* (Yaa Ruth, 68 years)

*“I once received a donation from my church and that was it”*  
(Sarah, 29 years)

*“For the church they visit and pray for me”.* (Juliet, 30 years)

A nurse added:

*“Ooh yes, some of them are fortunate. They have family and friends visiting. Some do come with food. They talk and laugh together. Others too you don’t see people visiting. Maybe once in a blue moon then they get visitors. However, I must add some Christian organizations visit the ward and share the gospel with them. When they come the patients are happy because they interact with them, pray for them and at times they give them food”.* (Nurse Titi)

It is important to note that findings from the study revealed that the perceived causes of the illness to some extent determine the kind of resources offered to patients. Support extended to patients either by their significant or general others was somehow influenced by the perceived causes of the illness. This was independent of patients' perceptions about the causes of their illness. Families and friends who appraised the illness as a natural cause, assisted patients with physical/material resources and vice versa. For example, Adama, Aunty Esi and Vero intimated that:

*“My sister for example always prays for me because according to her it is spiritual and should be tackled from the spiritual angle.”* (Adama, 35 years)

*“Yes there is a link. For example, when my son in abroad sends me money he specifically asks me to use the money for my hospital treatment. Anytime that I go for treatment elsewhere aside the hospital he gets angry and he delays with the transfer of money. [she laughs] I know his sisters have been giving him the information”.* (Aunty Esi, 60 years)

*“My brother brought herbal concoction because according to him it is very effective for serious diseases like breast cancer and it will clear the disease at once. I threw the medicine away because I don't believe in those herbal drugs. They can kill”.* (Vero, 32years)

### **In-group Support as means of Coping with the Illness**

*“I have friends. Yes, we communicate. I sometimes call them to find out how they are faring. They also call me”. (Money Matter, 50 years)*

*“Yes, I have friends. We talk about our welfare”. (Mama Lucy, 50 years)*

*“When we come here (hospital) we talk about our health and how individually we are coping with the illness. We learn from one another.” (Rukky, 48 years)*

From my observation, it was realized that patients had established informal group as a form of coping strategy. This observation was validated when patients were asked if they have informal associations. They indicated in the affirmative. The groups were formed based on the stage of their illness and days for review. The groups served as medium patients interacted and associated with one another. They talked about almost everything from television programs to progress of their health, to why some members of the group have/are absconding treatment. There was informal/in-house dissemination of medical information. Some of the groups had “in- house doctors” who explained to new patients what to expect when they go to the consulting room, the kind of treatment to expect for the stage of their illness and some side effects of the treatment. Also, some went to the extent of recommending alternative treatments to their friends.

It is important to recognize the fact that the social interactions, which existed between patients, was more of bridging (instrumental ties) than bonding. This is because patients only had face-to-face interaction when they met at the

hospital. Due to different geographical locations, face-to-face interactions outside the hospital were almost impossible. Group members stayed in touch via phone calls. For social media, WhatsApp was the medium used for interaction. This was common with the few patients who were technologically inclined. This finding shows the collectivistic nature of the Ghanaian society, as Ghanaians enjoy the solidarity that comes with being in a group.

### **Religion as a Soothing Therapy**

Both young and old viewed religion as a source of strength in their troubled time. Although some believed that the cause of the disease was not spiritual, the fact remained that the women displayed a high level of reliance on God for divine intervention and healing. Almost all the women held the belief that God is their healer though the doctors are doing their best to cure them. The women used their belief in God as coping strategy. Many engaged in personal prayers, sought religious support from local prayer groups, and Imams. Below are some accounts given by the women:

*“I have a strong faith that God will heal me. This is an accident in my body. People get accident and they die but I am living so am happy”.* (Comfort, 50 years)

*“Now I pray a lot. I want God to take this burden from me.”*  
(Sister Yankee, 45 years)

*“This is a trial that is temporary. As a Christian trials will come but you need to endure them. It will be off my back soon”.*  
(Sarah, 29 years)

From the observation I made from the Female Surgical ward, it was realized that patients were religiously inclined. This was evident with patients having Bibles and Korans on their beds close to their pillows. Others had devotional guides, prayer tracts and other religious materials. Patients were seen reading their Bibles and Korans. Some meditated while others were prayed for via telephone. Interestingly, some had gospel music as their ringtone and often sung along when their phones rang. Their interactions with one another and with health workers gave a clear picture of their reliance on God as their ultimate healer. Examples of such expressions were:

*“God is our helper”*

*“God is the healer; healing comes from God”*

*“God alone can save us; God alone saves”*

For the patients, religion has been a source of opium in coping with their illness. Despite their differences in religious beliefs/affiliations, it gave them comfort, reduced their fears and uncertainties, gave strength to fight on and look to the future, and a source of emotional strength. It further helped them to adjust to the diagnosis and treatment of the disease. For women in this study, the diagnosis of breast cancer strengthened their belief and reaffirmed their faith in God as the ultimate creator who will cure them. The need for spiritual support is well established in the literature. As argued by Arevian et al., (2011) and Post

(2014), irrespective of their faith, many breast cancer patients often seek spiritual assistance as a means of coping with their predicament.

The foregoing arguments on coping mechanisms bring to bear the ABC-X model. Breast cancer is now a stressor (A) for the patients and their families. In this study, for patients to either launch into crises (X) for example, getting other ailments like psychological problems, deterioration of their current condition, or not, to a large extent depended on formidable resources (B) and positive appraisal of the illness (C). The resources available to patients encompassed the individual, family and social supports. These resources included feeling of hope and self-reassurance, financial assistance, family cohesion, family adaptability (like role swap), fluid communication, emotional support, assistance from friends. It is pertinent to mention that, the support offered to patients was somehow influenced by the perceived causes of the disease. This brings in the “C” element which talks about subjective meanings of a stressor. Thus the meanings that individuals, together with significant and general others attached to the illness influenced their actions and the kind of resources they offered to cushion the impact of the illness on patients.

For patients who were optimistic about their chances of survival and were fortunate to have had support, they were relatively coping well with the illness thus, preventing the stressor from escalating into a crisis. For others, the absence of the aforementioned (support and good appraisal of the illness) significantly increased the impact of the illness on them as it was seen in the cases of Araba and Aunty Sam (page 117).



## CHAPTER FIVE

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### **Introduction**

This chapter draws the research journey to a close by providing summary of the research process, the key findings, draw relevant conclusions and make some recommendations based on the findings of the study.

#### **Summary of the Research Process**

The aim of this study was to explore the socio-cultural interpretations of breast cancer and how these interpretations influenced patients in seeking early medical attention. The study specifically explored the socio-cultural environments of patients; how socio-cultural interpretations influenced patients' health seeking behaviours; investigated the influence of socio-demographic characteristics on the health seeking behaviours of patients and finally, explored some coping strategies adopted by patients in managing the impact of the illness on them.

The qualitative research design informed the work. Convenient and purposive sampling techniques were adopted in selecting 20 patients and 5 health workers. In-depth interviews and observations were used to solicit data. The data was analyzed manually, using the thematic analysis approach. The themes derived were based on the research objectives.

## **Key Findings**

This is to give a synopsis of the findings of the study.

Although the literature suggests that breast cancer mostly affects women at their post-menopausal age, the age distribution of breast cancer patients in this study however shows that women as young as twenty years are being diagnosed with it.

Studies have enumerated factors like modesty (women feeling shy to expose their breasts to health workers), and socio-demographic characteristics as some reasons for women reporting late for diagnosis. This study revealed that inadequate knowledge, interpretations associated with breast cancer and residential location of patients were the main reasons why women delayed in the presentation of the illness to the hospital.

In addition, findings from the study revealed that socio-demographic characteristics influenced patients' treatment choices with respect to continuing with orthodox treatment or seeking alternative treatment.

Ghana is a medically pluralistic society. The treatment of cancer patients is not the exclusive right of scientific medical practitioners (orthodox treatment) but also alternative medicine.

Living with breast cancer has some adverse consequences like financial drain, stigmatization and dependence on others. Stigmatization in this study took two forms. The self-stigmatization and social stigmatization. Self-stigmatization emerged strongly in the voices of the patients. Some patients isolated themselves from people and became less sociable due to the negative misconceptions about

the disease, visible disfigurements and loss of bodily functions. This created a feeling of “social demise” for the women, as they were not able to actively engage in their previous social activities.

The study also revealed that most patients had subscribed to the National Health Insurance Scheme to cushion their medical expenses. The insurance unfortunately covered the less expensive component of the cancer treatment like laboratory tests and diagnostic scans and not chemotherapy which was expensive and crucial leading to serious financial drain on patients. As the amount for the chemotherapy was often out of reach for most patients, it created a state of distress as some had to forgo chemotherapy because of non payment of the treatment.

In addition, the illness created a situation where patients had to depend on others both in the domestic and public settings to provide support for them. The dependency on others for support further created uneasiness for patients as it reminded them of their incapacitation. The dependency also created some sort of power issues between those providing the support and the patients. Some patients who depended on others for a chunk of their resources were at the “mercy” of their benefactor. Decisions of the provider were taken at the expense of the patient’s health.

Illness is an inevitable phenomenon to be experienced at a point in time of one’s life. Coping with the illness is one key element in alleviating the negative impact of the illness on an individual. Through their own actions and support received from others, most patients were able to counteract the dire effects of the

disease on them. Some unfortunately did not get enough social support hence they were in a state of distress. As a way of avoiding social stigma and reducing the feeling of loss of body image due to the side effects of treatment, patients adopted mechanisms like wearing wig cap, padding their brazierres, among others, to make up for the loss. This gave them some sense of regained body image.

Strong psychological makeup proved to be an effective mechanism of coping with the illness. Patients who were optimistic about their current health and what the future holds for them had hopes for survival.

Religion was very instrumental in the coping mechanisms adopted by the women. It served as a safe haven for them, where spiritual, emotional, financial and material support were offered to them. Religion reaffirmed their optimism for survival.

The role social capital, especially the support of family, in the recuperating process of patients cannot be overlooked. Patients who were fortunate to get the support both material and non -material help from family and friends acknowledged the significant role the support played in their healing processes and vice versa.

## **Conclusions**

Breast cancer patients in this study generally experienced difficulty and distress, but it is worth noting that the women did not have universal experiences and burden. Their experiences and burden were influenced by their residential location, interpretations they attributed to the illness, their socio-demographic

characteristics and strategies adopted in alleviating the impact of the illness.

Therefore, in conclusion:

- The residential location of patients did not only determine their accessibility to the health facilities but also, presented a socio-cultural environment through which patients understood their realities as women living with breast cancer especially in terms of flow of knowledge and interpretations attached to the illness.
- Each woman's interpretation of the illness was subjective. It was a complex concept that permeate the entire health seeking behaviours of patients, for example, the interpretations given to the illness to a very large extent informed the time patients reported the illness for diagnosis, the sense of wellbeing. These factors underpinned, among others, patients understanding of the illness, how they endured the suffering or pains and the means they adopted in mitigating their woes.
- Socio-demographic characteristics especially age and marital status influenced patients' health seeking behaviours with respect to continuing with orthodox treatment or avoiding the orthodox treatment.
- Coping strategies patients adopted in buffering the impact of the illness on them were individual capital and Social support. The social support was very crucial in the treatment and management of breast cancer. It had the propensity of speeding up the recuperating process of breast cancer patients.

## Recommendations

The recommendations are in four levels; the micro, meso, macro levels and suggestion for further research.

### *Micro (individual level)*

The study recommends that individuals should be concerned about what goes on in their bodies. They should adopt a healthy lifestyle and seek regular medical screening to detect any form of sickness early.

### *Meso (organizational level)*

- A support system like a counselling unit can be established by the hospital to better explain and educate patients about their conditions to avoid cases where women abscond treatment due to misconceptions surrounding the disease. This counselling unit will provide the needed knowledge about the disease to the women. Furthermore, due to the high cost of breast cancer treatment, the hospital could ameliorate the financial burden by establishing a fund to partly support the patients to offset some of the cost incurred by them. Through this fund, they can solicit help from the public to aid the patients.
- Hospitals should identify and recognize informal groups formed by patients and utilize them as survivor groups to share their experiences with other women. For example, women who have undergone mastectomy can advise other patients who are reluctant to go for surgery. They can better explain and share their experiences with women and debunk all misconceptions surrounding the illness.

- From the study, it was realized that knowledge about breast cancer was very low. This implies that either awareness level is low or women do not understand breast cancer issues. It is incumbent on health workers, especially the public health and the community health nurses, to educate the public. Education on breast cancer could be organized at places where women usually congregate such as the ante natal clinics, markets, religious establishments, gynaecology units, family planning units, and women associations. These approaches when implemented well will augment the current efforts by some Non-Governmental Organizations in creating awareness of the disease.

*Macro (structural Level)*

A sentiment shared by the women regardless of their background was the cost of treatment especially chemotherapy. The cost of treatment was out of reach for the patients. Due to the expensive treatment of the disease some had to forgo chemotherapy (which is very crucial in managing the illness) for non payment, where delay could have dire consequences on patients. It is recommended that if possible the National Health Insurance Scheme should absorb the cost of chemotherapy and let the patients pay for the less expensive component of the treatment to alleviate the pains and difficulties patients go through.

### **Suggestions for Further Research**

In profiling the patients, it came out that, nine (9) out of twenty (20) patients had either diabetes or hypertension before being diagnosed with the disease, which is significant. There is therefore the need to investigate the two diseases in relation to the part they may play in inducing breast cancer, either through their own effects as diseases or through the effects of the drugs for treating the diseases. Furthermore, it became known from the study that seven out of twenty patients had used the injectable contraceptive. It would be appropriate to investigate also the effects of this type of contraceptive on the development of breast cancer.

In addition, because this study adopted a qualitative method, it came with its own challenges. It is therefore suggested that future research can adopt a mixed method to cater for the weakness of the qualitative approach, to give a holistic picture of breast cancer as a public health issue.

## REFERENCES

- Agarwal, M, & Dalal, A. K. (1996). Beliefs about the world and recovery from myocardial infarction. *The Journal of Social Psychology*. 133(3), 385-394.
- Ahmadian, M., & Samah, A. A. (2012). A literature review of factors influencing breast cancer screening in Asian countries. *Life Science Journal*. 9, 585-594.
- Arevian, M., Nouredine, S., & Abboud, S. (2011). Beliefs related to breast cancer and breast cancer screening among Lebanese, Armenian Women. *Health Care for Women International*. 32(11), 972-989.
- Asobayire, A., & Barley, R. (2014). Women's cultural perceptions and attitudes towards breast cancer: Northern Ghana. *Oxford Journals*, 8-20.
- Balekouzou, A., Yin, P., Pamatika, C. M., Bishwajit, G., Nambei, W. S., Djeintote, M., Ouansaba, E. B., Shu, C., Yin, M., Fu, Z., Qing, T., Yan, M., Chen, Y., Li, H., Xu, Z., & Koffi, B. (2016). Epidemiology of breast: Retrospective study in the Central African Republic. *BMC Public Health*.
- Banning, M., Hafeez, H., Faisal, S., Hassan, M., & Zafar, A. (2009). The impact of culture and sociological and psychological issues on Muslim patients with breast cancer in Pakistan. *Cancer Nursing*, 32(4), 317-324.
- Bardwell, W. A., Ancoli-Israel, S. & Dimsdale, J. E. (2001). Types of coping strategies are associated with increased depressive symptoms in patients with obstructive sleep apnea. *Sleep* 24(8), 905-909.

- Beiki, O., Hall, Per., Ekobom, A., & Moradi, T. (2012). Breast cancer incidence and case fatality among 4.7 million women in relation to social and ethnic background: A population-based cohort study. *Breast Cancer Research, 14*(1), 5.
- Berger, P. & Luckman, T. (1967). *The social construction of reality*. Harmondsworth: Penguin
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.
- Bryman, A. (2012). *Social research methods*. (4th Ed.). New York: Oxford University Press.
- Brinton, L. A., Figueroa, J. D., Awuah, B., Yarney, J., Wiafe, S., Wood, S., Ansong, D., Nyarko, K., Wiafe-Addai, B., Clegg-Lamptey, J. N. (2014). Breast cancer in Sub-Saharan Africa: Opportunities for prevention. *Breast Cancer Research and Treatment, 144*(3), 467-478.
- Buchanan, D. R. (1998). Beyond positivism: Humanistic perspectives on theory and research in health education. *Health Education Research, 13*(3), 439-450.
- Carroll, J., Epstein, R., Fiscella, K., Volpe, E., Diaz, K., & Omar, S. (2007). Knowledge and beliefs about health promotion and preventive health care among Somali women in the United States. *Health Care for Women International, 28*(4), 360-380.
- Charmaz, K. & Rosenfeld, D. (2010). Chronic illness. *Blackwell Companion to Medical Sociology*. 312-334.

- Chin, V. Y. W., & Noor, N. A. M. (2014). Sociocultural determinants of health and illness: A theoretical inquiry. *Geografia-Malaysian Journal of Society and Space*, 10(1), 49-59.
- Christou, A., & Thompson, S. C. (2012). Colorectal cancer screening knowledge, attitudes and behavioural intention among Indigenous Western Australians. *BMC Public Health*, 12(1), 528.
- Clegg-Lamprey, J., Dakubo, J., & Attobra, Y. (2009). During treatment in Ghana A pilot study. *Ghana Medical Journal*, 43(3).
- Costa, R. A., Fontes, F., Pereira, S., Goncalves, M., Azevedo, A., & Lunet, N. (2014). Impact of breast cancer treatments on sleep disturbances: A systematic review. *Science Direct Journal*, 1-13.
- Creswell, J. W. (2013). *Qualitative inquiry and research design choosing among five traditions* (3<sup>rd</sup> Ed.). Thousand Oaks, CA: Sage Publications Ltd.
- Currer, C. & Stacey, M. (1993). *Concepts of health, illness and disease: A comparative perspective*. (eds.). Oxford: Berg Publishers Limited.
- De-Graft, A. A., Boynton, P., & Atanga, L. L. (2010). Developing effective chronic disease interventions in Africa: Insights from Ghana and Cameroon. *Globalization and Health* 6(1), 6.
- Dei, S. M. O. (2013). *Contextual and individual level determinants of breast cancer screening intention among women in Ghana*. (Master's thesis). University of Lethbridge, Canada

- Donkor, A., Lathlean, J., Wiafe, S., Verna, V., Fenlon, D., Yarney, J., & Kyei, K. A. (2016). Factors contributing to late presentation of breast cancer in Africa: A systematic literature review. *Archives of Medicine*, 8(2).
- Dunn, L. (1991). Research alert! Qualitative research may be hazardous to your health! *Qualitative Health Research*, 1(3), 388-392.
- Elsie, K., Gonzaga, M., Businge, F., Michael, K. R., Nakatudde, R. B., & Zeridah, M. (2010). Current knowledge, attitudes and practices of women on breast cancer and mammography at Mulago hospital: Pan African. *Medical Journal*, 5(1).
- Errico, K. M., & Rowden, D. (2006). Experiences of breast cancer survivor—advocates and advocates in countries with limited resources: A shared journey in breast cancer advocacy. *The Breast Journal*, 12(1).
- Etherington, K. (1996). “The counsellor as researcher: Boundary issues and critical dilemmas”. *British Journal of Guidance and Counselling*. 24(3), 339-346.
- Flick, U. (2009). *An introduction to qualitative research*. London: Sage Publications.
- Frederick, D. A., Peplau, Anne., & Lever, J. (2008). The Barbie mystique: Satisfaction with breast size and shape across the lifespan. *International Journal of Sexual Health*, 20(3), 200-211.
- Ghartey, F. N. (2013). *Descriptive epidemiology of neoplastic breast lesions and molecular characteristics of breast cancer in Ghana*. (PhD thesis).

Department of Molecular Medicine, Kwame Nkrumah University of Science and Technology, Ghana.

Greig, A. D., Taylor, J., & MacKay, T. (2007). *Doing research with children: A practical guide*. London: Sage Publications Ltd.

Guidry, J. J., Matthews-Juarez, P., & Copeland, V. A. (2003). Barriers to breast cancer control for African-American women. *Cancer*. 97(1), 318-323.

Ham, O. K. (2005). The intention of future mammography screening among Korean women. *Journal of Community Health Nursing*. 22(1), 1-13.

Helman, C. G. (2000). *Culture, health and illness*. (4<sup>th</sup> Ed.). United Kingdom: CRC Press.

Holloway, I., & Wheeler, S. (2009). *Qualitative research in nursing and healthcare*. (3<sup>rd</sup> Ed). London: Wiley, Blackwell.

Hwang, J. J., Donnelly, T. T., Ewashen, C., McKiel, E., Raffin, S., & Kinch, J. (2015). Sociocultural Influences on Arab women's participation in breast cancer screening in Qatar. *Qualitative Health Research*. 27(5), 714-726.

Jemal, A., Bray, F., Center, M. M., Ferlay, J., Ward, E., & Forman, D. (2011). Global cancer statistics. *A Cancer Journal for Clinicians*. 61(2), 69-90.

Joffe, H. (2002). Social representations and health psychology. *Social Science Information*. 41(4), 559-580.

Joulaei, A., Joulaei, S., Kadivar, M., & Hajibabaei, F. (2012). Living with breast cancer: Iranian women's lived experiences. *International Nursing Review*, 59(3), 362-368.

- Karbani, G., Lim, J.N., Hewison, J., Atkin, K., Horgan, K., Lansdown, M., & Chu, C. E. (2011). Culture, attitude and knowledge about breast cancer and preventive measures: A qualitative study of South Asian breast cancer patients in the UK. *Asian Pacific Journal Cancer Prevention*, 12(6), 1619-1626.
- Kawar, L. N. (2012). Knowledge about breast cancer and negative influences affecting breast cancer screening among women in Jordan. *International Journal of Humanities and Social Sciences*, 2(18).
- Khakbazan, Z., Taghipour, A., Roudsari, R. L., & Mohammadi, E. (2014). Help seeking behavior of women with self-discovered breast cancer symptoms: A meta-ethnographic synthesis of patient delay”. *PLoS One*, 9(12).
- Khazae-Pool, M., Montazeri, Ali., Majlessi, F., Foroushani, A, R., Nedjat, S., & Shojaeizadeh, D. (2014). Breast cancer-preventive behaviours: Exploring Iranian women’s experiences. *BMC Women's Health*. 14(1), 41.
- Krombein, I. W., & De Villiers, P. J. T. (2006). Breast cancer-early detection and screening in South African women from the Bonteheuwel Township in the Western Cape: Knowledge, attitudes and practices. *South African Family Practice*, 48(5), 14-14.
- Langford, D. R. (2000). Developing a safety protocol in qualitative research involving battered women. *Qualitative Health Research*, 10(1), 133-142.
- Latham, B. (2007). Sampling: What is it? Quantitative Research Methods. *ENGL 5377, Spring 2007*.

- Lee, R. M., & Renzetti, C. (1995). *Dangerous fieldwork*. Thousand Oaks, CA: Sage Publications Ltd.
- Lui, C. W., & Chui, W. H. (2009). Ethnic experience of cancer: a qualitative study of Chinese–Australians in Brisbane. *Queensland: Social Work in Health Care*. 48(1), 14-37.
- Lynch, John, & Kaplan, George. (2000). *Socioeconomic position: Social epidemiology*. New York: Oxford University Press.
- MacLean, J., Kavanaugh-Lynch, M. H. E., Cordeiro, J. N., & Reynolds, P. (2004). Breast cancer in California: A closer look. *California Breast Cancer Research Program*, 22-24.
- Martei, Y. M. (2011). Effect of socio-cultural beliefs on late stage presentation of breast cancer among Ghanaian women. (Yale Medicine Thesis). *Digital Library Paper*, 1576
- McFarland, D. M. (2003). Cervical cancer and pap smear screening in Botswana: knowledge and perceptions. *International Nursing Review*, 50(3), 167-175.
- Meneses, D. K., & Yarbrow, C. H. (2007). Cultural perspectives of international breast health and breast cancer education. *Journal of Nursing Scholarship*. 39(2), 105-112.
- Ndikom, C. M., & Ofi, B. A. (2012). Awareness, perception and factors affecting utilization of cervical cancer screening services among women in Ibadan, Nigeria: A qualitative study. *Reproductive Health*. 9(1), 11.

- Oche, M. O., Ayodele, S. O., & Umar, A.S. (2012). Breast cancer and mammography: Current knowledge, attitudes and practices of female health workers in a tertiary health institution in Northern Nigeria. *Public Health Research*. 2(5), 114-119.
- Oduro, G. Y. (2013). *Beauty in space and time: The changing construction of beauty among Ghanaian youth*.
- Ohene-Yeboah, M. & Agyei, E. (2012). Breast cancer in Kumasi, Ghana. *Ghana Medical Journal*, 46(1).
- Ohene-Yeboah, M., Adofo, K., & Akpaloo, M. (2013). Breast cancer awareness among nurses in Kumasi Ghana: Knowledge, attitudes, and practice. *Postgraduate Medical Journal of Ghana*, 2(1), 21-30.
- O'Malley, M. S., Earp, J. A., Hawley, S. T., Schell, M. J., Mathews, H. F., & Mitchell, J. (2001). The association of race/ethnicity, socioeconomic status, and physician recommendation for mammography: who gets the message about breast cancer screening? *American Journal of Public Health*. 91(1), 49.
- Opoku, S. Y., Benwell, M., & Yarney, J. (2012). Knowledge, attitudes, beliefs, behaviour and breast cancer screening practices in Ghana, West Africa. *Pan African Medical Journal*, 11(1)
- Oppong, S. H. (2013). The problem of sampling in qualitative research. *Asian Journal of Management Sciences and Education*. 2(2), 202-210.
- Othman, A. K., Kiviniemi, M. T., Wu, Y. W. B., & Lally, R. M. (2012). Influence of demographic factors, knowledge, and beliefs on Jordanian women's

intention to undergo mammography screening. *Journal of Nursing Scholarship*, 44(1), 19-26.

Parsons, T. (1951). *The social system*. New York: Free Press.

Patel-Kerai, G., Harcourt, D., Rumsey, N., & Naqvi, H. (2015). Exploring the lived experience of breast cancer diagnosis and treatment amongst Gujarati speaking Indian women. *Diversity & Equality in Health and Care*, 12(1).

Pei, X., & Rodriguez, E. (2006). Provincial income inequality and self-reported health status in China during 1991-1997. *Journal of Epidemiology & Community Health*, 60(12), 1065-1069.

Petro-Nustas, W., Norton, M. E., & Al-Masarweh, I. (2002). Risk factors for breast cancer in Jordanian women. *Journal of Nursing Scholarship*, 34(1), 19-25.

Post, L. (2014). Representing disease: An analysis of breast cancer discourse in the South African Press. *Dissertation submitted to the Department of Media and Communications, London School of Economics and Political Science*. London, England.

Price, M. A., Butow, P. N., Charles, M., Bullen, T., Meiser, B., McKinley, J. M., Phillips, Kelly-Anne. (2010). Predictors of breast cancer screening behavior in women with a strong family history of the disease. *Breast Cancer Research and Treatment*, 124(2), 509-519.

- Remennick, L. (2006). The challenge of early breast cancer detection among immigrant and minority women in multicultural societies. *The Breast Journal*, 12(1).
- Ridge, D., Hee, A., & Aroni, R. (1999). Being 'real' in suicide prevention evaluation: The role of the ethnographer's emotions under traumatic conditions". *Australian Journal of Primary Health*, 5(3), 21-31.
- Robson, C. (2002). *Real world research*. Swanstons, Australia: Blackwell.
- Sarfo, L. A., Awuah-Peasah, D., Acheampong, E., & Asamoah, F. (2013). Knowledge, attitude and practice of self-breast examination among female university students at Presbyterian University College, Ghana. *American Journal of Research Communication*, 1(11), 395-404.
- Schettler, T. (2013). *The ecology of breast cancer: The promise of prevention and the hope for healing*. Ted Schettler.
- Schmauss, D., Machens, H. G., & Harder, Y. (2016). Breast reconstruction after mastectomy. *Frontiers in Surgery*, 2, (71).
- Segni, M.T., Tadesse, D.M., Amdemichael, R., & Demissie, H.F. (2016). Breast Self-examination: Knowledge, Attitude, and Practice among Female Health Science Students at Adama Science and Technology University, Ethiopia. *Gynecol Obstet (Sunnyvale)*, 6(368), 2161-0932.
- Sharma, G. N., Dave, R., Samadya, J., Sharma, P., & Sharma, K. K. (2010). Various types and management of breast cancer: An overview. *Journal of Advanced Pharmaceutical Technology and Research*, 1(2).

- Silverman, D. (2006). *Interpreting qualitative data: Methods for analysing talk, text and interaction*. London, Sage Publication.
- Soskolne, V., Marie, S., & Manor, O. (2007). Beliefs, recommendations and intentions are important explanatory factors of mammography screening behaviour among Muslim Arab women in Israel. *Health Education Research, 22*(5), 665-676.
- Suh, E. E. (2013). Cultural models of female breasts and breast cancer among Korean women. *Open Journal of Nursing, 3*(05), 404.
- Swami, V., & Tovée, M. J. (2013). Resource security impacts men's female breast size preferences. *PloS one, 8*(3).
- Teddlie, C., & Yu, F. (2007). Mixed methods sampling: A typology with examples. *Journal of Mixed Methods Research, 1*, (77).
- Thornton, H., & Pillariseth, R. R. (2008). Breast awareness and breast self-examination are not the same. What do these terms mean? Why are they confused? What can we do? *European Journal of Cancer*.
- Twumasi, P. A. (2005). *Medical systems in Ghana: A study in medical sociology*. Accra: Ghana Publishing Corporation Assembly Press.
- Uskul, A. K. (2009). Socio-cultural aspects of health and illness. In D. French, A. Kaptein, K. Vedhara, and J. Weinman, (Eds.). *Health psychology*. Oxford: Blackwell Publishing.
- Vieira, E. M., Santos, D. B., Santos, M. A. D., & Giami, A. (2014). Experience of sexuality after breast cancer: A qualitative study with women in rehabilitation. *Revista Latino-Americana de Enfermagem, 22*(3), 408-414.

- Walliman, N. (2006). *Social research methods: The essentials*. London: Sage Publication.
- Walford, G. (2001). *Doing qualitative educational research: A personal guide to the research process*. London: Continuum.
- Weiss, G.L. & Lonquist, L. E. (2015). *The sociology of health, healing and illness* (8<sup>th</sup> Ed.). U.S.A: Pearson Education Inc.
- Weitz, R. (2013). *The sociology of health, illness and health care: A critical approach* (6<sup>th</sup> Ed.). U.S.A: Wadsworth Cengage learning.
- World Health Organization (2009). “Medium Term Programme”. Geneva.
- Young, A. (1993). Internalising and externalizing medical belief systems: An Ethiopian example. In C. Currer & M. Stacey (Eds.), *Concepts of health, illness and disease: A comparative perspective* (pp. 139-161). Oxford: Berg Publishers Ltd.

## **APPENDICES**

### **APPENDIX A: INTERVIEW GUIDE**

#### **UNIVERSITY OF CAPE COAST**

#### **DEPARTMENT OF SOCIOLOGY AND ANTHROPOLOGY**

#### **“Exploring the Socio-cultural Interpretations of Breast Cancer and the Coping Strategies of Patients at the Cape Coast Teaching Hospital, Ghana”**

Thank you for your time and willingness to participate in this interview. The responses given will be used solely for academic purposes. Your identity shall remain confidential.

#### **Biodata and lifestyle pattern of patients**

##### **Biodata**

Can you please tell me:

- Your age
- Your level of education
- Your occupation

- Marital status
- The number of children you have
- The duration of breastfeeding
- Your ethnicity
- Your religion
- Are you a first time patient
- The stage of the illness

### **Lifestyle pattern of patients**

- Exercise
- Smoking
- Alcohol intake
- Diet
- Use of contraceptives

### **Knowledge and interpretations of the illness**

- Individual's knowledge of the illness

What do you know about breast cancer? (Trigger: your knowledge about the causes- purely medical condition, supernatural forces, punishment etcetera; symptoms and signs, screening methods and treatment options)

How/where did you get this information from?

- General knowledge of the illness

How do people in your community deal with illnesses such as breast cancer?

What are the general knowledge about breast cancer? (prompts: in terms of the causes, symptoms and treatment)

In your community, is breast cancer openly talked about like other illnesses?

### **Interpretations of the illness**

What meanings do people in your community assign to breast cancer?

- Religious/spiritual interpretations

(prompts: punishment for one's sin, supernatural forces, curse, witchcraft etc.)

- Social/cultural interpretations

(prompts: it is an illness that diminishes family's social standing in the community, hereditary defect, loss of femininity, shameful)

- Medical interpretations

Do you think these interpretations about the illness influence women to examine their breasts and report any abnormalities for early treatment?

### **Reactions to the illness**

How did you feel when you were diagnosed with the illness? (prompts: what were your main concerns; how long did you wait to see a doctor for treatment? Why is that?)

Did you tell others about your diagnosis? At what point and what exactly did you tell them? (trigger: did you tell them the truth from the onset?)

How did your family/partner/friends react to your diagnosis and treatment?

Has your diagnosis changed the way people relate to you? (triggers: sympathize, discriminate)

### **Socio-demographic categorization**

Did the following influence the time you presented the illness to the hospital?

Age

Marital status

Education level

Occupation

Income

Residence

Religion

Hereditary

### **Patients' treatment choices**

What kind of treatment(s) did you resort to when you were first diagnosed with the illness? (Triggers: orthodox, traditional healers, both and others...)

Why that option (s)? Was your choice (s) influenced by (prompts: the socio-cultural interpretations of the illness, family and friends, effectiveness of the treatment, socio-demographic issues etc.)

### **Impact of the illness and coping strategies/resources**

- The patient's health and physical wellbeing

How have you been affected by the illness?

(prompts; loss of self-esteem, issues with body image, changes in daily routine and lifestyle, effects of treatment on their health)

- Domestic sphere

In what ways have the illness affected your family?

(prompts: changes in roles performed in the home, depletion of family resources, depend highly on family members)

- Public sphere

How has the illness affected your job and your general responsibilities in the community?

### **Sources of resources**

- Individual capital

Personally, how did you cope when you were first diagnosed with the illness (triggers: spiritual help, strong will for survival, strong financial background etc.)

How are you coping with the illness now? (prompts: in terms of changes in your body, financial drain etc. Have there been changes in your resources?)

- Social capital

Aside your personal resources, do you get help from elsewhere?

(prompts: Significant others (close family relations); General others (friends, colleagues, health workers, community members, religious affiliates)

Nature of resources given (Triggers: emotional support, spiritual assistance, financial aid and others...)

Do you think there is a relationship between what they believe to be the cause of the illness and help offered?

Is there any other thing you wish to add?

Thank you for your time and for sharing your experience.

## APPENDIX B: INTERVIEW GUIDE FOR HEALTH WORKERS

### UNIVERSITY OF CAPE COAST

#### DEPARTMENT OF SOCIOLOGY AND ANTHROPOLOGY

#### “Exploring the Socio-cultural Interpretations of Breast Cancer and the Coping Strategies of Patients at the Cape Coast Teaching Hospital, Ghana”

Thank you for your time and willingness to participate in this interview. The responses that you will give will be used solely for academic purposes. Your identity shall remain confidential.

#### **Biodata**

Gender

Position/ rank

Years of service

#### **Knowledge level of patients**

How well do patients know about breast cancer? (are they conversant with screening methods, causes, signs and symptoms and available treatments)

#### **Beliefs and Reactions of patients**

What beliefs/ attributes do patients assign to breast cancer? Do patients share these beliefs commonly?

Do you think these beliefs influence the time patients present the illness for treatment?

Reactions of patients

What are the fears/ concerns of patients (divorce, social isolation, beliefs of fatalism)?

#### **Treatment of the illness**

Do patients abscond treatment after diagnosis? Why? (prompts: socio-demographic reasons, fears treatment, religious reasons)

- Patients' preferred choice of treatment

(prompts: Orthodox alone, traditional, faith healers)

- Attitude towards treatment

How receptive are they to treatment? (prompt: follow prescription)

### **Coping mechanisms**

Any idea as to how patients cope with the illness?

Are there support systems available in this institution to help patients cope with the illness?

Thank you for your time.

## APPENDIX C: OBSERVATION GUIDE

### UNIVERSITY OF CAPE COAST

#### DEPARTMENT OF SOCIOLOGY AND ANTHROPOLOGY

#### **“Exploring the Socio-cultural Interpretations of Breast Cancer and the Coping Strategies of Patients at the Cape Coast Teaching Hospital, Ghana”**

#### **Observe the kinds of interaction (verbal/nonverbal) that go on among patients**

- How friendly/receptive patients are with each other (how well do they bond)?
- How they help each other in relation to information dissemination and directions?
- Their line of conversation.
- If there are groups (informal groups/ associations)?

#### **Observe the interaction between them and significant/general others**

The category of people who follow patients to the hospital for treatment.

The kind of assistance they give to the patients.

The general countenance of significant/ general others.

#### **Interaction with health professionals**

How well do patients associate with health professionals (trigger: are health professionals friendly to them?)

Do patients prefer to interact with health professionals of the same sex/ gender?

#### **General demeanour of patients**

(triggers: disturbed, cheerful, agitated, calm etcetera)

#### **Availability of support systems (like counselling unit)**

## APPENDIX D: INFORMED CONSENT

Dear Participant,

I wish to invite you to take part in my study on the topic “Exploring the Socio-cultural Interpretations of Breast Cancer and the Coping Strategies of Patients at the Cape Coast Teaching Hospital, Ghana”.

Before agreeing to join this study, I want to explain the following statements about the study to you. Please you are free to seek for further clarifications regarding the study, before signing this form.

The purpose of this study is to gain in-depth knowledge on how breast cancer patients’ perceptions of the illness are influenced by socio-cultural interpretations and the coping strategies they adopt to mitigate this predicament. Your participation in this study will involve a face-to-face discussion lasting approximately forty-five minutes. The emphasis of the discussion will be on your interpretations of the illness, your experiences and how you are coping with the illness.

Though there are no known physical risks for taking part in this study, some emotional discomforts are anticipated. That is some of the questions may be sensitive and uncomfortable, in particular talking about unpleasant experiences. If you feel uncomfortable, you may refuse to answer any question or discontinue the discussion at any time. Nonetheless, all necessary steps will be taken to ensure your safety and comfort during the interview.

Please note that although you may not directly benefit from this study as a participant; your participation is very important because findings from this study may benefit other women or cancer patients now and in the future.

All information gathered in this study will be kept confidential. It will be used for research and educational purposes only. Your identity will not be disclosed thus; you are encouraged to take pseudonym or identification code. Please be informed that your participation in this study is completely **voluntary**.

Thank you.

It has been explained to me and I understand the above information regarding this study. I therefore consent to participate in the study.

\_\_\_\_\_  
(Participant's Pseudonym/ Co  
excde) (Signature) (Date)

I further agree that this interview will be digitally recorded and transcribed.

\_\_\_\_\_  
(Participant's Pseudonym/ Code) (Signature) (Date)