

HEALTH-SEEKING BEHAVIORS OF WOMEN WITH ADVANCED BREAST CANCER IN
SOUTHWESTERN NIGERIA

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ABSTRACT

Background: The survival rate of breast cancer in Nigerian women is low (56%). It has been observed in the empirical literature that Nigerian women present with advanced stages of breast cancer. The presentation of breast cancer at the advanced stages, reduces the options available to the women for the management of the illness, which had contributed to the low survival rate. Little is known about the health-seeking behaviors of women after they observed breast changes, how they interpreted and managed their breast changes and the factors they believe influence their health-seeking activities.

Purpose and Objectives: The aims of the study were to explore the health-seeking behaviors of women with advanced stages of breast cancer in Southwestern Nigeria and the factors that influenced them in engaging in specific health-seeking activities from their perspectives. The advanced stages of breast cancer were defined as Stage III or stage IV breast cancer.

Methods: Ethical approval to conduct the study was obtained from the University of Saskatchewan's Behavioral Research Ethics Board and the Joint Research Committee of University of Ibadan and University College Hospital Ibadan. Using purposeful sampling techniques, 30 women who were all diagnosed with advanced stage breast cancer were recruited as the study participants. The Health Belief Model (HBM), provided the conceptual framework, and interpretive description (ID) a qualitative research approach, was used to explore the health-seeking behaviors and the factors that influenced the study participants to engage in these health-seeking behaviors. Using semi-structured open-ended questions and non-leading prompts, I engaged the study participants in free discussions in which they described their health-seeking behaviors, and factors they believed influenced and motivated them to engage or not to engage in specific health-seeking activities, for the treatment of breast ill-health. A demographic form,

which was personally completed by each participant, was used to obtain the participants' demographic information. The demographic information of the study participants were analyzed using descriptive statistics while the interview transcripts were analyzed using thematic analysis.

Results: The main outcome of this dissertation research suggests that women in Southwestern Nigeria suffering from breast cancer have unique perceptions of breast cancer as a life-threatening illness that few people survive, may misinterpret breast changes perhaps due to poor knowledge of breast cancer symptoms, and seek divine intervention to manage the advanced stages of breast cancer. This study uncovered the women's personal and cultural beliefs and attitudes about breast cancer. It also generated information that provided deeper understanding of their health-seeking behaviors, as well as pertinent factors that influence Southwestern Nigerian women suffering from breast cancer in their health seeking for the management of the illness.

Conclusion: The outcomes of this study provided insight into how nurses can optimally and comprehensively manage breast cancer perceived to be a life-threatening illness that few people survive. This study also advanced the use of a qualitative approach to inquiry in seeking to explore and understand the health-seeking behaviors of women presenting with advanced breast cancer in Southwestern Nigeria, on which empirical literature had been scarce. It is hoped that this new understanding will contribute to the holistic nursing management of breast cancer that could result in improved treatment outcomes of the illness among women in Southwestern Nigeria.

Keywords Women, Advanced stages of breast cancer, Health Belief Model, Interpretive Description, health-seeking behavior, Southwestern Nigeria, Nigeria.

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DEDICATION

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LIST OF ABBREVIATIONS

AJCC	American Joint Committee on Cancer
CAC	Christ Apostolic Church
CCC	Celestial Church of Christ
C&S	Cherubim and Seraphim
CINAHL	Cumulative Index for Nursing and Allied Health
CMD	Chief Medical Director
EMBASE	Excerpta medical Database
HBM	Health Belief Model
ID	Interpretive Description
MCPDP	Mandatory Continuous Professional
IDN	Development Program for Nigerian Nurses
MEDLINE	Medical Literature Analysis and Retrieval System Online
NVIVO	Qualitative Data Analysis Software
PAWS	Personal Access to Web Services (University of Saskatchewan cabinet)
TNM	Tumor size, Lymph Node involvement, and Metastasis
UCH	University College Hospital
QSR	Qualitative Research Software Developer
REB	Research Ethics Board
UI	University of Ibadan
WHO	World Health Organization

HEALTH-SEEKING BEHAVIORS OF WOMEN WITH ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA

Chapter 1 INTRODUCTION TO THE PROBLEM

1.1 Statement of Problem

According to the World Health Organization (WHO, 2018), breast cancer is the most common cancer diagnosed among women in 154 out of 185 countries of the world and it is the leading cause of cancer-related mortality in over 100 countries (Globocan, 2018). Breast cancer is the fifth most common cause of cancer-related death globally (Ferlay et al., 2015). The breast cancer burden is on the increase all over the world, with almost 1.68 million new cases diagnosed in 2012, and about 2.1 million new cases diagnosed in 2018 (Ferlay et al., 2015; WHO, 2017; 2018). There are 6.3 million women alive who had been diagnosed with breast cancer in the previous years (Ferlay et al., 2015). The incidence of breast cancer has increased by 20% since 2008 estimates. Mortality has also risen by 14% (WHO, 2013b).

In contrast to the developed regions of the world, where breast cancer is second to lung cancer as the most common cause of cancer-related mortality, in developing parts of the world, breast cancer is the leading cause of cancer-related deaths in women (WHO, 2016; 2017; 2018; Ferlay et al., 2015). Approximately 60% of breast cancer deaths occur in low-income and economically developing countries (Jemal, Center, DeSantis, & Ward, 2010). The breast cancer burden in low-middle income countries is growing, with survival rates much lower than high-income countries (Farmer et al., 2010; Parkin & Fernandez, 2006; WHO, 2018). Breast cancer has been recognized as an urgent public health problem in high-resource areas of the world. It is becoming an increasingly urgent problem in low-resource regions (Anderson et al., 2008).

The low survival rate from breast cancer in developing countries (56% in Nigeria compared to 81% in Canada according to GLOBOCAN, 2018) is made worse by late stage

presentation and limited diagnostic and treatment capability (Anderson & Cazap, 2009). With the projected increase in the burden of breast cancer in developing countries, strategies to improve treatment outcome through early detection and access to treatment is highly recommended (Yip, Buccimazza, Hartman, Deo, & Cheung , 2015). WHO (2013b), stressed the need to bring morbidity and mortality in developing countries in line with the progress made in more developed regions of the world. WHO (2013b) also made an urgent call for the development of “effective and affordable approaches to the early presentation, diagnosis, and treatment of breast cancer in women living in less developed countries” (p. 2). Said and Ellis (2010) and WHO (2013b) have estimated that by 2025, without clinical advances, early detection and better access to health care, breast cancer in developing countries will only increase further.

1.2 Gap in the Literature

Research studies indicate that Nigerian women present with advanced stages of breast cancer (Adesunkanmi et al., 2006; Adisa, Lawal, & Adesunkanmi, 2008; Adisa et al., 2011; Azubuike & Celestina, 2015; Chiedozi, 1985; Ekanem & Aligbe, 2006; Ikpat, Kuopio, & Collan, 2002; Nggada, Yawe, Abdulazeez, & Khalil, 2008); and that the survival rate of the women presenting with the advanced stages of the illness, according to WHO (2018), is 56%. However, despite the physiological, psychological, and emotional reactions accompanying the illness, few studies explored the health-seeking behaviors of women with the advanced stages of breast cancer. Therefore, research is needed to uncover and understand the activities in which women engage, after they perceive symptoms of breast ill-health, as well as ways in which they attempt to recover from their illness and enjoy optimal well-being. An understanding of the health-seeking behaviors may assist nurse clinicians and other healthcare providers in identifying the behaviors and actions influencing delays in seeking competent care. Knowledge of the

factors influencing delays in seeking such care, might enable nurse clinicians to develop and implement strategies to increase patients' engagement of optimal health-seeking behaviors, thus greatly contributing to reducing the adverse effects of the illness.

1.3 Purpose of the Study

The disparity in breast cancer treatment outcomes in women living in developed and developing countries regions provides part of the impetus for this study. The goals and intents of the study were to explore the health-seeking behaviors and activities of women from Southwestern Nigeria with advanced breast cancer, as well as the factors that underlie these behaviors. Understanding the health-seeking behaviors of these women has the potential to generate research-informed knowledge to inform clinical understanding. This understanding may well assist in establishing interventions that bring about improved treatment outcomes.

The concept investigated and researched in this study was the health-seeking behavior of women with advanced breast cancer in Southwestern Nigeria. Attempts were made to explore and identify, from Nigerian women's perspectives, the series of activities and corrective measures they engaged in when they perceived that they had breast ill-health. Also, attempts were made to explore and understand from Southwestern Nigerian women's perspectives, the factors that influenced their decision-making processes in seeking to resolve their recognized breast ill-health.

1.4 Breast Cancer Staging and Classification

The American Joint Committee on Cancer (AJCC) has described the extent of illness progression in cancer patients and classified breast cancer into four stages. The committee used the tumor size, the lymph node involvement, and metastases or the spread of the disease (TNM) as the basis for the classification. Stage I breast cancer was described as the initial stage of the

disease. At this stage, the size of the tumor is small, and the tumor is contained within the organ where it started. At this stage, the illness is curable most of the time (Singletary & Connolly, 2006). Stage II breast cancer is counted as part of the early stages. The tumor size is bigger compared to stage I breast cancer. The lymph nodes closer to the affected breast are affected, but the tumor is still treatable, and the prognosis is good (Singletary & Connolly, 2006). In stage III breast cancer, the tumor has spread significantly to the surrounding lymph nodes and the surrounding tissues. In stage IV breast cancer, the tumor has spread to other organs and parts of the body.

Only five to 12 percent of stages I and II breast cancer patients die in the first decade after diagnosis, while over 60 percent of stage III, and over 90 percent of stage IV breast cancer patients die in the first ten years after diagnosis (Singletary & Connolly, 2006). Knowing the stages of breast cancer is useful because it enables the healthcare provider to estimate the prognosis for the illness. Knowledge can also provide valuable information about the most appropriate treatment options available to patients who present with breast cancer.

It must be pointed out that breast cancer is not a uniform illness, and many subtypes have been identified. Breast cancer subtypes vary across various populations and racial groups. One of the ways of defining the different categories of breast cancer is by using the hormone receptor status. The identification of the characteristics of the various categories is essential for the development and the provision of the most appropriate care strategies for the patients (Adisa et al., 2012).

1.5 Breast Cancer in Nigeria

The leading cause of cancer-related death among Nigerian women is breast cancer (Adesunkanmi, Lawal, Adelusola, & Durosimi, 2006; Jedy-Agba et al., 2012; 2016; WHO,

2016; 2018). Recently, an increase in breast cancer incidence has been reported in Nigeria; the patients are young, and they present late (Jedy-Agba et al., 2012; 2016). In low-income countries like Nigeria, advanced stages of the disease and delayed treatment represent significant problems (Adesunkanmi et al., 2006; Oluwatosin & Oladepo, 2006; Ogunkorode, Holtlander, Anonson, & Maree, 2017). Among the factors responsible for the presentation of advanced disease stages by women with breast cancer in Nigeria are the following: lack of breast cancer awareness, misconceptions about its causes, poor treatment outcomes, and several other sociocultural issues such as fear, stigma, and embarrassment (Ibrahim & Odusanya, 2009; Ibrahim & Oludara, 2012; Ogunkorode, 2015; 2017; Oluwatosin, 2012; Pruitt et al., 2015). Previous studies (Adesunkanmi et al., 2006; Adisa et al., 2011; Ibrahim & Odusanya, 2009; Ogunkorode, 2015; 2017; Okobia, Bunker, Okonofua, & Osime, 2006; Oluwatosin & Oladepo, 2006; Pruitt et al., 2015) also identified presentation with an advanced stage of the disease and delayed presentation to be responsible for the poor prognosis and low survival rate of Nigerian women suffering from breast cancer.

1.6 Physiological Reactions to Breast Cancer in Nigerian Women

An analysis of the biological and physiological features of breast cancer in Nigerian women indicated that the patients are relatively young, with many of them in their active reproductive years (30 to 50 years), and that most present with high-grade tumors at the advanced stages of the illness (Ademuyiwa et al., 2011; Adisa et al., 2011; Clegg-Lampsey, 2017; Galukande, Wabinga, Mirembe, Karamagi, & Asea, 2014; Kene et al., 2010).

The phenotype of the subtype of breast cancer identified in Nigerian women is the aggressive type (Adisa et al., 2012). This subtype is more responsive to chemotherapy than to hormonal therapy. The characteristics of this subtype are similar to those that are observed in

women presenting with breast cancer in some other African countries such as Ghana, and in African American women. These women have poor clinical treatment outcomes (Ademuyiwa et al., 2011; Adisa et al., 2011; Adisa et al., 2012; Brinton et al., 2014; Clegg-Lampsey, 2017).

Aghadiuno, Akang, and Ladipo (1994) reviewed the features of breast cancer and the survival rates of 18 Nigerian women who had simultaneous bilateral malignant breast tumors. Findings from the review indicated that the average survival time for 61% of the patients was between one and five months; the average survival time for 27% of the patients was between 12 and 15 months; while the remaining 12% survived for only five months. None of the patients survived for up to two years. The average survival time for the 18 patients was seven months. The results of the autopsies performed by Aghadiuno et al. (1994) indicated that the advanced stage breast cancer had spread to various organs and parts of the patients' bodies, including the liver, lungs, skull, vertebrae, brain, kidneys, and the endocrine glands.

Aghadiuno et al. (1994) were supported by Adisa et al. (2012), who observed that breast cancer in Nigerian women, women in some other African countries, and African American women, is the aggressive and rapidly progressive subtype. Late presentation of breast cancer, defined as periods longer than 12 weeks interval between the initial discovery of a breast symptom and the time of receiving medical treatment, may appreciably increase the possibility that a woman will have developed distant breast cancer metastases which may negatively impact the effectiveness of treatment, making it less likely that clinical interventions will improve the illness prognosis and treatment outcomes (Anderson et al., 2003). According to the authors - Ajekigbe (1991); Akhigbe and Akhigbe (2012); Maree and Wright (2010), these findings might partly explain why the diagnoses of breast cancer in African women is accompanied by fear, feelings of loss, fear of uncertainties, and fatalistic thinking. The findings, also, have

implications for the importance of early breast cancer diagnosis with prompt and accurate treatments.

1.7 Psychological Reaction to Breast Cancer in African Women

For many African women, the breast is an organ associated with numerous psychological, emotional, and physical functions. A woman's breasts are related to gender identity, motherhood, and caring, breast ill-health, therefore, endangers an African woman's psychological and emotional well-being (Akin-Odanye, Asuzu, & Popoola, 2011; Maree & Mulonda, 2015). The treatments for breast cancer revolve around the surgical removal of the breasts, chemotherapy, and hormonal therapy. Some African women perceive the surgical removal of their breasts as mutilation. The side effects of chemotherapy and hormonal therapy such as pain, fatigue, loss of hair, skin reactions, and the financial implications of breast cancer treatments may cause distress (Akin-Odanye et al., 2011; Clegg-Lamprey et al., 2009) and lead to feelings of guilt, worthlessness and hopelessness as well as fatigue and thoughts of suicide, loss of interest and pleasure in activities, and change in appetite. These signs are related to fatalism and depression (Akin-Odanye et al., 2011; Sperry, 2009).

In an exploratory, descriptive study, the study participants, advanced-stage breast cancer patients, reported that learning about the diagnosis resulted in shock, disbelief, fear, uncertainty, intense loneliness, isolation, and difficulties with accepting the diagnosis (Assaf, Holroyd, & Lopez, 2017). Some study participants in the same exploratory, descriptive study conducted by Assaf et al. (2017) also reported that they reacted to the diagnosis by keeping it a secret. Maintaining secrecy about a breast cancer diagnosis has implications for breast cancer late-stage disease presentations which may reduce the treatment alternatives available to the patients, and the disease treatment, care, and management outcomes (Adesunkanmi, Lawal, Adelusola, &

Durosimi, 2006).

1.8 Emotional Reactions to Breast Cancer in African Women

African women face notable physical, emotional, and social changes; and difficulties following the diagnosis and the commencement of treatment for the advanced stages of breast cancer (Odigie et al., 2010). Emotional distress after a diagnosis can result in marital problems, exacerbated by cultural beliefs about a woman's sexual desirability, loss of mothering roles after the loss of a breast, her perception that cancer was punishment from God, and that she was no longer a complete woman after mastectomy (Sperry, 2009). Similarly, in a qualitative study conducted by Odigie et al. (2010), six months after a mastectomy, some study participants reported a feeling of the loss of femininity related to a perception of their incompleteness as a woman, negatively perceived their body image, felt unable to breastfeed their children, and noted a decrease in their husband's affection. However, these findings were not universal because some of the same study participants also reported feeling adequate or indifferent towards their femininity. Maree and Mulonda (2015) also observed that the diagnosis of the advanced stages of breast cancer was accompanied by emotional torture in a group of Zambian women. The study participants expressed difficulties with the fulfillment of their roles as adult females, mothers, and wives. Other sources of emotional distress identified in the literature are fears related to uncertainty, various losses, surgery, embarrassment, stigma, financial implications of breast cancer treatments, divorce, and death (Ajekigbe, 1991; Donkor et al., 2015; Maree & Mulonda, 2015; Pruitt et al., 2015).

1.9 Timing of Breast Cancer Presentation in African Women

The timing of presentation of African women suffering from breast cancer is impacted by a complex interaction of various factors. Among these complex factors are the following:

contrary symptom understanding, interpretation, and explanation, fear, appreciation and confidence in the use of alternative medicine, the influence of social relations and networks, lack of trust and faith in orthodox medicine, and lack of access to healthcare (Donkor et al., 2015). Other factors identified by Gould, Fitzgerald, Fergus, Clemons, and Baig (2010) that may impact the timing of breast cancer presentation for medical treatments include: a low-risk perception of breast cancer, a denial which results in the rationalization of breast cancer symptoms, fears, and denial of the possibility of cancer.

1.9.1 contrary symptom interpretation. Contrary symptom interpretation relates to the perception of individuals about the changes occurring in their bodies. The initial symptoms of breast ill-health can influence the timing of seeking medical help for breast cancer. Women whose initial breast changes does not include a lump tend to delay presentation (Bish et al., 2005). An accurate symptom interpretation may result in timely decision-making to engage in health-seeking behavior while an inaccurate symptom interpretation may lead to ignoring the symptom and neglecting health-seeking activities (Donkor et al., 2015).

1.9.2 fear. Fear has been identified as a major factor impacting the timing of breast cancer presentation in Africa. This fear may be related to the fear of cancer diagnosis, fear of the outcome of breast cancer treatments, fear of cosmetic deformity, fear of the financial burden of breast cancer care, fear as a result of the socio-cultural misconceptions related to breast cancer, and fear of sexuality issues which could result in stigma, divorce, and embarrassment (Adisa, 2010; Ajekigbe, 1991; Pruitt et al., 2015; Donkor et al., 2015).

1.9.3 belief in alternative medicine. Using alternative medicine is common among cancer patients in Africa (Donkor et al., 2015). Ezeome (2010) in a qualitative study of delays in presentation and treatment of breast cancer, observed that patients who patronized the services of

the alternative medicine caregivers usually presented late with the advanced stages the illness. Two types of alternative medicine identified are locally based therapies which involve spiritual, traditional, and herbal therapies, and foreign-based therapies which include acupuncture and Chinese medicine. In many regions, the use of alternative medicine relates to spirituality and cultural diversity. Donkor et al. (2015) systematically reviewed the literature to explore the factors that contribute to late presentation of breast cancer by African women. The findings from the review indicated that African women with breast cancer use alternative medicine to treat or cure their breast cancer, and the highest use of alternative medicine was observed in West Africa.

1.9.4 the impact of cultural context. Women living with breast cancer experience their illness within the context of their everyday life. Therefore, personal, social, psychosocial, environmental, and sociodemographic factors all impact when and where women present their breast cancer symptoms for evaluation and treatment (Facione & Facione, 2006). Studies focusing on developed countries cannot be generalized to developing countries. Although similarities are sweeping through countries and populations, many differences between individual countries, cultures, and health systems have been observed (MacKian, 2003). Considerable variations exist in various social, cultural, and economic contexts (Sharma, Costas, Shulman, & Meara, 2012). Therefore, it is essential to carry out research studies in the participants natural contexts and environments.

Facione and Katapodi (2000) discussed a cultural aspect to breast cancer perception, early detection, and treatment. Within the same cultural background, people share similar knowledge and beliefs about breast cancer. These shared knowledge and beliefs are believed to impact participation in screening, detection, and health-seeking behaviors for breast cancer care (Forbes et al., 2011). The association between beliefs and behaviors can either increase or hinder

health outcomes. When individuals decide about their health-seeking behavior, the decision-making process is usually undertaken in the light of their immediate practical environment, their social connectedness, their socioeconomic situations, and their whole outlook on life (MacKian, 2003).

Findings from a systematic review of the literature on the factors contributing to delays in breast cancer presentation in Africa conducted by Donkor et al. (2015) indicated that in many African cultures, cancer is attributed to a curse, a bewitching, or God's punishment due to personal or family crime or abomination, or some other supernatural rather than biological basis. Therefore, treating an illness based in spirituality with physical therapies such as surgery, chemotherapy, and radiotherapy may be viewed as ill-judged. As a result, individuals would rather rely on their faith magicians, witch doctors, herbalists, priests, pastors, and other spiritualists for the treatment of illnesses like cancer (Donkor, et al., 2015). In part, these cultural beliefs and perceptions contribute to the reason why women would rather visit an alternative medicine practitioner for a cure after noticing signs of breast ill-health. Some women also believe that greater harm, injury, physical destruction of the body, waste of money, energy, and time result from receiving care for breast cancer from orthodox medical centers (Donkor et al., 2015).

1.10 Delays in Breast Cancer presentation

A delayed presentation is considered to be a period greater than 12 weeks between the initial discovery of breast symptom and the time of receiving medical treatment. Periods longer than 12 weeks have been associated with lower survival rates (Bish, Ramirez, Burgess, & Hunter, 2005; Richards, Smith, Ramirez, Fentiman, & Rubens, 1999). Putting off the diagnosis and treatment of breast cancer has been divided into two phases: the patient-initiated delay phase

and the provider-initiated delay phase. The patient delay phase has been defined as the period between a woman's first awareness of a symptom of breast ill-health and initial medical consultation. The provider delay phase corresponds to the time between the initial medical consultation and the initiation of actual treatment for cancer. The provider delay period is further subdivided into two phases—the time between the first visit, and final diagnosis of the cancer phase, and the time between medical diagnosis and the start of cancer treatment (Bish et al., 2005; Caplan, Helzlsouer, Shapiro, Wesley, & Edwards, 1996; Facione, 1993). The combination of patient and provider delays can lead to the progression of advanced disease stage, the worsening of the disease, and treatment complications. The consequences of these delays tend to reduce a woman's chance for surviving breast cancer (Caplan, 2014; Richards et al., 1999).

A systematic review of 38 research papers published between 1907-1996 revealed that patients who delayed seeking help for more than three months experienced, on average, a 12% lower five-year survival rate than those who sought medical help sooner (Bish et al., 2005). When a malignant breast cancer is left untreated, for a substantial period, for about one year or more, the cancer advances in stages and spreads. The increase in the stages of breast cancer may lead to decreased survival rates and poor prognosis for survival (Facione, 1993).

In Nigeria, both the patient-initiated and provider-related delays coexist. Patterns of delays reported in Ezeome (2010) revealed 79.2% in patient-related delays and 46.2% in healthcare provider-related delays. Also, two types of provider-related delays were identified. The first type relates to inadequate professional knowledge and practice in the care and management of breast cancer, lack of referrals, or delayed referrals, false reassurances by health personnel, and failure to obtain histology after a biopsy. The second type related to lack of infrastructure and organizational lapses (Ezeome, 2010). Delays between the initial consultation

and the ultimate treatment of breast cancer are mostly related to the patient's failure to follow up with their treatments. The reasons for patient-initiated delays are related to lack of appreciation for the potential danger of breast cancer symptoms, fear of surgery and mastectomy, fear of uncertainties, and lack of funds to continue with care (Ajekigbe, 1991; Ezeome, 2010). Ezeome's (2010) study also indicated that the advanced stages of breast cancer, defined as stages III and IV, occurred more often in patients whose delay periods were more than three months. Survival of breast cancer patients is positively related to the lower the stage of the disease at diagnosis (Richards et al., 1999). It could, therefore, be deduced from the findings that better treatment outcomes might result from shortening the delay period between the onset of the initial symptoms identification and the initiation of the actual treatment of symptomatic breast cancer in Nigerian women.

1.11 Factors Impacting Delay in Breast Cancer Presentation

1.11.1 personal factors. Personal factors relate to fear of the loss of a body part as in a mastectomy (Ajekigbe, 1991), fear of dying, fear of stigma, and fear of the disease itself, all of which might be associated with a delayed presentation. Other related concerns reported in the literature include fear of doctors and hospitals, fear of ridicule, and embarrassment, fear of chemotherapy and radiation therapy, fear of pain, loss of the female nurturing role, fear of abandonment, and concern with unmanageable expenses (Facione, 1993).

1.11.2 social roles. Delaying presentation because of perceived social roles demands such as caring for family members has been found to be associated with women living with breast cancer. Other factors that might impact breast cancer presentation include the habit of using health care services, relationships with health care providers, trust in the medical service system, and the economic situation (Ibrahim, Popoola, Oludara, Omodele, & Fadeyibi, 2011;

Ibrahim & Oludara, 2012). The habit of health care services utilization may also include the habit of using traditional healing houses, prayer centers, spiritual healing homes, herbalists, and engaging in self-care (Facione & Facione, 2006; Ibrahim & Oludara, 2012).

1.11.3 self-care. Some women engage in self-care practices with the hope that the breast ill-health signs will gradually resolve. Such self-care activities include applying antibiotic ointment to cure ulceration on the nipple, changing bra to correct pain under the breast, washing the nipple to clear secretions, rubbing hardened areas to soften the tissues, applying heat to painful skin areas, and pulling the nipple to correct nipple inversion (Facione, 1993; Lierman, 1988). Many women tell someone close to them about their breast symptoms shortly after discovery. Others do not. Those who disclose their symptoms are less likely to delay seeking help (Facione, 1993). According to Lierman (1988), the way a woman responds to the experience of breast ill-health may impact her decision about when and where to seek care and treatment. Her reaction and choice of health-seeking behavior may also impact her illness trajectory.

1.11.4 poverty. In a systematic review of the literature conducted by Sharma, Costas, Shulman, and Meara (2012), poverty was identified as the major factor contributing to delayed patient presentation of breast cancer in developing countries. Traveling away from home, family work responsibilities, and the high cost of diagnosis, and treatment constitute significant challenges for the poor. A study by Adisa et al. (2010) indicated that, in Nigeria, patients' inability to afford treatment was the single most important reason why patients could not complete their scheduled cycle of chemotherapy treatment for breast cancer. According to the authors Adisa et al. (2012), poverty might also be responsible for why patients chose faith or

traditional treatment over orthodox therapy. These patients engaging in traditional and faith healing methods might perceive these other options to be cheaper.

1.11.5 geographical access to care. The economically disadvantaged population usually reside in rural areas. When the healthcare delivery centers and physicians are not easily accessible in a geographical area, breast cancer screening, diagnosis, and treatment become more difficult. Therefore, women residing in disadvantaged communities may be required to travel long distances and endure long waiting times to access breast cancer screening and treatment facilities. Long travel time, public transportation hassles on bad roads, and inconvenient hours of medical facilities operation all can prevent women from regular visits to healthcare facilities (Adisa et al., 2010).

In low-middle income countries, healthcare facilities are typically located in urban centers (Sankaranarayanan et al., 2010). According to Schroen et al. (2005), distances as short as dozens of kilometers from the patient's home to the radiation therapy center could result in lesser use of radiation or fewer daily treatments per patient treated. In a country like Nigeria, geography or spatial accessibility to breast cancer treatment centers represent real obstacles (Oluwatosin, 2010). For example, cancer treatment such as radiation are only available at a few locations nationally and often only in the cities. For poor people, the cost of traveling may drain any financial reserves before the first cancer treatment is even initiated. Therefore, late-stage metastatic breast cancer presentation is still common (Oluwatosin, 2010).

Approximately 70-80% of women living with breast cancer in Nigeria, present with an advanced stage of the disease, stage III or IV. At this advanced stage, breast-conserving surgery is very difficult to realize (Adesunkanmi et al., 2006; Adisa, Lawal, & Adesunkanmi, 2008; Adisa et al., 2011; Azubuike & Celestina, 2015; Chiedozi, 1985; Ekanem & Aligbe, 2006; Ikpatt,

Kuopio, & Collan, 2002; Nggada, Yawe, Abdulazeez, & Khalil, 2008). Delays in seeking timely, appropriate treatment could result in advanced stage breast cancer, which has been connected with the poor prognosis of breast cancer survival in Nigerian women living with the illness. The advanced disease stage presentation could be due either to patient-related factors or health system-related factors. Patient-related factors could be due to economic status, lack of knowledge about breast diseases, and ignorance of the most appropriate health-seeking behaviors for the management of breast cancer. Health system-related factors could be due to the healthcare provider's characteristics, the waiting time for diagnosis and treatment of cancer, and lengthy referral protocols (Adesunkanmi et al., 2006; Ogunkorode et al., 2017; Pruit et al., 2015; Roy, Naher, Alam, Hanifa, & Sarkar, 2015).

In 2012, 27,304 cases of breast cancer were diagnosed in Nigerian women while 13,960 deaths were recorded (WHO, 2013b). In 2018, 26,310 cases of breast cancer were diagnosed in Nigerian women, while 11,564 deaths were recorded (Globocan, 2018). Comparing the statistics from Globocan 2012 and 2018, some improvements have been observed on the survival rates from breast cancer among Nigerian women, however, these statistics indicate that a significant number of women are dying from breast cancer. Breast cancer in Nigerian women accounts for 37% of all types of cancer (WHO, 2018). The current study concentrates on women presenting with stage III or stage IV breast cancer and would be classified as presenting with the advanced stage breast cancer and be regarded as late or delayed presentation.

1.12 Researcher's Role

The low survival rate from breast cancer in Nigerian women came to my attention while I was practicing as a bedside nurse and nurse educator for about 33 years in Nigeria. The impetus to conduct this study, therefore, arose out of the desire to acquire further knowledge and

understanding that could inform strategies which could be incorporated into nursing and other health care plans, with the goal of improving treatment outcomes of Nigerian women living with the illness.

The researcher is often regarded as the research instrument in qualitative research because, she or he is involved in all the stages of the research process from the conception of the study to its conclusion (Patton, 2008; Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014). Because qualitative research study is value-laden, biases are inevitable. The researcher's values influence the decision about what to study, how the topic could be studied, and how the data could be collected, analyzed, and interpreted. The researcher's values impact the selection of the paradigm and the substantive theory to guide the study. As the researcher and the research instrument in this study, and according to the literature, I have ensured in my decision-making internal consistency, value fit, and compatibility among the choice of the research problem, paradigm, methods, and context (Guba & Lincoln, 1982). Key to the researcher's role is to ethically engage in reflexivity to explore personal biases and the possible influence of these on the interpretation of the data. I have engaged in reflexivity through self-critique, which has helped me to be aware of and acknowledge my values and perceptions throughout the interview and data analysis process. As Creswell (2007) and Thorne (2016) advised, I have ensured that the findings have their origin in the data.

I have considered my philosophical orientation. I believe each person holds his or her own subjective truths and meanings based on their experiences in the world as further described in section 1.14 below. I have also considered my disciplinary assumptions, and my personal relationship to the subject under study before embarking on the study. These allegiances have informed the analytic lens, with which I have distinguished relevant patterns within the data. As

suggested by Thorne (2016), these allegiances have kept me focused throughout the data analytic pattern recognition. By accepting the possibility that all the variations in an unfolding theme might not have been captured, I have challenged myself and probed the analysis by inquiring about what else might be there to be seen and how it might be discovered.

It is important to note that I share the same ethnic background with the study participants. I also share the same local language, music, and cultural heritage with them. Their concerns are my concerns. I am passionate about women health issues. I long to see the time when the survival rate of breast cancer in women will be 100%.

1.13 Researcher Expertise

During my practice in Nigeria as a nurse educator, I completed a Master of Education and Doctoral studies in Guidance and Counselling. For my Master of Education and Doctoral Studies, I carried out two quantitative studies as part of the requirements for the two degrees. Thereafter, I practiced as a hospital counsellor in the State Specialist Hospital. During my practice as a hospital counsellor, I had the opportunity to develop my interviewing skills. Training and practicing as a guidance counsellor also helped me to develop active listening and clarification skills during interviews, skills that are important to becoming a qualitative researcher.

A further point of learning was during my Master of Nursing training. My supervisor and an experienced university librarian helped me to develop my expertise in conducting literature searches which led to the completion of my thesis, presentations of my research findings at international conferences, and the publishing of the results. These learning experiences helped me to build skills necessary to undertake this doctoral study.

1.14 Reflections on Being a Researcher

My experiences as a nurse for about 38 years and my religious calling as a Nun cannot but influence and shape the conduct of this research. My experiences as a nurse have varied and include practicing as a bedside nurse in a medical surgical unit, as a nurse educator, as a clinical nurse, as a hospital counselor, and as a parish nurse. My experiences also include several other personal and religious calling experiences, such as home visitations to the sick, and counseling services in the parish. I have a strong passion for everything I believe in and especially for women's issues particularly women's health issues.

I ascribe to the constructivist naturalistic orientation. I believe in patient-centered care; that the nurse should work collaboratively with patients and their families to maintain or improve the quality of life for all. I believe like Creswell (2007) and Thorne et al. (1997), in multiple realities where all people hold their subjective truths and meanings; based on their experiences in the world. Working with student nurses as a nurse educator, I very much enjoyed interacting with the students', listening to the questions that came from their inquiring minds, and answering their challenging questions. I also have passion for impacting knowledge and contributing to the development of future nurses. The assurance that I can make a difference in our nursing profession continually rekindles my passion for nursing, energizing me to continue to develop myself by engaging in further studies at a higher level. My work with different women's groups, especially the Catholic Women's Organization, Widow's Association, and the Family Fellowship Prayer Group, helped to deepen my passion for women health issues.

Because I believe that the knower and the known cannot be separated, it was important for me to position myself within this research because of the influence I had on the outcomes. Throughout the process of collecting and analyzing the data, and the process of writing about the

data, I had to reflect on myself and what the Lord is calling me to do for humanity by granting me this golden opportunity of conducting this research study. I believe the method chosen was appropriate, given the nature of the study. My reasons for arriving at this conclusion relate to the nature of the data I was able to collect.

In-depth personal interviews using open-ended questions was the primary means of data collection. I found this design very helpful because I was able to develop a relationship with the participants. I also became familiar with their situations as I sought to interpret their behaviors and experiences. I found that the open-ended questions used during the interviews enabled me to explore the variety of beliefs, perceptions, and the factors that influence the participants' health-seeking behaviors. I found that a strength of these kinds of questions is that they do not limit the responses. Through these questions, I was able to probe the participants' illness trajectory experiences and stories in ways that led to more profound understanding of their health-seeking behaviors and the factors that they believe influence their participation in these health-seeking activities. The interviews also, gave me the opportunity to probe the meanings, values, assumptions, and contextual issues connected to the participants' perceptions.

In addition to the methodology and being a researcher, it provided opportunities for me to reflect on my calling as a religious and as a nurse. The two callings go together. For example, while conducting the study, I became aware of the depth of passion I had for each participant's story. I believe that participants trusted me, and that they were willing to share their experiences with me. Some of them even expressed the willingness to collaborate with me in starting a non-governmental organization to address the issues relating to breast cancer in women whenever I would be ready to do that.

The fact that I was of the same culture, race, and ethnicity as the participants perhaps

made it easier for the participants to see me as one of them and open up in discussing their health issue. Most of the participants faced financial challenges in sourcing funds for chemotherapy and radiotherapy, and for some, these challenges were ongoing. This was a dilemma for me, as I could not offer any assistance except to share information I had received from other breast cancer patients as to how they got help for their drugs and other breast cancer treatments.

I was also amazed by the interest shown by the nurses, doctors, and other workers at the hospital where I collected the data, by the encouragement and support of my religious community, and the interest of my friends in my research study. Individuals who heard about the study were interested in this subject, mainly because breast cancer had caused these people sorrow for the death of young, vibrant, and promising young people, who were in the active phases of their social, economic, and reproductive developments. The faces of the women who shared their experiences, stories, hopes, and fears will remain part of me. My main goal as a nurse researcher is to improve the lives of individuals and families experiencing challenges with health or illness. I am left with thoughts about the next steps in actualizing my passion for the relief of suffering in women and the community at large.

1.15 Research Questions

The first purpose of this study was to explore and identify the health-seeking behavioral patterns of Southwestern Nigerian women with advanced breast cancer from the women's perspectives. The second purpose was to identify and understand the factors that the women believe influence their health-seeking behaviors. The research questions that guided the study were as follows:

- 1) How do Southwestern Nigerian women presenting with breast ill-health describe their health-seeking behaviors?

- 2) What factors do Southwestern Nigerian women presenting with breast ill-health believe influence their decisions to engage in any health-seeking behavior?

1.16 Significance of the Study

The survival rate of breast cancer in Nigeria is 56%, while the survival rate of breast cancer in Canada is 81% (GLOBOCAN 2018; WHO, 2018). WHO (2013b) has made an urgent call to all stakeholders in developing countries to intensify efforts at bringing the survival rate of breast cancer in line with the progress made in more developed countries. In Nigeria, late presentation of breast cancer, lack of adequate technology to handle the illness, and limited treatment options have been assumed to be among the factors responsible for the low survival rate of the disease. Exploring and understanding the health-seeking behaviors of Nigerian women with advanced breast cancer may help to identify the steps the women take when they perceive that they have breast ill-health. It may also enable the nurses and other health care providers to understand the factors that influence women to engage in any health-seeking behavior. A research-informed understanding has the potential to assist nurse clinicians in identifying critical areas and points where there might be delays in seeking competent care for breast cancer. Understanding the health-seeking behavior of women with advanced breast cancer has the further potential to empower nurses and other healthcare providers to develop, and implement, efficient and contextually appropriate strategies and interventions that could shorten presentation times. Early presentation, diagnosis, and treatment of breast cancer increases the probability of improved treatment and management outcomes.

I was unable to locate a single source in the literature on the health-seeking behavior of women presenting with breast ill-health from Southwestern Nigeria, the region for this study. Indeed, there was no information about health-seeking behaviors of women presenting with the

advanced stages of breast cancer in Nigeria itself. This study addresses a population not previously studied in this topic area. Therefore, this study has contributed to filling an existing gap in the literature. The findings from this study have brought to light factors that influence the health-seeking behavior of Southwestern Nigeria women and the other processes they go through before presenting for medical care. The study has uncovered some of the various factors influencing women's health-seeking behaviors with respect to benefits and dangers. The proper understanding of the factors that influence the timing of presentation may assist nurse clinicians in identifying key areas that impact the delays in seeking competent and effective care.

The findings resulting from this study might contribute to the holistic management of breast cancer in Southwestern Nigerian women. The outcome might also serve as the foundation for other future research studies in this knowledge domain. Pertinent issues that have arisen from this study might serve as resource materials that future researchers might consult for more information and ideas to replicate or build on.

Whether or not the health-seeking behavior is the source of women's delayed presentation of breast cancer resulting in low breast cancer survival rate, it contributes to the solution to the problem. The study findings also indicated the need for some policy development for the holistic management of breast cancer in Southwestern Nigeria. Behavioral solutions do not require advanced technology. They are not expensive to implement. Health-seeking behavioral solutions are practical and achievable in a developing country like Nigeria. Understanding the health-seeking behavior of Southwestern Nigerian women with advanced breast cancer might significantly improve the nursing care and other healthcare-related management of this population.

1.17 Organization of the Dissertation

This is a manuscript-based dissertation, in which the main findings are incorporated into four manuscripts. Chapter one is the introduction to the dissertation. Chapter two contains the literature review. The third chapter presents the research design and methodology. The fourth chapter presents manuscript one, which presents the study protocol. It serves as a summary for the methodology employed in conducting the study. The manuscript will be presented to the International Journal of Qualitative Methods for publication. The fifth chapter includes discussions on the suitability of the health belief model, a model developed within a Western context, and the conceptual framework adopted for the study, to explore the health-seeking behaviors of women with advanced breast cancer in an African context. This manuscript will be presented to the Nursing Outlook Journal for consideration for publication. In chapter six, I present manuscript three, in which I discuss the findings of the interpretive description study on the health-seeking behavior of women with advanced breast cancer in Southwestern Nigeria. This manuscript will be presented to the International Journal of Nursing Sciences for consideration for publication. In chapter seven, I present another outcome of this study, a manuscript on the factors influencing the health-seeking behavior of women with advanced breast cancer in Southwestern Nigeria. This manuscript will be presented to the International Journal of Nursing Science for consideration for publication. In chapter eight, I present manuscript four, on one of the major findings of this study: seeking divine intervention to manage breast cancer. This manuscript will be presented to Cancer Nursing for consideration for publication. Each of the manuscripts has an accompanying reference list. All the members of my advisory committee have indicated their willingness to be co-authors to the manuscripts. In chapter nine, I present the summary of the discussions, implications for nursing practice, nursing

education, ideas for future research, policy recommendations, strengths and limitations of the study, recommendations, and conclusions. Appendices include supporting information, such as ethical consent certificates, participants' consent documents, interview guides, and findings.

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Chapter 2 LITERATURE REVIEW

The review of the literature is integral to the research planning activities in preparation for conducting an interpretive description study. First, the literature review enables the researcher to know the “state of the science” with regards to the phenomenon under consideration (Thorne, 2016, p. 63). Second, the literature review gives insight into who had already studied the phenomenon under consideration, how it was investigated, the challenges encountered in studying it, and how the problems were resolved (Thorne, 2016). Finally, through reviewing the literature, the researcher decides if the phenomenon under consideration is worth exploring, and if it is, uses the review to justify the need for the study.

The search for articles on the health-seeking behaviors of women presenting with advanced breast cancer in Southwestern Nigeria was performed systematically with the assistance of an experienced university librarian. Different databases were used, including Cumulative Index for Nursing and Allied Health (CINAHL), Excerpta Medical Database (Embase), Medical Literature Analysis and Retrieval System Online (MEDLINE), and Google Scholar. The references list of papers identified were perused to find other relevant research studies. The search involved a multistage screening. The keywords used were breast cancer, breast neoplasm, “health-seeking behavior?r*”, health behavior?r*, health-related behavior?r*, attitude to health, women, Africa, Nigeria, and Southwestern Nigeria. The review began with a global scope, then concentrated on Nigeria, and Southwestern Nigeria, as presented in Table 2.1

Table 2.1 Library Search Operation

No	Search command	CINAHL articles	MEDLINE articles	EMBASE articles
1	“Health-seeking behavior?r*”	285	1,383	2,667
2	Health behavior?r*	34,739	43,655	55559
3	Health related behavior?r*	583	2,542	3,256
4	Attitude to health	33,177	81,612	96,353
5	Breast cancer	59,522	257,664	311,952
6	Women	14,023	14,656	7,594,489
7	Africa	6,161	27,634	57,248
8	Nigeria	5,253	25,683	32,940
9	Southwestern Nigeria	85	345	585
10	1OR 2 OR 3 OR 4	64,497	122,122	147,417
11	10 AND 5	1,584	2,963	1,538
12	11 AND 6	61	180	1,107
13	12 AND 7	0	0	3
14	11 AND 8	14	2	14
15	11 AND 9	0	0	0

The search for studies on the health-seeking behaviors of women with breast cancer in Southwestern Nigeria yielded no articles on CINAHL, MEDLINE, and Embase databases. The articles obtained under the search for the health-seeking behaviors of women living with breast cancer in Nigeria (Search number 14 above) were mainly related to knowledge of, attitude to, and the practice of breast self-examination. These topic areas are not directly relevant to this

study. Using the same keywords, articles were searched using Google Scholar. Some studies on health-seeking behaviors in the context of other illnesses in some other parts of Nigeria and other developing countries were obtained. These other studies were drawn on to guide this study of the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria.

2.1 Health-seeking Behaviors

Health-seeking behaviors refer to the activities in which an individual engages for promoting health, curing disease, and restoring health and well-being when the individual perceives that she or he is having health issues, or after the diagnosis of illness (Egbunike, Egboka, & Nwankwo, 2016; MacKian, 2003). Those who engage in health-seeking behaviors are likely doing so to enjoy well-being. Health-seeking is not a one-time, isolated event. Health-seeking behavior is a state of being, which is an integral part of daily life, and connected with the identity both of individual's and community's. It involves a person's social, personal, cultural circumstances, and lived experiences (MacKian, 2003, 2004; Poortaghi et al., 2015). Moreover, health-seeking behavior varies according to the type of disease (MacKian, 2003). At points of crisis, an individual's health-seeking behavior is brought into sharper focus (Mackian, 2004).

Health-seeking is one of the factors that determines the uptake and outcomes of health care. Health-seeking concerns factors that can either encourage or hinder people from making healthy choices in their lifestyle and their search for medical assistance and treatment (Facione, 1993). Health-seeking and its related activities and behaviors are influenced by culturally recognized signs and symptoms of illnesses and their associated interpretations. Therefore, health-seeking behaviors can be better understood within a cultural context (Facione, 1993, MacKian, 2002; Mackian, 2004).

2.2 Factors Influencing Health-Seeking Behavior

Health-seeking behavior is a multidimensional, contextual, and interactive concept (MacKian, 2003; Poortaghi et al., 2015). Many complex factors, such as socioeconomic status, gender, age, type of illness, access to healthcare services, and the quality of healthcare influence an individual's health-seeking behaviors and activities (MacKian, 2003).

Several studies have investigated the factors influencing health-seeking behaviors and activities. As part of a larger study investigating acculturation and health-seeking behavior of Filipino Australians, Maneze, DiGiacomo, Salamonson, Descallar, and Davidson (2015), grouped the health-seeking behavioral patterns of the migrants into individual, sociocultural, and environmental factors, and access to healthcare services. Individual factors included healthy eating, exercise, employment, financial status, social support networks, and spirituality. Sociocultural factors included attitudes, the meaning of the illness, beliefs, social and cultural identity, and traditional practices. Environmental factors included clean and peaceful environments. Access to health care services included the ease or difficulty encountered with contacting the healthcare system and facilities. In similar research, Majaj, Nassar, and De Allegri (2013) conducted a qualitative study, to understand the health-seeking behaviors of Palestinian women in the Occupied Territories. The factors influencing health-seeking behaviors identified by the study participants were sociocultural factors, such as gender roles both within and outside the family circle, and health system organizational factors, including the quality of care, accessibility to a healthcare facility, and financial affordability of health services. The results of Majaj et al. (2013) also showed that significant others such as husbands, children, and in-laws were instrumental in enabling women to engage in health-seeking activities and behaviors by offering encouragement, support, and assistance.

In related study, Egbunike et al. (2016) during a descriptive research designed study sought to ascertain the health-seeking behaviors of pregnant women attending antenatal clinic at selected primary health centers in Eastern Nigeria. Like Majaj et al. (2003), the authors identified spousal and significant others' opinions and decisions as being instrumental in health-seeking behaviors. In common with Majaj et al. (2013) and Maneze (2015), Egbunike et al. (2016) found other key influencing factors to be, financial capability, affordability of healthcare services, accessibility, and the perceived effectiveness of the care providers. Thus, all these studies have identified similar factors that influence health-seeking.

In a case study of one family residing in Tripuri, India, to understand why women opted for institutional delivery as opposed to the use of the conventional traditional birth attendant services in India, Oberoi, Chaudhary, Patnaik, and Singh (2016) identified provider-based concerns, caretaker perceptions, and biological signs and symptoms of the ill-health as other factors influencing health-seeking activities of the women. According to the authors, all these factors work together interactively to contribute to a framework of health-seeking behavior.

2.2.1 sociocultural factors. Cultural beliefs, perceptions, cultural practices about the cause of illness, and the status of women may contribute to the pattern of health-seeking activities. If individuals perceive a certain illness to be unrelated to biomedical causes, they may be less willing to seek medical care (Abubakar et al., 2013; Donkor et al., 2015; Maneze, 2015).

2.2.2 age. Bish, Ramirez, Burgess, and Hunter (2005) systematically reviewed the literature to understand why women delay in seeking help for breast cancer symptoms. They found that older women, aged 65 years and above, might have difficulties in identifying symptoms of breast cancer and the associated risk factors. Some of the study participants perceived fewer personal risks of developing breast cancer. Some held more negative beliefs

about breast cancer treatments. Some also exhibited great concerns about disability, disfigurement, and adverse economic consequences.

2.2.3 family. Individuals such as heads of families, husbands, and religious leaders, are highly esteemed and trusted in the community (Abubakar et al., 2013). Therefore, a woman with breast cancer might readily accept suggestions from these individuals to engage in a specific health-seeking behavior. Refusals to obey suggestions from social authorities could result in family chaos (Abubakar et al., 2013; Donkor et al., 2015). The family can influence when and where family members engage in a health-seeking behavior (Abubakar et al., 2013). In some communities, husbands make the final decision regarding where and when their family members engage in a health-seeking behavior. The legitimacy of this role is grounded on their positions and responsibilities as heads of the family and their power as the ones who provide funds for health care and treatments (Abubakar et al., 2013).

2.2.4 social relations and networks. Social relations and networks refer to various formal and informal social relationships surrounding an individual (Pescosolido, 1992). Formal and informal social networks include family, friends, co-workers, and religious congregation members (Pescosolido, 1992). These social relations and networks influence health-seeking through social support, influence, fellowship, caring, persuasions, information giving, and financial assistance (Donkor et al., 2015; Pescosolido, 1992).

2.2.5 access to healthcare. Access to healthcare has two dimensions. The first dimension relates to physical access. In situations where women must travel long distances to access health care services, obstacles arising from the financial implications, discomfort, and other social and family roles might deter women from seeking medical care. The second dimension relates to economic and financial issues. In many African countries including Nigeria,

patients are required to pay-out-of-pocket for medical expenses (Ezeome, 2010). Out-of-pocket payments for cancer care could result in low and middle-income households incurring catastrophic expenditures, forcing them into poverty (Ezeome, 2010; Pruitt et al., 2015). The high cost of health care might constitute a barrier that discourages people from using some health care services (Chauhan, Kandan, Purty, Samuel, & Singh, 2015; Donkor et al., 2015; Omotoso, 2010).

2.2.6 lack of trust in the health care system. The perception of individuals concerning the quality of health care services influences whether they will use these services. If people perceive that the health care center provides adequate care, they are more likely to patronize the center for health-seeking services (Chauhan et al., 2015). Lack of trust in the healthcare system in a developing country like Nigeria might also result from difficulty with or lack of access to quality health care resulting from the absence of human resources for cancer prevention, insufficient management and control, lack of adequate infrastructure, and other institutional barriers and obstacles (Ezeome & Anarado, 2007).

2.3 Health-Seeking Behavior Decision-Making Process

Health-seeking behavior is a recurrent process (Igun, 1979). Igun (1979) proposed a model consisting of 11 stages of a health-seeking behavioral process. The model describes the process of health-seeking from the initial recognition of signs of illness through to the moment when care is sought. However, MacKian (2004) observed that the model excludes the factors that predispose the individual towards making decisions about health-seeking behavior. When individuals see themselves as ill, they engage in decision-making before undertaking any health-seeking activity. The decision-making process is often influenced by the individual's immediate family members, close friends, and other social networks, and is frequently guided by personal

and household behaviors, community norms, and healthcare provider characteristics. The decision-making process involves weighing up social, economic, practical, cultural, and personal factors. Because health-seeking behavior decision-making is a reflexive and purposeful action (Olenja, 2003), it is not homogenous. Cognitive and non-cognitive factors shape an individual's health-seeking activities. Beliefs, along with socio-cultural, political, and economic factors, all influence the context in which individuals engage in health-seeking behaviors (Adegoke, 2007; Olenja, 2003).

Health-seeking could also be regarded as a conditioned behavior. When people perceive that they are ill, the actions they take in dealing with the illness have implications for the progression of the disease. Therefore, there is a need to understand the motivation behind engagement in such behavior (Bentur, Stark, Resnizky, & Symon, 2014). Seeking health intervention promptly to resolve a health issue is essential for appropriate and effective management of the disease. The identification of any impediments to timely and optimal health-seeking decision-making and behavior could greatly contribute to reducing the impact of a severe illness. When the factors shaping decision-making and behavioral practices are understood, interventions can be successfully planned and introduced into people's lives (Bentur et al., 2014). Adverse outcomes can result from delays in obtaining proper diagnosis and care. Prompt attention can reduce the complications that can arise from not engaging in timely and optimal health-seeking behavior (Afolabi, Daropale, Irinoye, & Adegoke, 2013). Knowing and understanding the factors that influence decision-making and health-seeking behavior is, therefore, critical to formulating and providing timely and effective patient-oriented intervention (Olenja, 2003).

2.4 Conceptual Framework

The theoretical framework adopted for this study was the Health Belief Model (HBM). The HBM is a health behavior model developed in the 1950s by social psychologists Hochbaum, Rosenstock, and Kegels (1952) while they were working in the US Public health services. The HBM explores the motivation, perception, and the circumstances confronting the behaving individual (Rosenstock, 1974). The model was developed to understand why people were not using relatively free health preventive screening and services for the early detection of non-symptomatic diseases, first for tuberculosis and later for cervical cancer, dental disease, rheumatic fever, polio, and influenza (Rosenstock, 1974b). The model was eventually extended to study peoples' responses to symptoms and their behaviors in responses to diagnosed illness, in particular, adherence to medical regimens (Becker, 1974; Glanz, Rimer, & Viswanath, 2008). In the 1950s, free or almost free tuberculosis screening programs were provided in the US for adults. When few adults used these programs, the organizers investigated why more adults did not present themselves for the free screening services. Hochbaum (1958), began to study what motivated the few who did use the services. Using questionnaires and interviews as research instruments for the investigation, Hochbaum (1958) learned that persons' perceived risk of disease and perceived benefits of action were essential factors in their motivation (Rosenstock, 1974a).

2.5 The Philosophical Underpinnings of the HBM

According to Rosenstock (1974b), the HBM's main components involve motivating factors and the perceptions of the individual involved. Rosenstock (1974), identified the HBM as a value-expectancy theory, which views behavior as a function of the value placed on an outcome and the probability that a specific health-related action will result in that outcome

(Rosenstock, 1966; 1974b). This value-expectancy theory approach to health-seeking views the acceptance of a health-related behavior as a function of the personal desire to lower the susceptibility to, and the severity of illness, and an estimation of the benefits minus the costs. Thus, the value of the health-related behavior to the individual lies in its potential to lower the individual's perceived susceptibility to a particular illness or reduce the consequential severity of the illness (Maiman & Becker, 1974). Rosenstock (1966, 1974b) contends that an individual's perception of her or his current situation determines whether she or he will engage in a health-related behavior. Historical viewpoints or past experiences play a role only if they typify the present situation.

The philosophical orientation of the HBM was impacted by the theories of Kurt Lewin (Rosenstock, 1966, 1974b) According to Lewin's theory, an individual exists in a cognitive life space (Rosenstock, 1966, 1974). Regions within the life space consist of positively valued regions, also referred to as the positive valence, negatively valued regions, also referred to as the negative valence, and the neutral regions. The negative valence exerts a force that repels a person from that region, while the positive valence exerts a force that pulls or draws a person toward the positive region (Rosenstock, 1974). An individual's daily activities and engagements are imagined and conceptualized as processes pulled by positive forces and repelled by negative forces (Rosenstock, 1966, 1974b). The need to move away from the negative region (negative valence) to a positive region (positive valance) causes a state of tension. According to Rosenstock (1966, 1974), this tension can be reduced either cognitively or behaviorally. A movement towards the positive region occurs if there are no stronger or higher counterforces from that region requiring movement into an even greater negative region (Rosenstock, 1966, 1974b). For example, breast cancer can be regarded as an illness that can push an individual into

a negative valence region. This state can create an uncomfortable feeling and reaction that will motivate the person to engage in health-seeking behavior to get rid of or manage the breast cancer.

The HBM explains health-related behavior from the behaving person's psychological state of readiness to undertake a specific health-related action and the degree to which a particular action is believed to help reduce the tension created by an illness. An individual's readiness to act is influenced by the extent to which she or he feels vulnerable to a particular sign of ill-health; readiness is also affected by the degree to which the individual feels that the illness could have serious adverse consequences. Although, these beliefs are impacted by cognitive and emotional elements, the emotional elements have greater influence than the cognitive or intellectual elements (Rosenstock, 1966). The cues to action deemed necessary for activating the readiness variables contains motivational values; these values trigger individuals to be consciously aware of their feelings and bring them to bear upon the particular health problem (Maiman & Becker, 1974).

Diseases such as breast cancer would represent a negative valence that would be expected to exert a force compelling an African woman to move away from that region. By engaging in health-seeking behaviors to remove the breast cancer, or reduce its impact or consequences, the woman will move toward the positive valence region, unless doing so would require movement into an even greater negative region. However, for an African woman to engage in a health-seeking behavior for breast ill-health, she must believe that she is susceptible to contracting, or has already contracted breast cancer; that the illness is severe; that the breast ill-health could have adverse consequences and inconveniences on some aspects of her life; that engaging in the health-related behavior would help reduce her risk and possible suffering from the illness; and

that such behavior would not involve encountering major barriers and other difficulties.

2.5.1 epistemology. Related to ways of knowing, epistemology concerns the relationship between the researcher and the objects of the study, as well as the knowledge the researcher possesses. In this way, epistemology forms, the basis of the claims to be made (Creswell, 2007). According to Rosenstock (1966), the decision to take a health-related action is influenced by an individual's state of psychological readiness to take the action; her or his socially or individually determined beliefs about the efficacy of available options; psychological barriers to actions; interpersonal influences; and cues or critical incidents that serve to trigger responses.

According to Chrisman (1977), individuals will most likely comply with and adhere to health information that is congruent with or perceived as being related to their needs and beliefs. Therefore, efforts to increase both response and the uptake of health-seeking behavior should consider aiming at: (a) increasing the individual's cognitive appreciation of the effectiveness of a health-related behavior; (b) increasing opportunities to act, thereby enhancing self-efficacy; (c) providing cues to trigger response; and (d) Minimizing barriers to action by reducing inconveniences, for example, by reducing the financial costs of services and distances that have to be travelled to obtain care; and setting hours for services that are convenient (Rosenstock, 1966).

Health decision-making can be seen as a process in which a person moves through a series of phases or stages. The activities undertaken at any of these phases impact the choices made at subsequent stages. Health decision-making is influenced by various personal, interpersonal, and situational factors at any of these stages. Therefore, attempts to encourage people to adopt a health-related behavior might successfully be applied at various points of the decision-making process. Thus, the model, uses a multidimensional and multi-stage approach to

health-seeking.

2.5.2 ontology. Ontology relates to the nature of reality. As perceived by the individual, the nature of reality is subjective (Creswell, 2007). The HBM relies strongly on individual choice. The HBM assumes the motivation to adopt a health-related behavior to avoid illness or reduce its impact is premised upon how strongly a person believes the following:

- a) He or she is susceptible to contracting the illness or has contracted the illness;
- b) The illness could have or is having a serious or severe impact on some aspects of his or her life;
- c) The recommended health-seeking behavior is effective and of value in reducing the susceptibility to or severity of the illness;
- d) The effectiveness of the health-seeking behavior is worth the costs;
- e) The influence of modifying factors is significant.

2.5.3 axiology. Axiology relates to the role of values in research (Creswell, 2007). As a value-expectancy model, the HBM is value-laden. Beliefs and values play significant roles in the philosophy behind the model. Hochbaum et al. (1952) postulated that adopting a health-related behavior is a function of the value the individual places on a particular outcome and the individual's subjective expectation that a particular health-related action will produce the desired outcome (Hochbaum et al., 1952; Maiman & Becker, 1974; Rosenstock, 1966). In this research, the assumption was that values underpin women's expectations or desires for outcomes: the desire that the cancer cells do not spread to other organs or parts of the body, and the desire to get well, the desire to see positive changes, and the desire to be a breast cancer survivor. The belief that the available treatment options prevent cancer metastasis and improve chances of survival may motivate an individual to engage in specific health-seeking behavior.

2.6 Constructs of the HBM

The six constructs of the HBM are perceived susceptibility, perceived seriousness, perceived benefits, perceived barriers, cues to action, and self-efficacy (Rosenstock, 1966, 1974b; Rosenstock, Strecher, & Becker, 1988).

2.6.1 perceived susceptibility. Perceived susceptibility means the subjective or personal risk of contracting an illness. The perception of risk can be measured along a continuum (Rosenstock, 1974). The two extremes represent opposites: individuals who deny the possibility of contracting an illness as opposed to individuals who experience feelings of threat about contracting an illness. The midpoint represents individuals who entertain the probability of its happening but who do not believe it will (Rosenstock, 1966).

The perception of one's vulnerability to a potentially serious disease provides impetus leading to action. The stronger the perceived risk, the higher the likelihood of engaging in health-seeking behavior to reduce the risk. If a woman's family members have been diagnosed with breast cancer and some of them have died from the illness, the woman might seriously consider that she is at risk for contracting the illness as well. Some of the factors that might influence individual perception of susceptibility to breast cancer include education level, family history, personality, social network members, and socioeconomic status (Rosenstock, 1974a). The decision to take a specific action could be influenced by the person's beliefs in the relative effectiveness of the known available options in reducing the illness threat (Rosenstock, 1966, 1974b).

2.6.2 perceived seriousness. Perceived seriousness, which varies from person to person, is judged by the degree of emotional arousal created by the thought of the illness and the kinds of inconveniences and difficulties a person believes an illness could create. Perceived severity

could relate to health outcomes such as reduction in long-term physical or mental functioning, permanent disability, or death. It could also relate to the effect that the illness might have on a person's job, family life, social relations, and other psychological and economic implications (Rosenstock, 1966, 1974b). Perceived seriousness can be greatly influenced by medical information and knowledge (Elvis & Francis, 2015). The combination of the perception of susceptibility and the perception of seriousness leads to perceived threat. The stronger the perceived risk, the higher the likelihood of engaging in behaviors to decrease the risk. Increased perceived threat might persuade an individual to initiate the decision-making process to engage in health-seeking behavior. Health-seeking behavior might include early presentation at the hospital for a timely and optimal diagnosis and management of the breast ill-health.

2.6.3 perceived benefits. The perceived benefits of taking action relate to how beneficial a person believes a particular health-related action to be. The perceived benefits relate to a person's belief about the value, usefulness, and effectiveness of available health-seeking option. What matters is the desire of an individual and the reduction of the illness threat. Perceived benefits also influence the choice of health-related behavior. The choice a person makes is determined by her or his awareness and perceptions about the availability and effectiveness of various health-related actions, not the objective facts about their effectiveness (Rosenstock, 1966). These beliefs are impacted by the norms, values, and pressures of his or her social groups (Rosenstock, 1966). In the case of breast cancer, women must believe in the role of early presentation in increasing the treatment options available to them, and how these can impact improving the survival rate of the illness.

2.6.4 perceived barriers. Perceived barriers relate to obstacles in undertaking specific health-related actions. Actions that are offensive, inconvenient, upsetting, painful, and

distressing could act as barriers to engaging in the health-related actions (Rosenstock, 1966). If the motivation to act is higher than its negative aspects, the action is likely to be taken. However, if the negative aspects are perceived to be greater than the motivation, the action is not likely to be taken. Although, a person may believe that a given action will be effective, she or he may be deterred from engaging in the action due to barriers which might include inconveniences, cost, fear, and pain (Rosenstock, 1966). These negative aspects might arouse a psychological conflict. Such a conflict could be resolved in three ways: 1) if the readiness to act is high, and the barriers are perceived to be weak, the behavior is most likely to be taken; 2) if the readiness to act is low and the negative aspects or barriers are perceived to be high, the behavior might not likely be taken; 3) the resolution of the conflict might be more difficult when the readiness to act is high, and the barriers to taking the action are also perceived to be high. Two possible reactions to the latter situation could occur. First, the person might remove herself or himself psychologically from the conflicting situation by engaging in activities and behaviors that do not reduce the threat. The second possible reaction could be increased fear and anxiety. If the anxiety becomes strong, it might render the individual incapable of thinking critically and making objective decisions (Rosenstock, 1966). For women presenting with advanced breast cancer, the desire to stay alive might transcend any barriers.

2.6.5 cues to action. These are triggers that initiate and encourage appropriate health-related actions. According to Rosenstock (1966), perceived susceptibility and seriousness lead to a state of psychological readiness to act while perceived benefits minus barriers provide a preferred path to action. Cues are necessary because they provide the energy to move a person from the state of readiness to act to actual health-seeking behavior. These cues to action can be internal or external factors. Internal factors are the perceived signs and symptoms of illness,

while external cues may be interpersonal relationships, the influence of significant others, knowing a person who has had the illness, mass media communications, the knowledge that one has become affected, and health promotion messages (Rosenstock, 1966).

2.6.6 self-efficacy. Self-efficacy was proposed as a variable to enhance the traditional health belief model in 1988 (Rosenstock et al., 1988). Self-efficacy relates to a person's ability to carry out a health-related behavior. Self-efficacy has a significant influence on how people feel, think, motivate themselves, and behave (Aghdam, Sanaat, Hassankhani, & Kochaki Nejad, 2013). Improving women's self-efficacy by enhancing their skills may encourage engaging in early breast cancer detection behaviors such as breast self-examination, mammography screening, and presentation for clinical breast examination (Masoudiyekta, Dashtbozorg, Gheibizadeh, Malehi, & Moradi-Lakeh, 2015).

The self-efficacy of breast cancer patients could be improved if health care providers use a variety of learning strategies including lectures, discussions, demonstrations, goal setting, contracting, modeling, and videotapes to provide aid and support to the patients (Masoudiyekta et al., 2015). The involvement of significant others, such as spouses or close family members could help in enhancing the self-efficacy of patients. Self-efficacy reduces the barrier dimensions of the model (Rosenstock, Strecher, & Becker, 1988).

2.6.7 modifying factors. Modifying factors are factors that influence an individual's perception including the following: (1) individual characteristics such as gender, age, and ethnicity; (2) socioeconomic status such as level of education and income; (3) structural variables such as the influence of significant others; and (4) socio-network group members (Rosenstock, 1966). These factors could make various significant contributions to a person's decision-making processes about health-seeking behaviors.

Individual Perceptions

Modifying Factors

Likelihood of Action

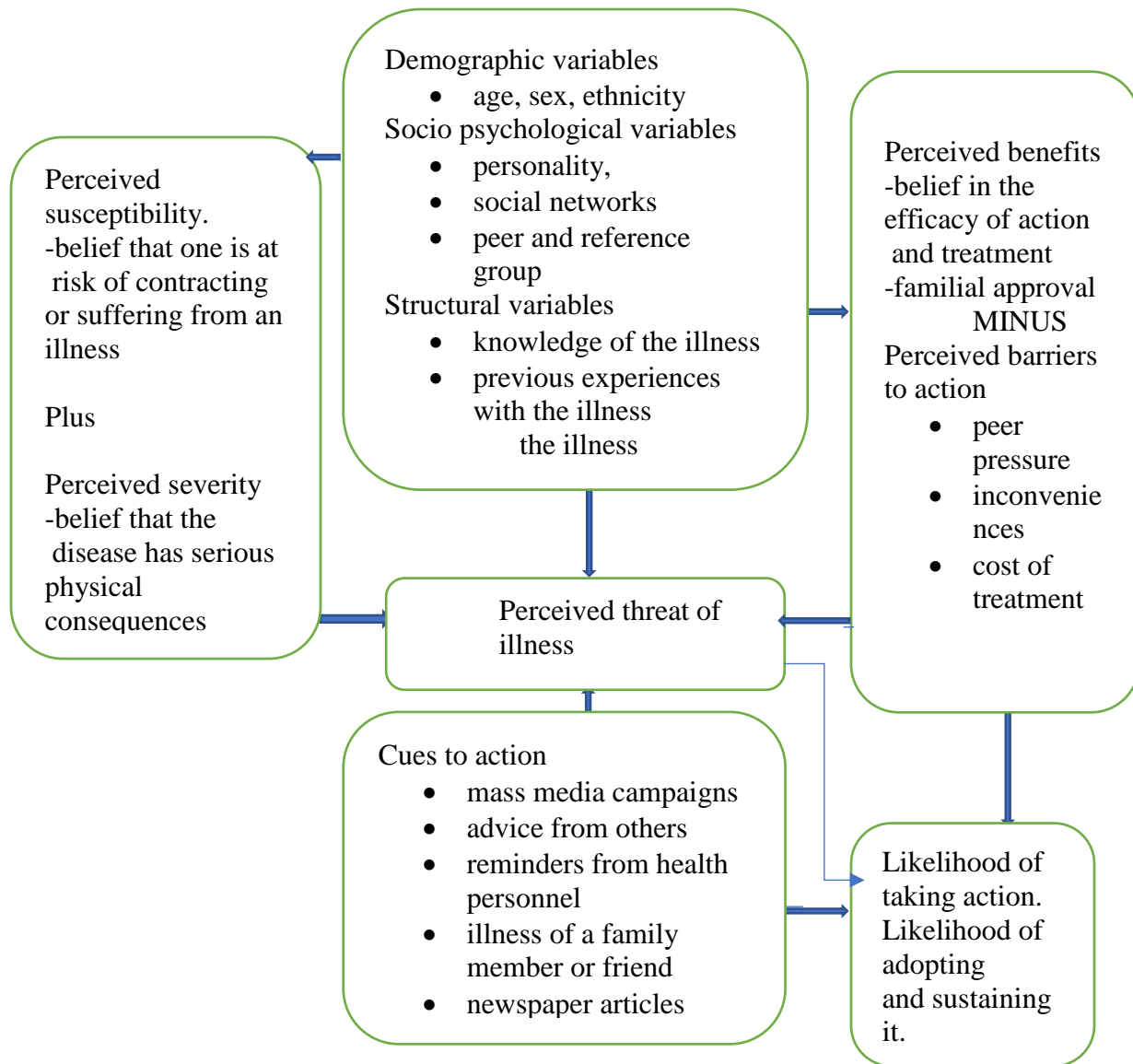


Figure 2.1 The Health Belief Model

The Health Belief Model adapted from Rosenstock, I. M. (1974). Historical origins of the Health Belief Model. *Health Education Monographs*, 2(4), 328-335.

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2.7 Empirical Testing of the HBM in Nursing

The HBM had been successfully applied in nursing to predict health behaviors across

several diseases and conditions. In a quasi-experimental study, Abd El, Abdel-Fatah, and Ibrahim (2016) evaluated the effect of the application of the HBM constructs on pregnant women's knowledge and health belief about pregnancy and urogenital infections. Their findings indicated that the HBM was effective in improving the women's knowledge, health beliefs, and health behavior about preventing urogenital infections. Through regular health education programs based on the HBM, pregnant women increased their awareness of urogenital infection. The HBM was used by Barros et al. (2014) during a descriptive cross-sectional study to identify the lifestyle of hypertensive patients while focusing on the patient's health behaviors. Their findings indicated that the study participants perceived the severity of the disease and felt susceptible to developing complications from hypertension. This perception motivated the study participants to receive timely and appropriate treatments. The authors concluded that the HBM empowered the study participants to adopt healthier lifestyles and that considering patients' perceived barriers during planning could improve nursing care.

Other researches have used the HBM as frameworks. Khani, Jaihooni, Hidarnia, Kashfi, Ghasemi, and Askari (2016), in a quasi-experimental study, applied HBM constructs to analyze the effect of a walking education program on osteoporosis among Iranian women. The study participants increased in their knowledge of the benefits of walking behavior that increased bone density. The study findings indicated that the HBM could be used as a basic framework for designing and implementing educational interventions for women with osteoporosis. Wang et al. (2014) in a randomized controlled trial research used HBM-based nursing interventions to assess Chinese patients with moderate to severe chronic obstructive pulmonary disease. Their findings indicated that nursing interventions based on the HBM improved patients' self-efficacy and health beliefs, which in turn improved the patients' exercise tolerance and performance of

activities of daily living. The authors concluded that these benefits reduce patients' healthcare costs and rates of hospital readmission and recommended that health care providers apply HBM-based nursing interventions to enhance patients' health beliefs, self-efficacy, and health care outcomes.

The HBM has been successfully applied to contribute to nursing knowledge in many other studies. Studies focused on preventive care include those that determine levels of breast cancer self-examination among university students- Ahmadian and Samah (2013); Erbil and Bolukbas (2014); those that assess breast cancer screening behavior of women - Mohmed, Ibrahim, Lamadah, and El-Magd (2016); Petro-Nustas, Tsangari, Phellas, and Constantinou (2013); and Shiryazdi, Kholasehzadeh, Neamatzadeh, and Kargar (2014); those that evaluate school health education for success in injury prevention- Cao, Chen, and Wang (2014); those that analyze the intention to participate in preventive pulmonary tuberculosis chest X-ray examination among indigenous nursing students- Chang, Hung, Chou, and Ling (2007); those that apply the HBM for HIV prevention program- Elvis and Francis (2015); those that apply HBM-based teaching methods to assess the knowledge and self-efficacy of nurses concerning the practice of standard precautions- Ghanbary et al. (2015). Finally, studies have used the HBM in the study of the prevention of cardiovascular diseases- Masoudiyekta et al. (2015), and the management of chronic diseases- Jeihooni, Hidarnia, Kaveh, Hajizadeh, and Askari (2016); Karami et al. (2012).

Janz and Becker's (1984) analysis of the application of the HBM to assess the uptake of influenza vaccine, revealed that perception of susceptibility, severity, and self-efficacy positively influenced the utilization of influenza vaccine. Analysis of the research studies using the HBM constructs from 1974-1984 provided strong empirical support for the appropriateness of the

HBM as a framework for comprehending individual health-related decision-making (Janz & Becker, 1984).

2.8 Operationalization of the HBM Constructs

Champion (1984) developed an instrument to assess the validity and reliability of the constructs in the HBM. The perception of susceptibility, seriousness, benefits, barriers, and cues to action constructs were found to be reliable and valid on Cronbach alpha and Pearson r values. Based on the results of the measuring instrument, Champion (1984) concluded that the HBM variables could be applied with confidence in the development of nursing interventions.

Hashemian, Shokravi, Lamyian, Hassanpour, and Akaberi (2013) conducted a confirmatory factor analysis of the Champion (1984) HBM scale to assess the uptake of mammography screening. The study participants were Iranian women with a family history of breast cancer. The items on the scale were translated into the Persian language. Findings from the study indicated that the Persian version of the Champion's (1984) HBM scale could provide a valid and reliable measure of Iranian women's uptake of mammography screening. The authors concluded that using the HBM constructs to design educational interventions could improve mammography screening practice. In a related research, King et al. (2012) developed a measure of skin care belief scales for persons living with spinal cord injury. The items on the scale were based on the HBM constructs (perceptions of severity, susceptibility, benefits, barriers, and self-efficacy). The findings indicated that skin self-care could be promoted with the knowledge of beliefs about barriers, benefits, and self-efficacy constructs in the HBM. The authors concluded that nursing interventions based on the constructs of the HBM, could improve skin-care behavior in persons living with chronic diseases.

Some other standard tools and measures have been developed and tested for validity and

reliability for the operationalization of the constructs of the model. Some of the tools include the following by authors: Champion, Skinner, and Menon (2005), self-efficacy scale for mammography screening; Champion (1984), instrument development for HBM constructs; Champion et al. (2008), instrument development for the measurement of mammography and breast cancer beliefs in African American women; Champion (1993), instrument refinements for breast cancer screening; Champion and Scott (1997), reliability and validity of breast cancer screening belief scales; Hashemian, Shokravi, Lamyian, Hassanpour, and Akaberi (2013), reliability and validity of the Champion's scale for mammography screening among Iranian women with a family history of breast cancer. These tools have improved the predictive power of the model constructs. The inconsistency observed between some studies concerning the weakness of the perceptions of susceptibility and severity as predictors of human behaviors indicate that future research studies are needed to examine the possibility of the effect of mediation and interactions among the variables as opposed to the current four-variable additive model (Carpenter, 2010).

2.9 Evolutionary Development Proposals

To improve the predictive validity of the constructs, Orji, Vassileva, and Mandryk (2012) proposed an extension of the HBM to include the following variables: consideration for future consequences, perceived importance, self-identity, and concern for appearance. The first variable, consideration for future consequences, measures the effects that the current health behavior and attitudes could have on future health and well-being. Orji et al. (2012) suggested that to be motivated to adopt a new behavior the participant should be able to see a positive long-term effect of the recommended behavior. The second variable, concern for appearance involves the degree to which individuals care about their appearance, attractiveness, and popularity. The

third variable, self-identity involves the perception individuals have about themselves. According to Orji et al. (2012), individuals who sees themselves as health conscious are more likely than others to engage in health-related behaviors. The final variable, perceived importance is related to the value an individual ascribes to the outcome of a particular action or health-related behavior. All these variables, according to Orji et al. (2012) taken together could help in predicting behavior.

In addition to Orji et al. (2012)'s variables that extend the HBM, others have also suggested extensions. In a study of hypertensive patients, King (1982) proposed adding a variable that would measure individuals' understanding of their high blood pressure. In a study of people living with HIV, Reece (2003) also proposed an extension of the HBM variable to include assessments of HIV-related mental health care and of HIV-related stigma. Orji et al. (2012) observed that the extensions proposed by King (1982) and Reece (2003) are disease specific, whereas their extended variables could be applied to any disease, health-related behavior, and health-care.

2.10 Strengths and Weaknesses of the HBM

The HBM was initially developed to explain why people failed to participate in no cost preventive health screening. The model was widely and successfully used to explain health-related actions and behaviors in diverse nursing situations. The HBM has been viewed as a theory of behavior at an individual level of analysis because the model inclines towards individualistic decision-making processes. In the model, the individual has always been treated as the primary unit of analysis (Davidhizar, 1983). The HBM presented an interactive and modifiable framework for decision-making concerning the motivations impacting health-seeking behavior. The decision-making process consists of a series of stages through which individuals'

move when making decisions. In each of these stages, individuals interact with other people and events.

Davidhizar (1983) observed that Rosenstock (1974b) explicitly identified all five constructs of the HBM: perceived susceptibility, perceived severity, perceived barriers, perceived benefits, and cues to action. Each of the constructs was unambiguously and distinctly defined by Rosenstock (1974a). The construct of self-efficacy was added later in attempts to improve the breadth and the depth of the model, and was distinctly defined (Rosenstock, Strecher, & Becker, 1988).

The operational definitions of the constructs of the HBM were neither provided nor linked to specific or concrete situations. Each researcher had operationalized the constructs according to their unique understanding. For example, no two studies using the model's five variables have used the same questions for ascertaining the presence or absence of belief. According to some studies, the lack of uniform operational definitions might be partly responsible for inconsistencies and contradictions (Tanner-Smith & Brown, 2010) and raises the probability that the constructs and attributes being measured could have varied from study to study. Furthermore, the absence of definitions might make it more difficult to compare findings from the different studies.

In a systematic review of the studies using the HBM to investigate the practice of mammographic screening, Tanner-Smith and Brown (2010) provided strong support for the perceptions of benefits and barriers. Weak support however was observed for the perceptions of susceptibility and severity. These disparities with other studies could also be related to the fact that the HBM failed to address contextual constraints that could influence women's preventive behavior. The model places blame on women for not engaging in preventive health behaviors

without taking into consideration many micro-level variables and conditions that adversely influence women's decision to engage in preventive health behaviors (Tanner-Smith & Brown, 2010). Some modifying factors such as sociocultural perception, definition, and interpretation of illness and health issues, all of which could strongly influence individual decision-making processes before adopting a behavioral change have not been included in the model (Davidhizar, 1983).

Several other weaknesses have been detected in the HBM. The universal relevance of the HBM has not been made clear. It has not been explicitly stated if the model can be applied to all different types of diseases or whether the model could be applied to all persons of all ages, cultures, or personality types (Davidhizar, 1983). The HBM does not differentiate between the first-time behavior and repeated behaviors (Davidhizar, 1983).

In addition to the single studies that have detected shortcomings in the HBM, a meta-analysis applying the HBM constructs in research with adults had similar findings. Results from Harrison, Mullen, and Green (1992) showed weak predictive power with regards to health behavior and effect sizes among the constructs of the HBM. The authors concluded that it is premature to have confidence in the predictive validity of perceived susceptibility, perceived severity, perceived benefits and perceived barriers constructs of the HBM. This judgement might be due to the lack of operational definitions or combination rules for the model variables or both (Taylor et al., 2007).

The HBM is a goal-oriented model. Learning is presumed to have occurred when the goals or objectives are quantifiably measured with positive outcomes (Thomas, 1995). However, this method of knowledge evaluation does not allow room for dialogue and sharing, meaning there is no opportunity for an in-depth exploration, understanding, and accurate interpretation of

diversity in human behavior and experiences (Thomas, 1995). In nursing, it is essential to explore these observations with a view to unraveling the subtle, hidden, and diverse meanings of the research participants' experiences. To ensure comprehensive and holistic nursing care, some other additional ways of knowledge acquisition in nursing have been presented by nurse researchers.

2.11 Fundamental Ways of Knowing in Nursing

Nurse researchers have identified other ways of knowing in nursing. Most prominent among these nurse scholars are three to be noted here: Carper (1978b), who identified “esthetic, ethical, and personal” patterns of knowing; Munhall (1993), who identified “unknowing” as another pattern of knowing in nursing; and White (1995), who proposed “sociopolitical” as another way of knowing in nursing. These characteristic ways of knowing present new perspectives for handling health and illness situations in nursing. They present different approaches to providing integrated nursing care.

Carper (1978) identified four patterns that typify specific ways of knowing about nursing phenomena, putting forth the view that the nursing specialty is uniquely characterized by multifaceted ways of knowledge acquisition. These ways of knowing can help the nurse to understand the whole person, thereby, leading to holistic nursing care of clients. These four patterns include empirics or the science of nursing; esthetics or the art of nursing; personal knowledge in nursing; and ethics, the aspect that concerns moral knowledge in nursing.

2.11.1 empirics. The dominant way of knowing in nursing is the empirical way, involving knowledge that is factual and descriptive, and is aimed at developing abstract and theoretical explanations. Interactively developed, it is open to testing and verification through experiment or observation (Carper, 1978). In the current study, previous empirical literature was

used to understand the conceptual framework adopted for the study. Empirical literature was also searched to understand the concept of interest and used to understand the current state of the science of the phenomenon under investigation. The study findings were compared with related previous empirical literature.

2.11.2 esthetic. The esthetic way of knowing is the knowledge gained through the nurse's subjective practical experiences in the performances of manual nursing skills, and so is sometimes referred to as the art of nursing. Because it involves actions taken by the nurse to provide for patients' needs, this way of knowing is active and has the potential to transform the patients' behavior. As such, it entails creativity and style in providing nursing care when it is needed and involves empathic understanding. Because it is so wide-ranging, the esthetic way of knowing makes available to the nurse a vast repository of choices in providing effective and efficient nursing care and leads to the provision of holistic nursing care (Carper, 1978). In the current study, I was present with each participant listening to their stories, assessing their needs at each moment, and meeting the identified needs that were amenable to nursing interventions. Different participants had different needs. Therefore, the needs and cares of the participants were individualized and those participants who needed specialist cares, were referred to the appropriate departments for the needed professional attention.

2.11.3 personal knowing. Personal knowing in nursing involves encountering and actualizing the individual self. This way of knowing emerges from the interpersonal relationship between the nurse and the clients. The nurse uses personal knowledge to establish an authentic relationship with the clients as individuals. In engaging in personal knowing nurses can create themselves as they see fit and perceive others, not as fixed entities, but as beings engaged continuously in the process of becoming. Just as the esthetic way of knowing involves empathy,

so does personal knowing, enabling the nurse to understand health and illness from the patient's perspective. In this way, personal knowing in nursing promotes wholeness and integrity in personal relationships and encounters (Carper, 1978). In the current study, the health-seeking behaviors of the participants and factors the participants believed influenced their health-seeking were explored from their perspectives. The participants were the experts in their health conditions. I was a learner. Therefore, I had to listen actively to what each participant was sharing. I also developed a collaborative inter-professional relationship with other caregivers such as the medical doctors, radiologists, record officers, laboratory technicians, psycho-oncologists, and pharmacists.

2.11.4 ethics. Ethics relates to the moral aspect of nursing. This way of knowing concerns what is morally right or wrong in caring for the patient and focuses on the nurse's obligation concerning what ought or ought not to be done (Carper, 1978). It generates discussions about clients' beliefs and values. Ethical knowing in nursing obliges the nurse to treat the client with dignity and respect (Carper, 1978). All the ethical considerations for the current study were rigorously observed. The participants and their families were treated with respect and dignity. Their values and beliefs were acknowledged non-judgmentally.

2.11.5 sociopolitical knowing. Presented as another way of knowing in nursing by White (1995), sociopolitical knowing concerns the sociopolitical environment of individuals and their interaction within that environment. This pattern of knowing situates the nurse within the broader setting in which nursing care is provided. It also concerns cultural identity and how the client's understanding of health, illness causation, language, personal identity, and connection with the land is influenced by this identity (White, 1995). In the current study, I observed and acknowledged the sociopolitical context of the study participants, which helped to define their

illness situation. The meaning the participants attached to their illness was also interpreted in the light of their sociopolitical environment.

2.11.6 unknowing. Proposed by Munhall (1993), unknowing is a state of openness that allows people with different cultural backgrounds to be taken seriously. According to Munhall (1993), because the intersubjective space allows two people to understand and know each other, unknowing can enable the nurse to understand the essence of the meaning an experience has for a patient. It opens the nurse to the realization that there are always more things to learn (Munhall, 1993). This way of knowing in nursing was incorporated into this study by my listening with keen interest and a non-judgmental attitude to the study participants as they described their health-seeking behaviors, and the factors they believed influenced their health-seeking activities. Non-verbal attitudes were incorporated to encourage the study participants to tell their stories. I used probes to ask for the clarification of the points that were raised.

All these methods and ways of knowing in nursing help to increase the awareness of the complex and diverse nature of nursing knowledge. According to Holtslander (2008), all these ways of knowing in nursing have been successfully used to guide nursing education, research, and practice. They indicate that nursing has the goal of providing exhaustive and integrated care.

2.12 Conclusion

In this chapter, I presented a review of the literature examining the HBM adopted for the study and the concept of health-seeking behavior at length. The HBM constructs have been successfully applied as an appropriate framework for assessing a wide range of health-related behaviors, thus, enabling health care providers to identify variables that act as prerequisites for health behaviors. The model is flexible and can be easily adapted to a great variety of health behavior and populations.

There was scarcity of empirical literature exploring the health-seeking behaviors and factors influencing the health-seeking activities of women with advanced breast cancer in Southwestern Nigeria. Thus, the literature review revealed significant gaps that supported a need for this study to be conducted. The next chapter presents the study methodology.

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Chapter 3 METHODOLOGY

3.1 Relationship of Chapter 3 to the Dissertation

In this chapter, I discuss the methodological approach adopted for the study. Also presented are the research design, sampling strategies, data collection, and data analysis, as well as ethical considerations and the strategies adopted for enhancing rigor or data trustworthiness.

3.2 Methodological Approach

The purpose of the research was to understand the health-seeking activities of Southwestern Nigerian women with advanced breast cancer. A qualitative approach was adopted. Creswell (2007) and Thorne (2016) suggest that qualitative research may be considered under the following conditions: little is known about the problem; the problem has not been previously studied; the participants have personal experiences with the topic; and the participants can and are willing to talk about the issue. Patton (2015) argues that a qualitative approach can help provide data generated in first-hand accounts through interactions with the participants involved. As the researcher in this study, I tried to understand situations as the participants perceived them, thereby, as Patton (2015) suggests, making sense of the behavior. Since little is known about the health-seeking activities of women with advanced breast cancer in Southwestern Nigeria, a qualitative approach was determined to be the best method to answer the research questions.

The qualitative methodological framework adopted for the study was interpretive description (ID), a research approach developed by Thorne, Kirkham, and MacDonald-Emes (1997). This method was chosen because like qualitative research in general, it is considered ideal for subjects on which little has been documented (Thorne, 2016), in this case understanding

the health-seeking behaviors of women presenting with advanced breast cancer in Southwestern Nigeria. Another reason for choosing this method is that it assumes an active role for the researcher, who engages in co-creation of knowledge with the participants who are experts in their subjects (Thorne, 2016). Researchers using this methodology are required to engage in self-reflection and dialogue, through which they identify and consider their own values in interpreting the data (Thorne, 2016).

The ID research methodology was developed within the domain of nursing as a feasible alternative method of generating knowledge grounded in clinical nursing contexts (Thorne et al., 1997). The ID methodology grew out of the conviction that traditional qualitative research methodologies, such as those developed within grounded theory, phenomenology, and ethnography, were not appropriate to address issues of interest to clinical nursing practitioners (Thorne, 2016). The findings from an ID study have their origins in data, but unlike traditional qualitative methodologies, ID researchers are always engaged in the exploration of meanings and explanations that may be applicable in clinical settings (Thorne et al., 2004; Thorne, 2016). Thus, the outcomes of ID studies can inform clinical understanding of phenomena (Thorne, Kirkham, & O'Flynn-Magee, 2004; Thorne et al., 1997).

3.2.1 epistemology of ID. Epistemology refers to how “knowledge is acquired, created, and communicated” (Scotland, 2012, p. 4), and concerns the relationship between the researcher and the researched (Creswell, 2007; Denzin & Lincoln, 2017). In ID, there is a close connection between the researcher and the researched. Through their close collaboration and interactions, they influence each other, co-creating understanding, knowledge, and meaning of the phenomenon being studied, thus, they cannot be separated (Thorne, 2016b; Thorne et al., 1997). In this study, I co-created knowledge with the study participants by listening to the participants’

stories, asking questions for clarification of the ideas being shared, using probes as necessary, and interpreting the participants' shared experiences. In ID, the researcher is recognized as the research instrument. Using the ID approach, the truth is approximated by considering multiple realities and data sources. Personal and experiential sources of knowledge are recognized as authentic sources of research information (Thorne, 2008, 2016; Thorne et al., 1997).

3.2.2 ontology of ID. Ontology refers to what makes up reality, involving and exploring the nature of reality (Creswell, 2007; Guba & Lincoln, 1982). The ID research approach is affiliated with the interpretive naturalistic orientation, which acknowledges that human experience is both contextual and constructed (Hunt, 2009; Thorne, 2008, 2016; Thorne et al., 1997; Thorne et al., 2004). ID acknowledges that reality is complex, local, subjective, and multiple. These multiple realities are to be analyzed and studied holistically (Guba & Lincoln, 1982; Thorne, 2016). ID recognizes that investigation into each of the realities may be different, and that constructed realities may be contradictory. However, both familiar and unique facts are accepted (Thorne, 2016). As much as possible, ID studies are conducted in participant's real-life situations, and ID researchers must pay attention to the conveniences of the study for the participants, and to the standards of correct research conduct (Hunt, 2009; Thorne, 2016). Following the interpretive naturalistic orientation, ID researchers interpret what they find in the field and they explain the meanings others have about their world (Thorne, 2016; Creswell, 2007). They acknowledge that this interpretation is shaped by their own personal, cultural, and historical experiences (Thorne, 2016).

3.3 Research Design

Interpretive description methodology is a flexible, creative, and pragmatic approach. The researcher using ID methodology may have prior insight into the research context. However,

because of the multiple, complex, varied, and unpredictable nature of what is perceived as reality, this prior insight is not sufficient to develop a fixed research design (Thorne, 2016). The logic framework of ID is based on the reasoning and logic applied at each decision-making point in the research process (Thorne, 2016). Thus, this approach allows reasoning to govern actions.

Throughout the research process, I was open to acquiring new knowledge and understanding. This openness included acknowledging common and shared experiences, as well as individual variations, all of which the researcher must consider in ID (Thorne, 2016; Thorne et al., 1997; Thorne et al., 2004). As Thorne (2016) suggests, I concentrated on understanding the meanings of the participants' subjective experiences, which are time and context bound, and on interpreting these meanings in human behavior. Additionally, following the lead of Thorne (2016) and Thorne et al. (1997), I kept it in mind that researchers using the ID methodology can borrow qualitative techniques from other research traditions such as ethnography, phenomenology, and grounded theory as long as the borrowed techniques help the researcher to answer the research question.

ID researchers seek to identify patterns and themes within human personal experiences, in order to determine what is likely to be encountered in future clinical practice and to respond to these future experiences in ways that are relevant and valid (Thorne, 2016). The quality of an interpretive description study depends on the degree of congruence between the research question and this methodology as appropriate and adequate to address the research question (Thorne, 2016).

3.3.1 target population. Nigeria is a vast country, divided into six geopolitical zones: The Southwestern region, the Southsouthern region, the Southeastern region, the Northwestern region, the Northeastern region, and the Northcentral region. To do a thorough study, the

population for this research was limited to women with advanced breast cancer in only one of the geopolitical zones: Southwestern Nigeria.

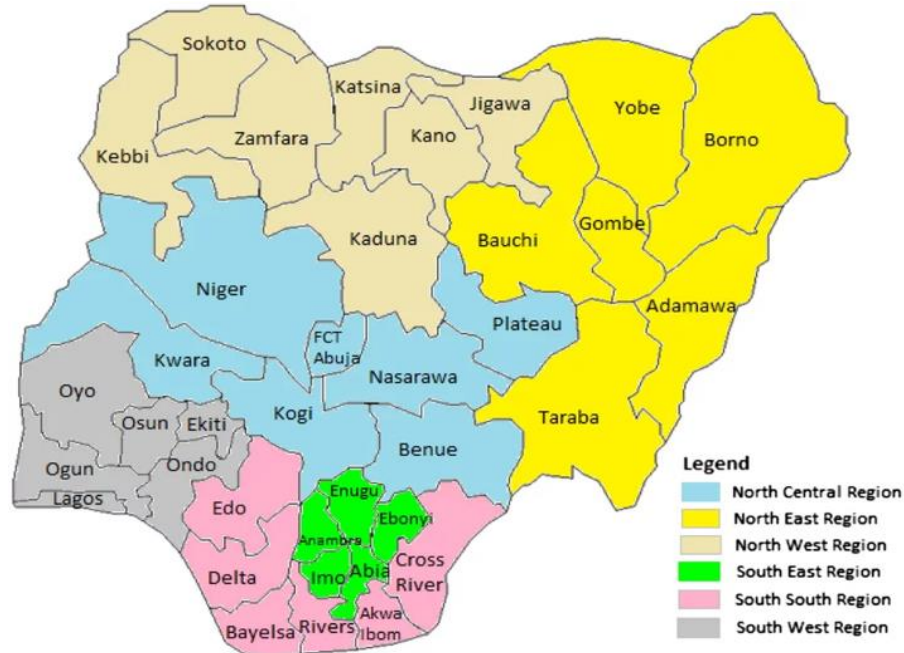


Figure 3.1 Map of Nigeria showing the Six Geopolitical Zones

Google Maps Retrieved from <http://www.naija.ng/1117167-south-west-states.nigeria.html>.



Figure 3.2 Google Maps Retrieved from <http://www.naija.ng/1117167-south-west-states.nigeria.html>.

Southwestern Nigeria is on the Gulf of Guinea, very close to the bay. The northern and eastern boundaries of Southwestern Nigeria are formed by the Niger River. Much of the region is Savanah and tropical forests.

Southwestern Nigeria is made up of six states: Lagos, Oyo, Ogun, Ondo, Ekiti, and Osun, all of which were the focus of this study. Lagos state occupies an area of 3,577 km², with a

population of 9,113,605. Ogun state occupies an area of 16,980.55 Km², with a population of 3,751,140. Oyo state occupies an area of 28,454 Km², with a population of 5,580,894. Ondo state occupies an area of 15,500 Km², with a population of 3,460,877. Ekiti state occupies an area of 6,353 Km², with a population of 2,398,957. While Osun state occupies an area of 9,251 Km², with a population of 3,416,959. The people live in the major cities and villages (Google search, 2018).

The Southwestern region of Nigeria is majorly a Yoruba-speaking region. However, there are different Yoruba dialects among the people of the region. All the regions of Southwestern Nigeria have common climate and weather conditions throughout the year. Southwestern Nigeria has periods of rain in the raining season from March to November and experiences dry season from November to February.

(Retrieved from: <https://www.naija.ng/1117167-south-west-states-nigeria.html#1117167>)



Figure 3.3 Map of Southwestern Nigeria. The States where the Study was conducted

3.3.2 the context of the study. The context of this study was Southwestern Nigeria, where the Yoruba ethnic group dominates. The Yorubas are descendants of a common ancestor Oduduwa (Hughes, 1976; Jegede, 2002). As for religious beliefs, people are mainly traditional worshippers of various gods and deities. For the Yoruba people, there is one Supreme God, the Almighty called Olodumare. The Almighty God (Olodumare) is served by smaller gods who act as intermediaries between the Supreme God and man (Ademuwagun, 1969).

The Yoruba people share a common worldview (Hughes, 1976; Jegede, 2002). For them, nature is filled with religious significance and mysteries, and everything in creation is a carrier of the divine. God is the ultimate creator and controller of all vital forces, but God the Almighty has endowed a few human beings with the knowledge and ability to manipulate and use these vital forces (Ademuwagun, 1969). Some people use these powers positively while others use the powers negatively within their communities and among their fellow human beings.

(Ademuwagun, 1969).

Part of the perception the Yoruba people's worldview is the perception of health, illness, and health-seeking behaviors. They interpret health and illness within their socio-cultural and religious frame of reference (Jegade, 2002). For the Yoruba people, health and illness are two opposing phenomena. Ill-health is an abnormal occurrence that necessitates engaging in health-seeking behaviors to restore health (Jegade, 2002). The Yoruba people perceive unhealthiness to have four sources: the enemy, nature, heredity, and the unknown. All these categories require different health-seeking behaviors (Ademuwagun, 1969; Adegoke, 2007; Jegede, 2002).

The Yoruba people usually start health seeking with the use of home remedies. After trying home remedies, the sick person either goes to the traditional healer or the hospital. They go to the hospital only after their other attempts have failed (Jegade, 2002). Jegede (2002) conducted a qualitative study to explore how study participants defined health and illness and to understand their perceptions of illness prevention and cures. He observed that health-seeking behavior was influenced by the perceived seriousness of the illness. According to Jegede (2002), "illnesses not considered serious were mostly treated with home remedies, while the serious ones were taken to the traditional healer (Babalawo), and more serious ones are taken to the hospital, after all other attempts have failed" (p. 332). This observation suggests that the process of health-seeking behavior starts with self-care and ends with going to the hospital. In an earlier study, Hughes (1976) also observed that the Yoruba people usually use indigenous medicine and patronize the services of indigenous healers before going to the hospital. Thus, both Jegede (2002) and Hughes (1976) confirm that the hospital is usually the last resort in health seeking. As Jegede (2002) argues, the implication of this delay in seeking appropriate care is the worsening of the illness resulting in its presentation at advanced stages and unsurprisingly, leading to high

mortality rates.

3.3.3 setting.



Figure 3.4 University College Hospital, Ibadan. The Setting of the Study

Source: <http://www.google.ca/url/?Uch-ibadan.org.ng>

The research data was collected at University College Hospital, (UCH Ibadan), in Ibadan, Southwestern Nigeria, and the largest city in West Africa. UCH Ibadan is a Federal Government hospital established in 1952 to train medical personnel and professionals for Nigeria and the West African Sub-Region. UCH Ibadan is a general, teaching, and research hospital, primarily a tertiary institution, affiliated with the University of Ibadan, the first University in Nigeria. UCH Ibadan is an 850-bed hospital with 56 service and clinical departments. It runs 96 consultative outpatient clinics a week. UCH Ibadan has undergraduate medical studies and provides residency training for general medical practice in internal medicine, obstetrics and gynecology, pediatrics, ophthalmology, anesthesia, radiology, radiotherapy, and dentistry. The hospital is also a training center for health management medical laboratories, nursing, midwifery, perioperative nursing, and occupational health nursing (UCH, 2017).

This center was chosen because a diverse patient population visits the hospital. UCH Ibadan is one of the best-equipped hospitals in Nigeria, and a treatment center where patients receive top-quality medical assessment, treatment, and care. The hospital is a referral center for patients with various diseases. People travel from both the rural and urban areas of Nigeria to be assessed and to receive treatment in the hospital. The oncology section and the radiotherapy department of the hospital operate a daily outpatient clinic. The patients in the oncology section are either there for surgical intervention or for chemotherapy for the management of breast cancer, while the patients in the radiotherapy department are normally referred from other clinics in the hospital, where other treatment modalities such as surgery or chemotherapy have been carried out. At the oncology section, patients with different stages of breast cancer are seen and assessed twice weekly. This oncology section was the recruitment outlet for the study.

3.3.4. sampling strategies. As Thorne (2016) argues, interpretive description (ID) does not suggest that one way to sample is better than others. The available options for sampling include convenience sampling, purposeful sampling, and theoretical sampling (Thorne, 2016). Sampling considerations in naturalistic inquiry include the following: a) the purpose of the study, b) the research audience and knowledge users, c) the research questions guiding the study, d) the type of data that will shed light on the research question, e) the available resources to carry out the study, and f) the criteria that will be used to judge the quality of the study (Patton, 2015). For an ID study, the reasoning behind the chosen sampling method must be transparent and logical. The sampling strategy chosen must be the method that is most likely to enhance the nature, magnitude, and outcome of the study (Thorne, 2016).

For this study, the purposeful sampling technique was used to choose participants with characteristics that could best contribute to the objectives of this study, in this case, women with

advanced breast cancer. The rationale and robustness of purposeful sampling lie in securing participants who possess knowledge of, and experiences with the phenomenon under investigation. Participants are considered knowledge-rich if the researcher determines that they have much to contribute to the understanding of the core issues and phenomenon under consideration (Patton, 2015). All the participants selected for this study were women referred from other hospitals for professional and specialist management of their advanced breast cancer and were willing to share their rich knowledge, which I, as the researcher, determined would shed light on the phenomenon under consideration. The participants' shared mastery would lead to a deeper understanding of the health-seeking behaviors and factors the women believed influenced their health-seeking activities, that is, the issues of key importance in this study.

3.3.5 inclusion and exclusion criteria. The inclusion and exclusion criteria that guided the selection of participants for this study included: a) female gender

- b) diagnosis with stage III or stage IV breast cancer
- c) ability to communicate in either English or the Yoruba language or both
- d) ability to take part in an interview
- e) participation approved by the oncologist and contact or gate-keeper nurses
- h) inpatient at the hospital.

The exclusion criteria included:

- a) women with the diagnosis of stage III or stage IV breast cancer, which impeded the women's ability to participate in an interview
- b) those with advanced stage breast cancer who find it difficult to communicate
- c) an inability to communicate in either English or the Yoruba language

3.3.6 participant recruitment. Recruitment of participants and data collection occurred from March to April 2018. I applied for and obtained a letter of support from the authorities of UCH Ibadan, Nigeria on the 9th January 2018 (Appendix A). I applied for and obtained ethical approval from the Research Ethics Board (REB) of the University of Saskatchewan, Saskatoon, Canada on the 10th January 2018 (REB # 18-03; Appendix B). I also applied for and obtained ethical approval from UI/ UCH Research Ethics Committee on the 1st of March 2018 (UI/EC/18/007; Appendix C). With copies of the letter of support from UCH Ibadan, the ethical approval from the University of Saskatchewan, and the ethical approval from UCH Ibadan, I then applied for and obtained operational approval to collect the data for this study from the Chief Medical Director (CMD) of UCH Ibadan on the 5th March 2018 (Appendix D). I presented an introductory letter addressed to the head of the oncology department of the hospital from the CMD of the hospital, together with a copy of the ethics approval from the UI/UCH Research Ethics Committee, and an information sheet that contained the full details of the study (Appendices E & F). Two nurse clinicians in the oncology unit who follow patients with advanced stages of breast cancer were enlisted to serve as links or gate-keepers for the study. I interacted with the link nurses to specify the particular characteristics and features of the study. They were provided with a reminder sheet that described the purpose of the study, and the inclusion and exclusion criteria, as well as an information sheet that contained the full details of the study (Appendix H). The information sheet given to the gate keepers was used as a guide in recruiting appropriate participants. My local phone number was made available to the link and gate-keeper nurses, so they could alert me when a potential participant was identified.

3.3.7 sample size. Researchers generally agree that the sample size of qualitative research varies according to the subject being studied and the research question (Sandelowski,

1995; Thorne, 2016). As Sandelowski (1995) maintains, the sample size must not be too large as the researcher needs to engage in a deep analysis of the data; it also cannot be too small because the researcher needs to reach a new and thorough understanding of the phenomenon under consideration. Interpretive description studies can accommodate either large or small sample sizes. Just as in an ID study, there is no one ideal method for sampling, neither is there a standard rule about an ideal sample size (Thorne, 2016). Although Thorne (2016) suggests that a small sample size can be justified in an interpretive description study, she argues that the researcher must acknowledge that participants could be added to the study. However, both Thorne (2016) and Sandelowski (1995) concur that more important than actual size is the case the researcher makes for why the planned number of cases or observations are likely to achieve a beneficial research outcome. Thorne (2016) goes on to suggest several criteria to be put into consideration when making decisions about the sample size in an interpretive description study: a) the kind of knowledge needed, b) the chances of getting as reasonably close to the required information as possible, and c) the way of carrying out the study such that it is respectful, consistent with professional standards, and ethical (Thorne, 2016). In consideration of all these criteria, I determined that a sample size of 20 would be ideal for the current study.

Data saturation was also used to determine the appropriate sample size in this study. Data saturation, also referred to as data redundancy (Thorne, 2016), occurs when the data collected has obtained adequate depth and richness. Researchers determine the point at which data saturation has occurred by being attuned to the number of times they hear the same information from a number of participants (Thorne, 2016). When they can anticipate that they will hear this same information from other participants, data saturation has been reached. At this point, the researchers are confident that no new differences on the emerging theory would likely appear

from additional data collection.

As the data collection exercise continued in the current study, I reached data redundancy after about the 17th interview. However, to address the concerns of UI/UCH research ethics committee members, on the proposed number of study participants, and to ensure that no variations were missed, I continued with the interview, until I interviewed 30 participants, while at the same time looking for negative cases, variations, and dissimilarities. When I observed that I was not getting any new information that could enrich the pattern emerging from the data analysis, which usually occurs concurrently with data collection in qualitative studies, I realized that I had enough study participants.

3.3.8 participant characteristics. The study participants were women presenting with the advanced stages of breast cancer, in UCH Ibadan, Southwestern Nigeria. The patients attending UCH Ibadan, a tertiary hospital, were normally referred from other hospitals for specialist medical care. The advanced stages of breast cancer were defined as stages III and IV of the illness. The study participants were in different phases of breast cancer care. Appointed gate-keeper oncologists and nurses assisted in identifying and approving prospective study participants in different units of the oncology section of the hospital. After a prospective participant had been identified, the gate-keeper nurses called me. Then I called the trained research assistant who had been hired to reassess the potential study participant identified. The research assistant assisted in screening the potential participants to confirm suitability for the study while maintaining confidentiality. Consent to participate in the study was obtained by the trained research assistant. I ensured that the research assistant, the gate-keeper nurses, and I had no relationship with any of the study participants who were recruited for the study based on their

interests to participate in the study. Only consenting prospective participants were recruited for the study.

3.3.9 research assistant. The research assistant was hired to safe-guard against a power imbalance between the prospective participants, gate-keeper nurses, oncologists, and myself, a Reverend Sister. As mentioned, the research assistant assisted in recruiting study participants and obtaining their informed consent. The research assistant was a trained professional who had participated in many research studies. She had trained in guidance and counseling at the University of Ibadan and had also undergone studies at the National Institute of Health. In her previous research, she had played many roles: recruiting study participants, collecting consent from prospective study participants, collecting data from study participants, transcribing data, and conducting data analysis.

3. 4. Data Collection

3.4.1 pre-data collection. Before commencing data collection, I met with the hospital and oncology unit counselors to arrange for therapeutic and counseling services for participants who might need such services because of their participation in the study. I also planned for a private room within the oncology unit, where the research interview would take place. I checked that the room was ideal for recording the interviews, protecting the privacy of the study participants, and safeguarding the confidentiality of the interview conversation.

Before collecting the data, I met with prospective study participants. An appointment for an interview at the participant's convenience was scheduled. The interview took place in the above-mentioned room at the hospital arranged for the purpose. To those patients willing to take part in the study and whose participation had been approved by the oncologists and the gate-keeper nurses, I introduced myself. I then described the purpose, goals, objectives, methods,

potential or anticipated discomfort, right to withdraw from the study even after the informed consent had been obtained, the time commitment required from them, and the possible benefits of the study. I also reviewed with the participants the data collection procedure, audio-recording, and note-taking during the interview, issues relating to the use of the data to be obtained, confidentiality of the information to be provided, and anonymity of the study participants. Ample time was given to the prospective participants to ask questions, and to consider their participation in the study.

3.4.2 data collection instrument. There is no preferred method of data collection in an ID study. The goal of data collection in ID is to use the most appropriate and justifiable method or methods that allow the researcher to be as close as possible to the personal experiences recounted by the participants (Thorne, 2016). According to Thorne (2016), all sources of data have strengths and limitations. When selecting a method of data collection, researchers need to consider what they want to learn about the phenomenon under consideration. The approach chosen must be the one that has the greatest potential for yielding the most significant data (Thorne, 2016).

For this study, data collection was in two phases. In phase One, each participant personally provided her demographic information by anonymously completing the participant demographic form (Appendix I). The demographic form was numerically coded for data entry purposes. No identifying information was recorded on the questionnaire. In ID interviewing is considered to be a feasible option for data collection and knowledge development. Health care professionals acknowledge that many features and characteristics of the illness experience are known only to the person going through the experience, and interviewing affords the researcher the opportunity of engaging in in-depth conversation and exploration of a phenomenon with the

client (Thorne, 2016). Phase two data collection for this study consisted of semi-structured, one-on-one, face-to-face interviews with each participant conducted by the researcher and guided by open-ended questions (Appendices J & K).

The interview guide, study information, and consent forms were submitted to two separate professional Yoruba translators for translation into the local Yoruba language. Their submissions were back-translated into English by another independent translator. I then evaluated their translations for congruency and consistency with the original documents. To assess for adequacy and appropriateness to obtain data on the health-seeking behaviors of women presenting with the advanced stages of breast cancer, the interview guide was submitted separately to two breast oncology specialists, working as consultants at the breast cancer section of the hospital where data was to be collected. They did not suggest any amendments to the documents.

3.4.3 pilot testing of the research instrument. Pilot testing is defined as a small-scale version or a trial run of a study designed to test aspects of the research methods and procedures to be used in a larger or parent study (Polit & Beck, 2008). For this research, a pilot study was carried out to assess the interview questions for suitability, adequacy, comprehensiveness, and clarity in exploring the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria. The other aim of pilot test was to identify any other practical difficulties that may require modification before the main study.

The pilot testing of the interview protocol took place within the same setting as the research study, that is, at the oncology unit of the University College Hospital Ibadan, Nigeria. The same criteria used to select prospective participants for the larger study were used for the selection of the two participants who took part in the pilot study. One interview was conducted in

English and the other in the Yoruba language. Before beginning the interview, I established rapport with the selected participants, by introducing myself, telling them the aims and objectives of the study, and reviewing the following: the study procedure, potential risks and benefits of the study, potential consequences of participation in the study, and time requirements. Other issues discussed with the participants related to the confidentiality of the data to be collected, the anonymity of the participants, and any third-party that may be involved in the process of data collection, privacy, the audio-recording of the interview, note taking during the interview process, and the use to which the study findings would be made.

The data collection tools used for the pilot interviews were the same as those planned for the major study: the participant demographic forms and the interview guide with semi-structured, open-ended questions. Each pilot interview took 25 minutes. They were audio-recorded, and notes were taken during the interview.

Towards the end of the interviews, a summary of the interview conversation was relayed back to the individual participants. As suggested by Lincoln and Guba (1985), requests for clarification, elaboration, verification, and amendments of shared experiences were made. After the interview, I transcribed the audio-recordings verbatim. I also translated the one transcript that needed to be translated from the Yoruba language into English language.

The pilot testing of the interview protocol and process helped me to assess the appropriateness and suitability of the interview questions and the data collection processes. It also aided in determining the feasibility of the administration procedures and the amount of time required for the interviews. The first participant narrated a long story about how she learned about her illness. This shared experience provided answers to some other questions on the interview guide. I learned from this observation that I would need to listen carefully to the

participants' stories to avoid asking them more than once for the same information. Otherwise, the study participants might have the impression that I was not listening to them.

3.4.4 demographic information collection and the interview process. At the beginning of each interview, before collecting the demographic information, information about the study was again reviewed with the participants, including their rights as study participants and the details of the study procedure. The participants were assured that they were free to change their minds about taking part in the study for any reason and without any penalty and that they could refuse to answer any questions that made them uncomfortable. They were assured that the data supplied would be confidential and that codes assigned to each participant during the recruitment and interviewing would ensure data anonymity. The participants were also told that codes would be used when quoting their verbatim expressions, and that the raw data would be accessible to only the researcher and the supervisors. The demographic information gathering form was then given to the participants to complete.

After filling out the demographic form, the participants were involved in a face-to-face, one-on-one semi-structured interview using an interview guide. The interview guide contained open-ended questions composed according to the information gathered from the literature review (Appendices I & K). Open-ended questions gave the participants latitude and scope in explaining and elaborating on their health-seeking behaviors and the factors they believed influenced their health-seeking activities (Morse, 2015). Non-leading probes were used to explore detailed explanations of shared experiences. The interviews were a one-to-one encounter between each participant and in a face to face sitting position. No family member was present at any of the interview sessions. The interview questions were in the English and Yoruba languages, and each participant was interviewed in the language of her choice. The participants were told to express

themselves in the language with which they were most comfortable at any moment during the interview. During the interviews, some participants switched back and forth between the English and Yoruba languages and vice versa. Adequate time was provided for the participants to answer the questions as well, the participants' non-verbal communications were noted and acknowledged to the participants.

To obtain high-quality data from interviews, the researcher must pay meticulous attention to the overall context of the interview process, the viewpoints being expressed, the method of interaction, and communication style (Thorne, 2016). I allocated a great deal of time for the interview. During the interview, I focused on the participant, hearing and listening attentively to, what she was sharing. I also showed genuine interest in what the participant was saying with both verbal and non-verbal communication while, at the same time, using probes to more deeply understand her shared experiences. Towards the end of the interview, I provided a summary of the major points and ideas that the participant had contributed, explaining, as well, that I would transcribe the recorded interview, think, and reflect on it. I asked if I could contact her again should I think of any other questions and if I could share with her the findings of the study after I had analyzed the interview. Study participants who wished to be contacted wrote their contact information in a note book provided for this purpose.

ID encourages triangulation or the use of multiple data collection sources (Thorne, 2016; Thorne et al., 1997; Thorne et al., 2004). Multiple lines of evidence help to ensure rich data. Using multiple data sources can also contribute to the trustworthiness of the study findings (Thorne, 2016). For this study, interviewing was the primary source of data collection, but I used several other data sources, such as field notes and reflective journaling. I also took steps to eliminate social desirability bias. All of these are elaborated on below.

3.4.5 field notes. Field notes are jottings of salient points that are written in detail later the same day that an interview has taken place. Field notes are written accounts of the things that the researcher hears, sees, experiences, and thinks while collecting or reflecting on data (Morse & Fields, 1995). An audio-recording cannot portray the physical settings, the impressions that the researcher picks up, and non-verbal communications.

In this study, I wrote field notes before, during, and between interviews to help me collect and analyze the data as suggested by Charmaz (2014). I kept a descriptive account of what was happening in the hospital setting to describe the community in which the participants are a part. These observations included describing facial expressions, and relationships between family members. I also wrote analytic notes to capture my thoughts, including my ideas, questions, and the things I learned, and observed. The reasons for writing field notes were explained to the study participants.

After the interviews were complete, the field notes were sorted, coded, and organized in a manner that helped identify emerging themes. As proposed by Morse and Fields (1995), the themes were compared across the interview data to determine their relevance and applicability. Writing and sorting the field notes helped to keep me involved in the data analytic process early in the study.

3.4.6 reflexivity and reflexive journaling. Reflexive journals contain subjective accounts of each research event. Self-reflection involves being self-aware of evolving insights and continually questioning and contemplating them. During data collection, some words and phrases attracted my attention, and I needed to reflect on why this occurred. I thus kept reflexive journal in which I recorded notes about myself and the study. I used this journal to capture my own biases, pre-conceptions, and opinions, as suggested by Lincoln and Guba (1985). The

reflective journal provided a forum to reflect on the environment in which the interviews were held and the emotional state of the participants during the interview. As Thorne (2016) claims, reflective journaling sensitizes researchers to their prejudices and biases while, at the same time, informing them of their impact on the study and the credibility of research outcomes. My reflective journal sensitized me to my own biases and ultimately, made me more confident in my research. The journal also provided an audit trail of the events, documenting what occurred and why such events transpired. Finally, constant reflection on my perception of “appropriate or normal” health-seeking behavior was needed to conduct and interpret the data without imposing my personal views on the meaning that emerged.

3.4.7 social desirability bias. Social desirability bias involves the tendency for interviewees to give answers that they think the researcher would like to hear. It is an attempt to make a good impression on the researcher by providing positively viewed responses and feedback (Hewitt, 2007). Participants in a face-to-face, a one-on-one interview might be worried about the researcher’s evaluation of them. To alleviate this concern and reduce disapproval, participants may try to rationalize their behavior or make statements to present the behavior in a favorable light (Collins, Shattell, & Thomas, 2005; Polit & Beck, 2008).

In this study, I was aware that my physical appearance, mode of dress, demeanor, and personal attributes could lead the study participants to portray themselves in a good light, withhold, or distort information. I tried to minimize the social desirability bias by creating rapport with the study participants, assuring them of confidentiality, and letting them know that there were no right or wrong answers to the questions (Hewitt, 2007). I also used indirect questioning, which involves asking about what a third-party thinks, feels, and how they usually behave when in this kind of situation, that is, asking what other women do when they perceive

they have breast cancer. Indirect questioning can allow respondents to project their feelings and behaviors onto others and still provide honest representative responses (Hewitt, 2007).

3.5 Data Management

The ID data management involves tracking, organizing, and sorting the data brought from the field, thus ensuring that the information is readily available to the researcher (Thorne, 2016). In this study, the consent forms and the participants' demographic information documents were separated and kept in a secured cabinet while I was in Nigeria. I personally transcribed the interview data after each interview was concluded to facilitate early immersion and familiarization with the data. During the transcribing, all information with the potentials to identify the participants, or any other person whose name was mentioned during the interview, was removed and replaced with initials. Folders were then created for each participant. Each participant's data was labelled letter P (for participant) and assigned a number to differentiate them (that is P1, P2, P3, P4, etc...). The transcribed information was stored in my personal computer using a pseudonym to keep the information confidential. The computer was made more secure with a password known only to me.

After transcribing the audio-recordings, I translated the transcript that needed to be translated from Yoruba language into the English. Equivalent English words that matched the Yoruba words were chosen. The Yoruba language is rich, and the Yorubas have different ways of saying the same things. For this study, I made sure that the precise meanings of participants' words and conversations were maintained. To be as accurate as possible, the translated interview scripts were given to another PhD candidate, specializing in epidemiology, to back-translate to the Yoruba language to ensure accuracy. The PhD candidate was born and brought up in Southwestern Nigeria. He did his medical education studies at UCH Ibadan. Before the script

was given to the independent translator, he signed an oath of confidentiality (Appendix L) not to reveal any information about the data to anyone.

3.5.1 data storage. The collected data was stored with a different title in a password-protected computer file which was kept in my private filing cabinet. I also saved a copy in my cabinet on PAWS. During transportation from Nigeria to Canada, all data were kept on a secure computer, which was carried on the airplane as hand luggage. Electronic copies of the transcribed interviews were made and saved in a password-protected storage memory flash drive. The participants' demographic information forms and consent forms were kept in separate files and stored in a locked-up cabinet at the university. Now that the study is completed, the data, however, will be stored by my research supervisors for at least five years following publication of the results.

3.6 Data Analysis

Data analysis in ID is an interactive process that involves moving back and forth as needed throughout the period of the data analysis (Thorne, 2016). In this study, the demographic information of the participants was analyzed separately from the audio-recorded interviews. Descriptive statistics (means, median, and simple percentages) were used to depict study participants' demographic characteristics and to describe the participants as a whole (Table 2).

In ID, data collection and analysis occur concurrently and inform one another. This concurrent data collection and analysis also indicates the direction of the inquiry as new possibilities arise and are considered (Thorne et al., 2004). Data analysis in ID engages the inductive, thematic approach, as attempts are made to capture themes, patterns, and commonalities believed to characterize individual subjective perceptions of the phenomenon under consideration (Thorne et al., 2004; Thorne, 2016). Creswell (2007) describes thematic data

analysis in qualitative research as consisting of preparing and organizing the data for analysis; reducing the data into themes through coding and condensing the codes; and finally, presenting the data in figures, tables or as a discussion. As stated earlier, data analysis in ID involves the “tracking, organizing, and sorting” (Thorne, 2016, p. 150) of the data brought from the field.

3.6.1 tracking. Tracking involves carefully documenting the analytic decisions informing the research process. It entails providing the research consumer with enough information about the decisions made and the rationale behind the decisions to explain why the data exist in the way they do. Tracking of events within the research process allows for the production of an accurate and detailed audit trail as part of the research report (Thorne, 2016). In this study, the rationale for the decisions made were included at each decision-making point.

3.6.2 data sorting and organizing. To adequately sort the data, the researcher needs to know the data. Ways of knowing the data include the following: 1) listening to the recorded interviews, 2) reading and re-reading the transcribed data, 3) spending time with the transcribed material and making detailed notes, 4) purposely dwelling on it, 5) immersing oneself in the records, and 6) intentionally developing a relationship with the data (Thorne et al., 1997; Thorne et al., 2004, Thorne, 2016).

I attempted to know the data in all of the above ways. To make sure the transcriptions accurately recorded the interview, I listened to the audio recording several times while looking through the transcribed interviews. As I listened to the audio-recording, I made notes and recorded new thoughts and ideas emanating from the data (Thorne, 2008). While I personally transcribed the audio recording, I became immersed and mentally absorbed in the data, developing a relationship with them. Transcribing the audio-taped data personally also allowed me to notice the nuances included in the data such as participant’s voice intonation, use of

pauses, and any non-verbal communication.

I read the transcribed data several times to gain a holistic understanding and comprehension of the meaning, which were essential to start to make sense of the data (Thorne, 2016). On several occasions, as Morse and Fields (1995) and Thorne (2016) suggest, I stepped back and reflected on the interview, wrote notes that were general in nature, and summarized the entire interview, while keeping in mind that there were many more themes to be learned from the data and that many other things remained unknown to me.

3.6.3 data coding and organizing. I read and reread the data several times to have a full understanding of them. Once I had a good understanding of the scope and context of the shared experience, the participant's individual interview documents were uploaded into NVIVO 12 software. NVIVO 12 is a qualitative data analysis software package developed by QSR International based in Melbourne Australia. Using NVivo 12, participants' interview transcripts were coded individually. Coding was an interactive engagement with the data. Coding meant interactively engaging with the data because, as Thorne (2016) proposes, it involved putting the elements of data together and beginning to compare them. Throughout the coding process, terms used were borrowed as much as possible from participants' own words. Similar interview excerpts were coded as nodes, and some were also saved into multiple nodes. The coding process was guided by the research questions. It was data driven. As coding continued, any interview excerpt coded as established nodes was constantly reviewed to ascertain consistency. The first level coding helped to summarize segments of the data. Code names were assigned, and as suggested by Thorne (2016), the codes were broad.

The second cycle of coding was more focused. Summaries from circle one coding were analyzed for similarities. Coding helped to uncover the meanings embedded in the text. Repeated

rearrangements of the coding allowed for a thorough understanding of the emerging themes. Similar segments were grouped and compared with similar or dissimilar ideas expressed by other participants. These comparisons helped to determine the ideas and themes providing the initial understanding of the health-seeking behaviors of the participants.

As proposed by Morse and Fields (1995) and Thorne (2016), the emerging themes and patterns were then reflected upon in more detail, verified, confirmed, and reconfirmed with data from other participants. Codes from all participants were later combined with codes from all other types of data that have been collected including fieldnotes, memos, and reflective journaling to develop the data as a whole. Themes emerged when categories were similar and frequently occurred.

Theme names were initially descriptive. After I consulted with my supervisors, the descriptive themes gradually shifted into more interpretive language. The themes took shape through ongoing analysis, writing, and conversations with my supervisors and another member of my advisory committee. Thereafter, a thematic framework was drafted. Many drafts of the thematic framework were shared with my supervisors and another member of my advisory committee and colleagues.

After each consultation, there were always new points to consider, which required returning to the interview, staying open to the data, and becoming engrossed in understanding their meanings. Discussions and negotiations took place to flesh out and clarify the themes and enhance the thematic framework. The subthemes were notions and ideas found to be common across most interviews. Thorne (2016) recommends three ways to confirm the bases of the emerging patterns and themes: “repeat interview, constant comparison, and theoretical sampling” (Thorne, 2016, p. 176).

3.6.4 repeat interview. According to Thorne (2016), going back to the source of the data can help confirm the bases of the emerging patterns and associations between segments of the data. Reconnecting with the source of the data during data analysis can help both to expand the comprehensiveness of the tentative groupings among aspects of the whole data set and to challenge the direction of the researcher's thinking before final conclusions are made (Thorne, 2016). It can also help in transforming the data into findings.

In this study, the initial tentative synthesis and interpretations based on the data collected were shared with the study participants through telephone interviews. These telephone interviews gave the study participants the opportunity to consider if the ideas emerging from their previous encounter with the researcher resonated with their experiences. It also afforded me the opportunity to listen to and respond to their comments and suggestions before completing the study.

All the study participants who had provided their contact information and were willing to carry on with the study were contacted. They all confirmed that the findings resonated with their experiences. According to Thorne (2016), reconnecting with the source of data also helps to build confidence in the credibility of the tentative findings.

3.6.5 constant comparison. Constant comparison is another strategy recommended for use in interpretive description data analysis (Thorne, 2016; Thorne et al., 2004). Constant comparison entails comparing one set of data with others that may be different or similar to understand the possible relationships between the various parts. The process of constant comparison helps to determine if data supports the emerging themes. According to Thorne (2016), all data must be compared with other data from the study. In this study, intra-participant

comparison of data was carried out as part of the data analysis process, to identify patterns of experiences.

This analytic technique of comparing data and sharing the initial interpretation of findings with research participants, helped me to understand in a deeper way the health-seeking behaviors of the women and the factors the women believe influence their health-seeking behavior.

3.7 Ethical Considerations

As earlier mentioned, research ethics approval for human subjects was obtained from the University of Saskatchewan Research Ethics Review Board. To enter the research environment and collect data for the study, ethical approval was obtained from UI/UCH Research Ethics Committee, and operational approval was obtained from the Chief Medical Director (CMD), UCH Ibadan, Nigeria. The ethical approval from UI/UCH Ethics Committee, the operational approval from the CMD, and a letter of introduction was presented to the directors of the oncology units of University College Hospital Ibadan, Nigeria. The purpose, objectives, study procedure, inclusion and exclusion criteria, and any potential benefits and risks of the study were discussed with the directors of the units.

The core principles that express the value of human dignity as laid down in the Tri-Council Policy Statement (TCPS-2, 2014) and the principles of research ethics in Africa (Kruger, Ndebele, & Horn, 2014) guided the conduct of the study. These core principles include respect for persons, concern for the welfare of study participants, justice, and additional protective measures for vulnerable individuals with limited autonomy (Kruger et al., 2014; TCPS-2, 2014).

3.7.1 respect for persons. Through informed consent, the researcher shows her respect for the study participant as a person capable of decision-making. Respect for persons obliges the

researcher to honor study participants' autonomy and to ensure that participation in the study is voluntary (Kruger et al., 2014; TCPS-2, 2014). The details of the study were explained to the prospective study participants first by the research assistant and thereafter, by me, the researcher. To ensure that study participants understood the purpose of the study and its risks and potential benefits as appropriately and as practicably as possible, prospective study participants were given ample time to think about the information provided to them. All their questions were answered before their informed consent was sought. The consent process was open and ongoing (Kruger et al., 2014; TCPS-2, 2014).

3.7.2 informed consent. Informed voluntary consent has been defined as a clear, straightforward agreement, freely made, without any inducement, undue influence, coercion, and incentives, by a prospective participant to take part in a research study (Holloway & Wheeler, 1995; Kruger et al., 2014; TCPS-2, 2014). Informed consent requires adequate information, clear understanding, and freedom to decide to participate without undue influence (Kruger et al., 2014; TCPS-2, 2014).

The protocol for obtaining informed consent, as outlined in the manual for ethical conduct of research in Africa, was performed by the research assistant who, as earlier stated, was employed for this purpose. The informed consent document was a written document in the language that the participant understands (Kruger et al., 2014). In the consent procedure, the prospective participant was provided with all the necessary information for making an informed decision. The information included the aims and objectives of the study, the study methods and procedure, potential risks and anticipated benefits, the right to withdraw from the study at any time during the research process without any penalty, including the right to withdraw data and the audio-recording of interview sessions. Also included in the information was consent for note-

taking during the interview process, the use to be made of the data to be collected and the study findings. As well, issues relating to confidentiality of the information were provided, including anonymity of participants and any other third party mentioned during the interview. Information was additionally provided on the time commitment required from the prospective participant, the opportunity to ask questions, the opportunity and time to consider whether to participate, and the knowledge of potential consequences of participation. Finally, assurance was given that the process would be free from undue influence or intimidation, which can occur in any of the following ways: using threat of harm to achieve compliance in participating in the study, controlling influence of a close relative, the perceived or real threat of withdrawal or limitation of access to essential health services, and offer of an excessive, unwarranted or inappropriate reward to potential study participants for their agreement to participate (Kruger et al., 2014; TCPS-2, 2014). Prospective participants were informed that no incentives were attached to participation in the study. Each prospective participant who met the inclusion criteria and agreed to be part of the study was asked to give her consent by reviewing and signing the consent form, to indicate her understanding of the procedure and rights as a study participant (Appendix E). The participants in the current study all had some level of education ranging from junior secondary to post-graduate studies. Therefore, they were all able to read, write, and append their signatures on the informed consent forms.

In a qualitative research study, data collection and analysis occur concurrently. The researcher focuses on the meanings and the interpretation of the participant's words and experiences and may develop new ideas grounded in the data. The researcher's personality and perspectives may also affect the research and its findings. Need may arise to incorporate new ideas into the study because of the probing, which took place during the interview process. Any

unanticipated issue or event that may increase the risk to a study participant, has ethical implications, or affects the study participant's welfare needs to be reported to the research ethics review board (Kruger et al., 2014; TCPS-2, 2014) and to the participant. Additionally, any major recommended amendments to the research questions may require the research ethics review board to re-approve the research. Therefore, the first consent obtained at the initial stage of the research process may have to be amended. The amendments may have to be approved and signed by the study participant (Hewitt, 2007; Holloway & Wheeler, 1995; Kruger et al., 2014; TCPS-2, 2014). Informed consent, therefore, is an ongoing process because of the flexible nature of qualitative research methodology (Holloway & Wheeler, 1995). During this study, there were no occurrences that indicated the need for major adjustments of the study protocol. However, the study participants were constantly reminded of their rights and the voluntary nature of the study.

In the African context, informed consent can be challenging. These challenges may relate to poverty, low literacy levels, language or cultural barriers, differences between the research participant's and researcher's belief about the cause of an illness, involvement of family members, and limited access to health care (Kruger et al., 2014). To address potential challenges with communication, the formulary for the informed consent in this study was translated into the local language (Appendix G). The translation was back-translated into English by another independent translator. Each study participant was provided with the option of giving informed consent in the language of her choice, that is, either in the Yoruba language or the English.

Because the family plays significant roles in the health-seeking decision-making among the Yorubas, family members were allowed to be with the study participant while she was being provided with the information for the informed consent. However, the decision to take part in the study belonged to the prospective participant alone. Therefore, after the information session, the

prospective participant was given ample time to consider whether to participate in the study. To safe-guard against the possible consequences of a power imbalance between the prospective study participant, the gate-keeper nurses, and the researcher, as earlier stated, the research assistant was assigned to conduct the procedure and obtain the participant's informed consent.

3.7.3 respect for autonomy. Respect for autonomy obliges the researcher to comply with the research participant's decision to either take part or not take part in the study. In this study, the participants' autonomy was ensured by involving only those individuals who showed interest in participating in the study. Because the participants of a study must be told that participation is voluntary (Holloway & Wheeler, 1995; Kruger et al., 2014; TCPS-2, 2014), each participant in this study was informed that she could withdraw her participation from the study at any time even after signing the consent form without any adverse consequences to her care (Kruger et al., 2014; TCPS-2, 2014). Each participant was also told that she could withdraw any information she had contributed prior to withdrawing her consent, provided she made the request before the data from all the other participants had been integrated. At such a time, it might be impossible to identify the specific participant's contributions.

3.7.4 concern for welfare. The concern for study participants' welfare obliges the researcher to respect their privacy, their confidentiality, the security of the data they provide, and the control of information about them. The concern for the welfare of participants' welfare also involves providing them with enough information, so they can assess the risks and potential benefits associated with their involvement in the study (Kruger et al., 2014; TCPS-2, 2014). In the current study, I discussed with each participant issues relating to the confidentiality of the data by assigning codes as identifier, the anonymity of the data collected, including the name of any participant or third-party whose name was mentioned during the data collection process, and

the extent to which the information shared will be used in reports. As recommended by Kruger et al. (2014) and Richards and Schwartz (2002), I ensured that both the questions of the study participants and their family members were adequately answered. I was explicit in stating the requirement expected for the participant, as well as the specifics of the research study, so, using this information, they could decide whether to take part in the study. All their other concerns were adequately addressed.

3.7.5 anonymity and confidentiality. The principle of secrecy obliges researchers not to divulge the information impacted to them in a research study. It also compels the researcher not to reveal the identities of research participants (Holloway & Wheeler, 1995; Kruger et al., 2014; TCPS-2, 2014). As O'Byrne and Holmes (2008) argue, to gain a participant's trust, confidentiality must be assured. If research participants fear that their confidentiality will be broken, they might not be willing to provide valuable and relevant information. Gelling (1999) also argues, if participants do not trust the researcher or the process, they may hold back key information from the researcher, resulting in invalid findings. In this study, the research participants were assured of confidentiality. They were told that all the tools used for the study would be kept secure, and that their identities would be disguised to ensure confidentiality. They were also told that codes and pseudonyms would be used to replace their names and identities. Additionally, they were told, as suggested by Holloway and Wheeler (1995), that audio-recorders would be kept safe in locked cabinets, and they would be erased five years after the research study had been concluded. Some cases of confidentiality, however, require particular and careful consideration. Such cases include situations where the researcher gained a piece of information that might be detrimental if kept confidential (Gelling, 1999). This issue was adequately explained to each study participant.

3.7.6 justice. Justice requires that the researcher places the needs of the research participant before the objectives of the study. It also requires that the researcher be fair to all participants. I ensured that equal opportunities were given to all eligible persons to participate in the study. I also ensured accurate interpretation and the presentation of the study findings by asking questions and engaging the study participants in all the different phases of the study. I frequently discussed the study with and asked questions of my supervisors and members of my advisory committee.

3.7.7 misrepresentation and misinterpretation of data. The conceptual framework used in the study, epistemological commitments, personal characteristics, and the preconceptions of the researcher all influence the analysis and interpretation of data. All these could lead to the misrepresentation of participants' views (Richards & Schwartz, 2002). Misunderstanding and misinterpretation of data could occur when the researcher is working in isolation. In this study, the risk of misrepresentation and misinterpretation were minimized through my close work with my research supervisors, other PhD candidates, and other Master of Nursing Students. Engaging in self-reflection and reflexive journaling helped me to be aware of the personal biases and professional and personal characteristics I brought into the study situation (Richards & Schwartz, 2002). According to Munhall (1988), describing the experiences of others as accurately and as faithfully as possible is an essential ethical responsibility of the qualitative nurse researcher.

3.7.8. beneficence. Beneficence implies doing good for others. The potential benefits of the study must be greater than the risks. Beneficence entails that the research outcome must not only increase knowledge, but also that society must benefit from the study. In this study, emphasis was placed more on research participants' safety than on any other factor, as recommended by the literature (Gelling, 1999; Kruger et al., 2014; Reynolds, 1972; TCPS-2,

2014). This study has uncovered certain health-seeking behaviors of women presenting with advanced stages of breast cancer in Southwestern Nigeria. It has offered new insights on a topic that had not been previously examined. The study participants may have benefited in several ways from being in this study: from emotional relief experienced when they told their stories to someone who cares; from the opportunity and privilege to contribute to the nursing care of other women who may benefit from the outcomes of this study; and from contributing to the holistic and more effective nursing care of women with breast cancer. Nurses may benefit using education strategies to recommend health behavior to their patients and in planning, designing, and implementing comprehensive nursing care. The study findings may also benefit women of Southwestern Nigeria by indicating the need for policy development for breast health in this region.

3.7.9 non-maleficence. Non-maleficence is closely related to beneficence. It requires that no physical, emotional, social, or economic harm come to an individual through their participation in a research study. This study required participants to complete a demographic form and participate in an individual one-on-one interview. It was anticipated that these activities could result in temporary discomfort, including possibly fatigue, headache, muscle tension, anxiety, embarrassment, and worries about time commitment. These discomforts could be seen to be like those which the research participants typically encounter in ordinary daily life (Gelling, 1999; Reynolds, 1972). However, in my study, I surmised that the discomfort could provoke more anxiety than those experienced in everyday life. For this reason, prior to commencing the data collection, I had arranged with the hospital psycho-oncologist to assist any participant who might need counseling services after recounting her experiences of health-

seeking behaviors in living with the advanced stage breast cancer. The participants were told that counseling services were available to those who might need them at no cost to them.

The participants were informed that the findings from the study would be disseminated to research consumers. However, they were assured of anonymity during the publication phase of the study. They were also told that it would not be possible to trace any responses to any individual during the dissemination of study findings. They were assured that no harm would come to any participant by reason of her participation in the study. Study participants were provided with contact details so that their questions and concerns could be adequately addressed during and after data collection.

3.7.10 the professional role versus the researcher's role, and power imbalance. The focus of qualitative research is exploring, examining, and describing people, their behaviors, and their experiences in their natural environments. The concepts of relationship and power are implanted between the researcher and the research participant. Any qualitative researcher must, therefore, consider the ethical problems that may arise from such interactions (Orb, Eisenhauer, & Wynaden, 2001). Because I was conscious of the (nun) nurse researcher's role as investigator rather than as counselor or educator, I did not allow myself to be caught up in multiple roles of health professional, counselor, religious, educator, and researcher.

3.8 Rigor

The basic question a researcher asks about rigor is "How can an inquirer persuade his/her audiences (including self) that the findings of the inquiry are worth paying attention to" (Lincoln & Guba, 1985, p. 290). Rigor or trustworthiness in an ID study is based on the quality of the analytic decisions made by the researcher at every stage of the research process and the rationale behind the decisions (Thorne, 2000). Rigor is influenced by the researcher's creativity,

sensitivity, flexibility, and skill at incorporating verification strategies at all the stages of the study (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Lincoln and Guba (1985) proposed four criteria for judging the trustworthiness of naturalistic inquiry: credibility, applicability, consistency, and confirmability (Lincoln & Guba, 1985) of the study findings.

3.8.1 credibility or the truth value. The credibility of a qualitative study is participant oriented. The credibility of research findings will depend on how specific analytic decisions were made, contextualized within the larger picture, and presented (Thorne, 2016). A qualitative research study will be seen “as credible if it presents such a faithful description or interpretation of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own” (Sandelowski, 1986, p. 30). In other words, credibility refers to the extent to which the findings and interpretations are consistent with the ideas and meanings intended by the study participants.

To ensure the credibility in this study, I engaged in reflexive journaling. This process made me aware of the biases, opinions, and experiences I was bringing to the study and ensured that these biases did not influence the findings. Credibility was ensured by my choice of an appropriate sample was, large enough to demonstrate recurrent themes from the interview data. Throughout the study, I remained open to new themes and to new constructions of knowledge about people’s illness experiences. Another way of ensuring credibility was through participant-debriefing and transcription. During the interview process, I asked participants to clarify the shared experiences. I personally transcribed each interview audiotape verbatim, and I was repeatedly immersed in the data throughout the data analysis. The translations were back-translated by another translator. Before data analysis began, I read and reread the translations to confirm the clarity, integrity, and accuracy of the document. The words and direct quotations of

the participants were used to analyze the findings.

To further ensure credibility, I consulted often with my thesis supervisors and members of my advisory committee, who reviewed the data and assessed the accuracy of my ideas, as well as, the patterns and themes emerging from the data. Lastly, credibility was furthered by confirming research results with participants. I engaged in telephone interviews with the participants who had expressed the desire to remain involved with the research process and to discuss the initial findings emerging from the data. They commented on or confirmed the accuracy of the findings.

3.8.2 consistency or dependability. Consistency or dependability involves the stability of research procedures. Findings from a study are judged dependable if another researcher could follow the decision trail of the study and achieve the same or comparable results (Sandelowski, 1986). In other words, a study is dependable if it could be replicated by another researcher in a similar context with similar participants, and the findings would be the same or close to the same. One measure for evaluating the consistency or dependability of a qualitative study is auditability as proposed by Lincoln and Guba (1985). For this study, I created a clear decision trail from beginning to end. Using this trail, another researcher could follow the same methods of participant recruitment, data collection, data analysis, and interpretation. Other ways of verifying dependability were the continual rereading and confirming of transcripts and the checking of the coding process by my supervisors and my advisory committee members. Dependability was also improved, and my personal biases minimized through constant consultations with experts throughout the research process.

3.8.3 applicability. Applicability refers to the extent to which study findings fit into contexts outside the study situation and are viewed as relevant by other audiences to their unique

experiences (Sandelowski, 1986). According to Lincoln and Guba (1985), the main way to confirm transferability is to provide detailed descriptions of the characteristics of the study. In this study, transferability was tackled by providing rich and detailed descriptions of the research contexts and by providing detailed background information to readers, in other words, by providing a “thick description” (Lincoln & Guba, 1985, p. 290). All research documents and materials concerning each phase of the study are available so that another researcher could follow the progression of the events and understand their logic.

3.8.4 confirmability or neutrality. Confirmability refers to a bias free research process and product (Sandelowski, 1986). Confirmability depends on “auditability, applicability, and credibility” (Sandelowski, 1986, p. 33). I made sure that the study findings have their origins in the data. Confirmability also occurs when two or more external evaluators assess the data and agree on its accuracy, significance, and meanings (Polit & Beck, 2012). By using semi-structured interviews and discussions, I developed a comprehensive understanding of the issues relating to the health-seeking behaviors of women presenting with the advanced stages of breast cancer in Southwestern Nigeria. I developed rapport with the study participants, and I spent a great deal of time listening to their stories. Having participants review the initial interpretation of the data was another strategy used to ensure confirmability.

Other aspects of rigor in ID identified by Thorne (2008; 2016) include representative credibility, analytic logic, interpretive authority, moral defensibility, disciplinary relevance, pragmatic obligation, and contextual awareness.

3.8.5 analytic logic. To ensure the analytic logic in an ID study, the research study must reflect systematic reasoning from the beginning of the study, through the data collection and analysis to the new knowledge claims, made because of what was learned in the research process

(Thorn, 2016). The decision-making processes used throughout this study were documented in detail. They are available to other research consumers who wish to assess the adequacy of the decisions

3.8.6 interpretive authority. Interpretive authority is the assurance that the interpretive outcome of the study reflects some truth external to the researcher's bias. Interpretive authority requires an understanding of the epistemological basis of the methodology, and the recognition of the disciplinary setting to which the research reports and outcomes are directed (Thorn, 2016). By engaging in reflexivity and reflective journaling, I confirmed that the study findings have their bases in the data.

3.8.7 moral defensibility. The moral defensibility of the study implies accounting for the likely usefulness of the study outcomes. There must be a relationship and interconnection between the prospective benefit of the study to those being served and the reasons for conducting the study. The knowledge outcome of the study must in one way or another have a positive influence on health consumers or have practical implications (Thorn, 2016). The outcomes of this study are expected to empower nurses who provide integrated and comprehensive nursing care to women presenting with advanced breast cancer in the region. It is also hoped that the outcomes of this study would be a source of empowerment to women in Southwestern Nigeria. Finally, this study should inform the work of policy makers in Southwestern Nigeria seeking to improve women's health through government action. It is hoped that policy makers will act on this essential need for breast cancer to be managed effectively.

3.8.8 disciplinary relevance. Disciplinary relevance implies that the research study outcome must contribute to the knowledge development of the specialty. Therefore, the researcher needs to explain the relationship between the research study and the disciplinary

knowledge (Thorn, 2016). The research question for this study was generated within the context of nursing and the views of this researcher. The relevance of the context is that it shaped the lens through which data was collected and analyzed (Thorne, 2016). Efforts were made to ensure that the methodology was adequate to addressing the research question. There was congruence between the selected method, the data collection methods, and the analytic processes. The outcomes are capable of informing quality nursing care.

3.8.9 pragmatic obligation. Pragmatic obligation implies that the new knowledge generated must be usable particularly in a clinical or practical setting (Thorn, 2016). As mentioned, the outcomes have the potential to help nurses, physicians, other health care providers and policy makers to understand the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria and that this understanding will lead to improved breast cancer treatment outcomes.

3.8.10 contextual awareness. Contextual awareness involves understanding that there are other realities not yet visible to the researcher. Researchers need to appreciate that their worldviews are limited by the cultural, political, and economic backgrounds of their setting and their disciplinary viewpoints. Researchers are expected to present their findings in relation to the circumstances that form the setting for the study (Thorn, 2016). In the current study, contextual awareness was addressed by providing a detailed description of the research contexts and background to readers and research consumers. Since I have the same cultural, political, and economic background as the participants. I was able to clarify any issues not clearly presented or understand.

3.9 Chapter Summary

In this chapter, I have described the ID research approach. The population, setting,

sampling strategies, data collection, and the data analytic processes used for the study were presented. The ethical considerations of the study were discussed in some detail, as were data trustworthiness and the ways they were enhanced. I have described and provided information about the decisions made at every stage of the research process. The rationale behind the decisions were explicitly provided at each stage of the study process in such a way that a different inquirer should be able to follow the same decisions and reasoning.

This approach has enabled me to interact with the study participants, to describe their health-seeking behaviors and the factors that they believe influence them in engaging in specific health-seeking activities after noticing a breast abnormality. Through this method, the present study has also generated information that provides understanding of the participants' beliefs, challenges, and motivations for engaging in specific health-seeking behaviors. In the next chapter, I present a manuscript on the study protocol.

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Chapter 4 MANUSCRIPT 1

**STUDY PROTOCOL FOR EXPLORING THE HEALTH-SEEKING BEHAVIORS, AND
FACTORS INFLUENCING THE HEALTH-SEEKING ACTIVITIES OF WOMEN
WITH ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA**

STUDY PROTOCOL FOR EXPLORING THE HEALTH-SEEKING BEHAVIORS, AND
FACTORS INFLUENCING THE HEALTH-SEEKING ACTIVITIES OF WOMEN WITH
ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA

4.1 The Relationship of Manuscript 1 to the Dissertation

In this manuscript, I present the protocol employed in exploring the health-seeking behaviors and the factors influencing the health-seeking activities of women with advanced breast cancer in Southwestern Nigeria, from their perspectives. This manuscript provides a summary of the study methodology. This manuscript will be submitted to the International Journal of Qualitative Methods for consideration for publication.

STUDY PROTOCOL FOR EXPLORING THE HEALTH-SEEKING BEHAVIORS, AND
FACTORS INFLUENCING THE HEALTH-SEEKING ACTIVITIES OF WOMEN WITH
ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA

4.2 Abstract

Background: Globally, breast cancer is second most common cancer. Breast cancer is the most common cancer in women both in more and less developed regions. It is the second cause of cancer-related mortality in women in developed regions after lung cancer, and the most common cause of cancer-related deaths in women in less developed regions. The leading cause of malignancy-related mortality among Nigerian women is breast cancer. In Southwestern Nigeria, women typically present with advanced stages of the illness, making the survival rate very low (48%). The aim of this study was to explore the women's health-seeking behavior from their perspective, as well as the factors the women believe influence their engagement in specific health-seeking activities.

Method: This research was a qualitative study guided by a constructivist naturalistic orientation to knowledge development. The conceptual framework adopted for the study was the health belief model (HBM), and the methodological approach was the interpretive description (ID). The study population were women in Southwestern Nigerian with advanced breast cancer, defined as stages III and IV. The study setting was a large, tertiary, and referral hospital in Southwestern Nigeria. Data were collected through one-on-one, semi-structured interviews guided by open-ended questions and from a demographic information form individual participant completed in advance. The interviews were audio-recorded, and data analysis of interview transcripts were inductive. Descriptive statistics were used to illustrate the study participants' characteristics. All interview transcripts were analyzed using a thematic analysis approach.

Findings: A thematic analysis of the study participants' interview transcripts was conducted to reveal the study participants' health-seeking behaviors and the factors the women believe influence their health-seeking activities. Methodologically, this study advances the use of a qualitative approach to inquiry in seeking to explore and understand the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria, a subject on which empirical literature is scarce.

Keywords: Advanced stages of breast cancer, health belief model, interpretive description, health-seeking behavior, women, Southwestern Nigeria, Nigeria.

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4.3 Statement of Problem

Breast cancer is the fifth cause of global cancer-related death and it is the second cause of cancer-related mortality after lung cancer in more developed regions of the world (Ferlay et al., 2015). In less developed countries, breast cancer is the leading cause of cancer-related deaths among women (Ferlay et al., 2015). Both the incidence and mortality rates of breast cancer have been rising in developing countries (Akarolo-Anthony, Ogundiran, & Adebamowo, 2010). In low-income countries, projections show that the incidence of breast cancer will continue to rise because of changes in population parameters and lifestyles (Porter, 2008). The breast cancer burden in low-middle income countries is growing, with survival rates much lower than those in high-income nations (Farmer et al., 2010; Parkin & Fernandez, 2006). Approximately 60% of breast cancer deaths occur in low-income, and economically developing countries (Jemal, Center, DeSantis, & Ward, 2010). In low-income countries, women present with the advanced stages of the illness (Jemal, Center, DeSantis, & Ward, 2010).

In Nigeria, breast cancer is the leading cause of cancer-related mortality among women (Adesunkanmi et al., 2006; Jedy-Agba et al., 2012; WHO, 2016), with 70-79% of women presenting with advanced stages, which are stages III and IV of the illness (Ezeome, 2010; Jedy-Agba, E., McCormack, Adebamowo, & dos-Santos-Silva, 2016). Research findings indicated that in low-income countries like Nigeria, women do not typically present until the illness has reached advanced stages, and delayed treatment represents significant problems for these women (Adesunkanmi, Lawal, Adelusola, & Durosimi, 2006; Oluwatosin & Oladepo, 2006).

Furthermore, in the advanced stages of the illness, conservatory surgery is difficult to realize (Adesunkanmi et al., 2006; Adisa et al., 2011; Azubuiké & Celestina, 2015).

In 2012, 27,304 cases of breast cancer, which accounted for 53% of other types of cancer, were diagnosed in Nigerian women while 13,960 deaths were recorded (GLOBOCAN, 2012; WHO, 2013). This figure amounted to a 48.9% survival rate. In the Western part of Nigeria, young women present with an aggressive subtype of breast cancer at the advanced stages of the illness (Adisa et al., 2012; Ntekim, Nufu, & Campbell, 2009; Pearson, 1963). The stage of breast cancer at diagnosis is a vital determinant of the illness survival rate; earlier stage disease presentation has often been associated with a better prognosis than later-stage disease presentation (Allemani et al., 2015). That is, advanced stage breast cancer has often been associated with a low survival rate (Ntekim, Nufu, & Campbell, 2009).

Delays in seeking appropriate treatment could result in advanced stage disease presentation. Presenting with advanced stages of the disease could be due to either patient-related factors or health system-related factors. Patient-related factors include age, education, economic status, sociocultural factors, knowledge about breast diseases, and health-seeking behaviors. Health system-related factors include the healthcare provider's characteristics, the waiting time for a cancer diagnosis, and lengthy referral protocols (Roy, Naher, Alam, Hanifa, & Sarkar, 2015).

Despite this high incidence of and mortality rates from breast cancer in Nigerian women, no empirical literature was found that explored the health-seeking behaviors of this population. The study sought to fill this gap in the literature by exploring the health-seeking behaviors and reasons why women delay in seeking medical attention and care in the hospital, when they suspect they might have breast cancer.

4.4 The Objectives of this Paper

The primary objectives of this paper are to present the methodology employed in exploring and understanding the series of activities and corrective measures in which Southwestern Nigerian women engage to restore their health after they perceive breast changes, and the factors they believe influence them to engage in specific health-seeking behaviors. The second aim is to share methodological ideas and insights with other students and researchers. The concept explored from the women's perspectives was the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria.

It was hoped that the findings from this study would inform strategies that nurses, and other healthcare providers could incorporate into their care plans. It was also hoped that the incorporation of these strategies would result in a more holistic approach to the management of breast cancer in the population studied. This comprehensive and holistic approach to care might lead to better breast cancer treatment outcomes and survival rates. The findings would hopefully, also, contribute to filling the gap in the literature.

4.5 Health-seeking Behaviors

Health-seeking behaviors are activities and initiatives in which individuals who perceive themselves to have health issues engage to resolve their perceived health problems. Health-seeking behaviors can either lead to a cure for the illness or reduce its effect on the individual's life. The measures undertaken are components of the health-seeking process (Chrisman, 1977). When individuals are ill, they are responsible for taking steps to restore their health by seeking help from appropriate and competent healthcare providers and return to full social functioning as soon as possible (Parson, 1951).

Health-seeking behaviors are often influenced by factors such as socioeconomic status,

gender, age; type of illness, the influence of significant others and other social networks, and the quality of healthcare services (MacKian, 2003). Delays in obtaining proper diagnosis and care could result in the worsening of symptoms, potentially leading to adverse effects or outcomes (Afolabi, Daropale, Irinoye, & Adegoke, 2013). For healthcare providers, understanding the health-seeking behaviors and factors that influence health-seeking behavior is, therefore, critical and crucial in providing patient-oriented services (Olenja, 2003).

4.6 Research Questions

The two research questions that guided the research study are as follows: 1) How do women presenting with the advanced stages of breast cancer in Southwestern Nigeria describe their health-seeking behaviors. 2) What factors do women presenting with the advanced stages of breast cancer in Southwestern Nigeria believe influence their health-seeking behaviors?

4.7 Material and Methods

The conceptual framework adopted for the study was the HBM, the methodological approach was the interpretive description (ID). Interpretive description is a qualitative research approach that can be used to investigate a problem originating from the practical setting and about which little is known. The findings from an interpretive description study can be practically used by the nurse and other professional in the applied professions.

4.8 Conceptual Framework

The conceptual framework adopted for the study was the health belief model (HBM), a social psychology model proposed by Hochbaum, Rosenstock, and Kegels (1952). The HBM was developed within the US Public Health Services (Rosenstock, 1974; Ahmadian & Samah, 2013). The HBM attempts to explain an individual's behaviors in seeking to avoid disease, exploring motivation, perception, and the circumstances confronting the 'behaving' individual

(Rosenstock, 1974). The originators of the model believed that individuals' current situation and circumstances determine their actions (Rosenstock, 1966).

The originators postulated that an individual has three regions of valences: positive, negative, and neutral. An illness represents a negative valence, which is supposed to move an individual towards the region of positive valence unless doing so would move the individual towards a deeper negative valence. An individual's activities are perceived as processes attracting that person towards the regions with a positive valence and repelling a person from those regions with a negative valence (Rosenstock, 1974). Initially, the model consisted of five constructs: perceived susceptibility, perceived seriousness, perceived benefits, perceived barriers, and cues to action. Through evolution and to enhance its breadth and the depth, the model was updated by adding self-efficacy (Elvis & Francis, 2015; Rosenstock, Strecher, & Becker, 1988). The assumptions of the HBM are that individuals will take actions to avoid a disease if a) they believe that they are susceptible to it, b) they believe that the disease threatens some aspects of their life, and c) they believe that taking a particular action is beneficial, either because it leads to a cure for the illness or reduces its severity (Rosenstock, 1974).

4.8.1 perceived susceptibility. Perceived susceptibility refers to the personal risks of contracting an illness. Perceived vulnerability varies from person-to-person (Rosenstock, 1974). Perceived susceptibility can be measured on a continuum (Rosenstock, 1974). The two extremes of this continuum are an individual who denies any possibility of contracting a given illness and an individual who may feel he or she is in real danger of contracting the illness (Rosenstock, 1974). When the perception of susceptibility is combined with the perception of seriousness, the result is a perceived threat (Rosenstock, 1974). The more intense the perceived threat, the higher the likelihood of engaging in behaviors to decrease the threat (Rosenstock, 1974). In the case of

breast cancer if women realize that late presentation could impact the treatment options and treatment outcome available to them, and mastectomy as possible outcome of late presentation, the perceived threat might increase. An increased level of perceived threat might convince a woman to engage in health-seeking behaviors, such as presenting early for diagnosis, treatment, and care of breast cancer.

4.8.2 perceived severity. The perceived seriousness of an illness also varies from person-to-person (Rosenstock, 1974). The perceived seriousness may be judged by an individual's emotional reaction to having the illness and the personal inconveniences the individual believes the illness will cause. Examples of inconveniences might be the effects of the illness on one's job, family life, and social relations (Rosenstock, 1974). Perceived seriousness is based on medical information or knowledge (Elvis & Francis, 2015). For breast cancer, the outcome of not taking appropriate action (death, or loss of a body part as in a mastectomy) might be presented to the patient.

4.8.3 perceived benefit. Perceived benefit is a person's beliefs about the value or usefulness of a health-related behavior in reducing the threat (Rosenstock, 1974). The perceived benefit concerns the effectiveness of the available options in reducing the illness threat. The perceived benefit influences the choice of behavior (Rosenstock, 1974). An individual's actions are also influenced by the standards and pressures of her or his significant others and social groups (Elvis & Francis, 2015; Rosenstock, 1974). In the case of breast cancer, women must believe that early presentation improves breast cancer survival rates. To maximize the potential for actions, and to convince women about the effectiveness of a health-related behavior, pictures of breast cancer survivors, who had engaged in the health-seeking behaviors, could be presented to the patients.

4.8.4 perceived barriers. Actions that are offensive, inconvenient, upsetting, painful, and distressing could act as barriers to engaging in specific health-related actions. If the motivation to act is higher than its negative aspects, the action is likely to be taken (Rosenstock, 1974). However, if the negative aspect is perceived to be higher than the motivation, the action is likely not to be taken (Elvis & Francis, 2015; Rosenstock, 1974). The cost of breast cancer treatments and any other inconveniences associated with breast cancer treatments could act as barriers to engaging in specific health-seeking behaviors and activities.

4.8.5 self-efficacy. Self-efficacy is a belief in one's ability to do something or to engage in an action. Self-efficacy is an individual's confidence with regards to the action (Rosenstock, 1974). In the case of breast cancer, self-efficacy could be related to the accurate performance of breast self-examination leading to the detection of either a breast lump or any other type of breast abnormality.

4.8.6 cues to action. Cues to action are internal and external factors that interact with an individual's believe to influence action. Cues to action can include events, people's opinions, advice from others, media messages, campaigns, and reports, knowing a person who has had the illness, reminders from healthcare personnel, and the influence of family members. Other motivational factors include demographic variables, psychological variables, and structural variables such as knowledge about the illness, socioeconomic status, and prior contact with the disease (Rosenstock, 1974).

4.9 Methodological Approach

A qualitative approach was adopted to explore and understand the activities in which Southwestern Nigerian women with advanced breast cancer engage to restore health or ameliorate their illness. This approach was chosen because a qualitative research approach

enables the researcher to explore, examine, and describe people, their experiences, and behaviors in their natural environment (Creswell, 2007; Orb, Eisenhauer, & Wynaden, 2001). The interpretive description (ID), a research methodology developed by Thorne, Kirkham, and MacDonald-Emes (1997) guided the collection and analysis of the data. This approach was chosen because little has been documented about the health-seeking behaviors of women presenting with the advanced stages of breast cancer in Southwestern Nigeria. As Thorne et al. (1997 p. 173) contends, “Interpretive description contributes to the understanding of how people experience their health and illness and what nursing can do to make a difference.” Thus, this research methodology seems ideal for determining the activities in which Southwestern Nigerian women who suspect they have breast cancer engage and the meaning of these activities to these women.

The ID research methodology was developed within the domain of nursing as a feasible alternative method of generating knowledge grounded in clinical nursing contexts (Thorne et al., 1997). Interpretive description captures themes and patterns embedded in personal experiences. The outcomes of ID studies can inform clinical understanding of phenomena (Thorne, Kirkham, & O’Flynn-Magee, 2004). Interpretive Description aligns with an interpretive naturalistic orientation, which acknowledges that human experience is both contextual and constructed (Thorne et al., 1997).

Rather than a specific set of procedures, the ID is a pragmatic approach, which uses a logic framework in implementing qualitative research techniques (Thorne, 2008). The logic framework is based on the reasoning applied at each decision-making point in the research process (Thorne, 2008). Beginning with the research question and proceeding through all the phases of the research study, the quality of the study relies on the goodness of fit between the

research question, and the decisions made in conducting and concluding the study (Thorne, 2008).

Interpretive description is different from other traditional qualitative descriptive methodologies in that ID researchers look below the surface of clinical issues by exploring the meanings and the explanations that might be applicable in clinical settings (Thorne et al., 2004). ID involves an inductive reasoning process that generates findings that are well grounded within the data (Thorne, 2016).

4.9.1 setting. The study participants were recruited from the oncology section of a large, urban tertiary, and university-affiliated hospital in Southwestern Nigeria. The hospital is a referral center for the whole country and West-African Sub-region. In the hospital, patients referred from hospitals near and far usually receive comprehensive, and specialist assessment, diagnosis, quality treatment, and care of breast cancer and other illnesses. Data were collected at the oncology section of this hospital.

4.9.2 the study population. The population for the study was women presenting with the advanced stages of breast cancer in Southwestern Nigeria. This part of Nigeria is dominated by the Yoruba ethnic group. Southwestern Nigeria consists of 6 states—Lagos, Oyo, Ogun, Ondo, Ekiti, and Osun. Southwestern Nigeria is on the Gulf of Guinea beside the bay. The Niger river forms its northern and eastern boundaries. Much of the region consists of the savanna and the tropical forests. The people live in large cities and villages.

4.9.3 sample selection. The purposeful sampling technique was used to select participants for the study. Purposeful sampling entailed the selection of information-rich participants (Patton, 2014). These participants can provide the researcher with a great deal of information about the issue under consideration. They must be willing to share this information

with the researcher (Patton, 2014). The information shared by the participants shed light on the phenomenon under study providing the researcher with critical information and leading to an in-depth understanding of the issues of central importance in the study (Patton, 2014). The inclusion criteria for the study were: a) a diagnosis of either stage III or stage IV breast cancer, b) the ability to communicate in either the English or the Yoruba language or both, c) being of the female gender, and d) the ability to take part in an interview.

4.9.4 participant recruitment procedure. A letter of support was requested from the authorities of the hospital where the data were collected. Ethical approval was obtained from the University of Saskatchewan, where the researcher is studying. Ethical approval was sought and obtained from the hospital where the data was collected. Permission to engage in data collection was obtained from the Chairman of the Medical Advisory Committee of the hospital. A letter of introduction and a copy of the ethical approval document were presented to the director of the oncology section to allow the researcher to gain access to prospective participants.

Two nurse clinicians at the oncology unit/ward who follow patients with advanced breast cancer were enlisted to serve as gate-keepers for the study. The researcher interacted with the gate-keepers before the commencement of the study to specify the characteristics and features of the study. These individuals were also provided with a reminder information sheet that described the purpose of the study, the inclusion and exclusion criteria, and other details. The gatekeepers assisted in recruiting participants in line with the inclusion and exclusion criteria of the study. The information sheet was given to the gate-keeper nurses, who helped the other nurses in recruiting appropriate participants. The researcher's local phone number was made available to the gate-keeper nurses, so they could alert the researcher when a potential participant was identified. After the researcher had been notified about a prospective participant, the researcher

called the research assistant, who reassessed the identified prospective participant and obtained the informed consent to participate in the study.

An appointment for an interview was scheduled at the consenting participant's convenience. The interview took place in a private room, which was previously arranged for the purpose in the hospital. Before the interview began, information about the study were reviewed with each participant. The researcher stressed that the participant was free to change her mind and not take part in the study, and to do so without penalty.

4.9.5 sample size. A sample of any size could be used in an ID study. The sample size adopted depends on the complexity of the issue under consideration. Many studies using this approach or some variation of it use small sample sizes between “five and thirty participants” (Thorne, 2016, p. 103). The researcher needs to put forward logical reasoning to justify the number of study participants, ensuring that the number of participants recruited for the study will generate credible and beneficial research outcomes (Thorne, 2016). In an ID study, data collection and analysis take place concurrently.

In the study, 30 participants were involved, a number guided by the saturation principle, also known as data redundancy. This phenomenon occurs when the researcher begins to hear the same comments again and again, can anticipate responses to the questions being asked, and realizes that no new information could enrich the emerging pattern from the data analysis (Thorne, 2016). At that point, according to Thorne (2016), the researcher understands that she or he has adequate participants to address the research question.

4.10 Data Collection

The goal of data collection in qualitative research is to describe a phenomenon from the participants' perspectives, typically through interviews and observation. In data collection,

researchers must keep in mind the focus of the research and be clear about their roles as researchers (Creswell, 2007). To facilitate a productive interview, rapport must be established between the interviewer and the interviewee. However, a balance that enables interaction but also preserves objectivity must be sought and maintained (Smith, Flowers, & Larkin, 2009). The data collection for the study occurred in two phases: first, each participant completed a personal demographic form, and second, the researcher conducted an audio-recorded, face-to-face, one-on-one, semi-structured interviews with study participants. These interviews were guided by open-ended questions.

4.10.1 participant demographic form. Each study participant who met the eligibility criteria and who consented to take part in the study were required to personally complete a researcher-designed demographic form. The demographic form obtained information on the participant's ethnic affiliation, age, educational attainment, yearly income, employment status, family history of breast cancer, and religious affiliation (Appendix A-1).

4.10.2 interviews. Each study participant participated in one-on-one, face-to-face, semi-structured interviews guided by open-ended questions (Appendix B-1). The interviews were conducted by the researcher. The interview questions and protocol were designed by the researcher based on the information obtained from the literature review. Broad questions on the interview guide asked for information on the participant's breast changes, health-seeking behaviors, knowledge and perceptions of breast cancer, and significant health-seeking behavior challenges. The interview protocol was translated into the local language by a professional Yoruba language translator (Appendix B-2) and then translated back by another independent translator to ensure consistency with the original meaning.

The interview protocol was assessed for its suitability to collect the required data by two

senior and experienced breast oncologists who have carried out research studies on breast cancer in the same context in Nigeria. To ensure the protocol was suitable and adequate to generate data on the health-seeking behaviors of women with advanced breast cancer, the protocol was pilot tested by interviewing similar breast cancer patients in the same setting as the study.

Once the protocol was deemed acceptable, study participants were interviewed in the language of their choice, either in Yoruba or English language. Questions on the health-seeking behaviors and factors that influenced their health-seeking behaviors were asked. Probes were used to encourage the participants to share the details of their experiences. The interviews were audio-recorded. Towards the end of the interview, a summary of the points that the participants shared were presented to them by the researcher for clarification. The duration of each interviews ranged from 10-45 minutes, depending on the information the participants were ready to share.

Field notes were written by the researcher to describe the setting and the environment of the interview. Non-verbal communication and interactions between each participant and the researcher were observed and acknowledged. Immediately after the interview, the researcher documented her thoughts and feelings about the interview. The researcher also engaged in reflexivity to explore and expose her personal biases (Thorne, 2016), to ensure that these biases do not negatively influence the study.

4.11. Data Analysis

Descriptive statistics (means, median, and simple percentages) were used to analyze and illustrate the participants' characteristics. The individual audio-recorded interviews were transcribed verbatim by the researcher into a Microsoft Word document. The researcher transcribed the interviews while listening to the audio recordings and made necessary corrections. The data were cleaned by removing all the data that could identify an informant or

any third party whose name was mentioned during the interview and replacing them with initials. The transcribed interviews in the Yoruba language were translated into the English language by the researcher. The translations were back-translated by another independent translator, who signed the confidentiality agreement, to ensure that the original meaning of the interviews was maintained. Individual participants' files were uploaded into NVivo, 12 software (QSR, International, 2018). The software was used to facilitate and organize the initial phase of analyzing the data into nodes.

Data analysis was inductive. Inductive data analysis entailed starting the data analysis process with immersion in the details and unique properties of the inquiry (Patton, 2014). It also involved knowing particular cases intimately, abstracting relevant common themes from these individual cases, and discovering central themes, patterns, and relationships (Thorne et al., 1997).

4.11.1 reflexivity. The researcher engaged in reflexivity, by exploring and paying attention to whatever emerged, to produce usable knowledge (Thorne et al., 1997). By engaging in reflexivity, the researcher brought to the surface, acknowledges, and reflects upon her ideas, which might influence the design and implementation of the study (Thorne, 2016).

4.12 Ethical Consideration

The core principles that express the value of human dignity as laid down in the Tri-Council Policy Statement (TCPS-2, 2014) and the principles of research ethics in Africa (Kruger, Ndebele, & Horn, 2014), guided the conduct of the study. Ethical issues were addressed before, during, and after the study. Human subject research ethics approval was obtained from the University of Saskatchewan Research Ethics Review Board before starting the study. To enter the research environment and collect data for the study, ethical approval was obtained from the

Joint Ethics Committee of the university and hospital where data were collected. Operational approval was obtained from the Chairman of the Medical Advisory Committee (CMAC) of the hospital.

Study prospective participants were fully informed of their rights as study participants. To safe guard against a possible power imbalance between the researcher, the gate-keeper nurses, and the study participants, a neutral person was employed as a research assistant, to obtain participants' informed consent to take part in the study. The research assistant, who was especially hired for this purpose, obtained informed consent from each participant. The written consent outlined the purpose of the study, the procedures to be followed, and potential benefits. Also, included in the consent form were information on data handling and storage, confidentiality, the right to withdraw consent to participate in the study at any time if the participant so wishes without any penalty, the right to answer only the questions the participant was comfortable with, permission to make an audio-recording of interview and for note-taking during the interview, ethics approval number, contact information of research supervisors, and that of the ethics board were given to each study participant. To ensure confidentiality, the participants' names did not appear on the demographic form and interview transcripts. Codes were used instead.

4.13 Rigor

Rigor in qualitative research refers to the truth value or trustworthiness of the study findings (Lincoln & Guba, 1985). Lincoln and Guba (1985) proposed four criteria for judging the integrity of the finding from a naturalistic inquiry: "credibility, applicability, consistency, and confirmability" (Lincoln & Guba, 1985, p. 290). Credibility is the extent to which the interpretations of the data are consistent with the ideas and meanings of the study participants.

To guarantee that the results are credible, and to ensure that the findings and interpretations are those of the study participants, the researcher engaged in reflexivity as noted above. During and after the interview, the researcher asked for clarification of the participants' shared experiences to ensure that the points being shared were accurately understood. As the data analysis progressed, the initial interpretations of the findings were discussed with the study participants to clarify if they resonated with their experiences. Consistency involves the stability of the research procedures. Creating a detailed audit trail will enable another researcher to follow the same process. Applicability refers to the extent to which the findings could fit into contexts outside of the study situation, and the results could still be found meaningful (Sandelowski, 1986). In the study, applicability was ensured by providing a detailed description of the research context and background to research consumers. Confirmability refers to a bias-free research process. Confirmability was met by ensuring that the study findings were grounded in the data (Sandelowski, 1986).

Other methods of ensuring methodological rigor proposed by Thorne (2000) include the following: following the principles of epistemological integrity, analytic logic, and interpretive authority. Epistemological integrity entails guaranteeing defensible coherence between the research question, study design, and methods (Thorne et al., 1997). Analytic logic applies to the ability of an outsider to understand the decisions made by the researcher throughout all the phases of the research process (Thorne et al., 2004). Interpretive authority entails making sure the researcher's interpretations are accurate and illustrate some truth external to the researcher's biases (Thorne, 2016).

4.14 My Experience as a Novice Researcher

As an international student studying in Canada, I went to Southwestern Nigeria, my

ethnic origin, to collect data for my thesis on the health-seeking behaviors of women with advanced breast cancer and factors the women believe influenced their health-seeking activities. Before I got ethical approval from the University of Saskatchewan Research Ethics Board (REB) to conduct the study, I was asked to get a letter of support from the University-affiliated hospital where I intended to engage in the data collection exercise for the study. After I obtained the letter, I attached a copy of the letter of support to the application package for ethical approval at the University of Saskatchewan seeking for permission to conduct the study. Thereafter, the approval certificate to conduct the study was issued to me.

On getting to the site of data collection, I presented the letter of support previously issued to me, the ethical approval certificate from the University of Saskatchewan where I am a student, and a letter of support from my research supervisor to the office of the Chief Medical Director of the hospital. At the Chief Medical Director's office, I was directed to go through the hospital's research ethics committee. On getting to the research ethics committee's office, I was asked to apply for ethical approval to engage in data collection in the setting. Therefore, I was given their research ethical approval application form to complete, and I was told to attach a shorter version of my study proposal, and the ethical approval to conduct the study from the university where I am studying. After I submitted all the requirements, I was informed that it might take a couple of weeks before I get feedback from them because of the enormous number of applications being submitted by other researchers.

While waiting for a response from the research ethics committee, I walked around the vast hospital complex, while at the same time reflecting on what the next steps might be. I realized that it was vital for me to establish connections with various important hospital community members and stakeholders before the research commenced, hoping that the

connection could allow the community to become comfortable with my presence, when I eventually start the data collection.

The following day, I went to the Director of Nursing Service's office, but I was informed that she had traveled for a program, and she might not be in the office for another week or so. I asked for directions to the Deputy Director, Nursing Services' office. I went there and introduced myself to her as a nursing doctoral candidate. I explained the purpose and the aims of my study to her, she was thrilled, and she escorted me to all the other relevant nursing departments, introducing me to them as a nurse, 'one of us', that is, giving me a kind of insider status, letting them know that I will be coming to the unit at any time so, they have to let all the other nurses know, and asking them to give me the necessary support during the data collection. That gave me the liberty to go in and out of the different units at any time without any embarrassment from anyone.

On another day, I approached the oncologists, introducing myself to them and explaining to them the purposes and aims of my study. I let them know that I had applied for ethical approval to engage in data collection in the setting and that I was waiting for feedback from the research ethics office. I engaged in free discussions with them. During one of my discussions with a senior breast oncology consultant, I was advised to submit my study protocol to two other experienced, senior breast oncologists (their names were given to me), who had conducted many research studies on breast cancer in the setting, and who are in right positions to assist me in evaluating the study protocol for its suitability and adequacy in collecting the required data for the study.

After the consultants returned the protocols to me, they did not suggest any changes. After that, I conducted a pilot study with the protocol. The lesson I learned from the pilot study

was that the first participant narrated a long-detailed story of her illness and her health-seeking behaviors. Many of the questions I had on the interview guide had been answered in the process. I quickly learned that I would have to listen very attentively to what subsequent participants will be sharing so that I will not be asking them questions to which they had already provided answers.

After I had been introduced to the relevant departments in the hospital, I started attending different clinics, counseling sessions, and breast cancer support group meetings scheduled for the different days of the week. I met with the Psych-oncologist, and I made arrangements with her to provide counseling services for any of my study participants who might be in need of such services after taking part in the study. I interacted with the gate-keeper nurses and all other breast cancer stakeholders daily, until I got the ethical and operational approvals to conduct the study. I also employed a neutral person to the position of a research assistant, and I explained her roles and responsibilities to her. The nurse managers in the different units provided the rooms where the interviews were conducted.

After about 12 days of submitting my application for ethical approval at UCH Ibadan, I got a notice that the number of study participant proposed (20) was too small. They advised that I reconsider recruiting a higher number of study participants. I explained to them that in qualitative studies, a sample of any size could be used, it depends on the peculiar characteristics of the study and the phenomenon under consideration. I, however, adjusted the proposal and increased the number of proposed study participants to 50, while stressing that the principle of data redundancy will be used to determine the final sample size.

After the amendment as requested by the research ethics committee, the ethical approval certificate to conduct the study was issued to me. I wrote a letter to the Chairman of the Medical

Advisory Committee, requesting operational approval for my study. To ensure the protection of the study participants during the time they will be actively participating in the study, and that the research proposal was implemented according to the written research proposal without any deviations, I was required to co-opt an oncologist in the local setting to both observe the informed consent process and monitor my research activities. Because I had already established relationships with almost everyone in the different relevant units, it was easy for me to approach another breast oncology consultant to write a letter stating that he will ensure that the study participants are adequately protected while the research will be conducted. After that, the operational approval was granted to me. A letter of introduction was written by the chairman of the medical advisory committee to the different relevant units where I needed to collect the data, telling them to allow me to have access to the prospective participants and telling them to cooperate with me during the data collection exercise.

4.15 Challenges

I encountered some challenges and difficulties during the initial phases of the data collection. In one of the units, the room assigned to me for conducting the interviews did not seem to be comfortable for the participants to express themselves. One could hear noises coming from the corridors. On one occasion, in the same unit, the interview room was not available for a participant to be interviewed because I met some other people in the room, giving me the impression that maybe some other researchers had access to the room. However, on letting the nurse manager in charge of the unit know about this problem, she promptly assisted in finding another location for me to carry out the interviews.

4.16 Strengths and Limitations of the Study

4.16.1 strengths. This study is unique in that the researcher shares the same ethnic background with the study participants. She also shares the same local language, music, and cultural heritage with them. She is a religious (a consecrated woman who lives, ministers, and prays within the world), and she is passionate about women health issues. Nigerians are very religious, and they revere religious personnel, trusting them, and in most cases, being open to discussing their problems with them. The personality of the researcher as a religious hopefully, therefore, created a haven where quality discussions took place to explore the issues under consideration. Such an environment also, enabled the collection of rich and high-quality interview data. Another strength of the study was that the participants were given the opportunity to choose the language of their preference for the interview, that is, either in the local or the English language. The researcher understands both the local and the English languages. There was no need for an interpreter. The researcher, however, appreciated that the narratives of the participants were their interpretations and representations of their experiences.

4.16.2 limitations. As mentioned, a sample size of 20 participants was proposed for this study. Even though the small sample size is not an issue in qualitative studies, the results of the study might have to be interpreted with caution. However, despite the small size of the sample, the results of the study are likely to be relevant to other women with breast cancer. Care must be taken, though, in interpreting the results as representing the perception of other ethnic groups in Nigeria. In fact, in interpretive description, generalization is not the aim as this method acknowledges that phenomena are neither time nor context-free. The goal is knowledge development. Nevertheless, depending on the extent and degrees of similarities of settings and

circumstances, transferability of knowledge from one situation to another might be possible (Creswell, 2007).

4.17 Significance and Implications

In Nigeria, late presentation of breast cancer, and limited treatment options have been assumed to contribute to the reasons for the poor prognosis of the disease. Exploring and understanding the health-seeking behaviors and the factors that influence the health seeking activities of Southwestern Nigerian women with the advanced stages of breast cancer could help identify the steps women take when they perceive breast ill-health and the actions that hinder an earlier presentation in the hospital. This new understanding could empower nurse clinicians and other breast cancer care stakeholders to recognize the critical areas and points contributing to delays in seeking medical attention for breast cancer and to develop and implement useful and contextually appropriate strategies, and interventions to encourage earlier presentation. Early presentation, diagnosis, and treatment of breast cancer might lead to improved treatment outcomes.

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Appendix 4.A.1: Participant Demographic Information Questionnaire

Please answer the following questions by checking a response or writing the answer in the space provided.

Date.....

Code no.....

1. What is your ethnic origin?

2. What is your primary language?

1. Yoruba

2. Ibo

3. Hausa

Some other language

(Specify): _____

3. How old were you on your last birthday?

_____ Years old

4. What is your highest level of education?

1. Less than primary six

2. Secondary School

3. Some college/Associate's
degree/technical certificate

4. Bachelor's degree

5. Graduate degree (e.g.
Master's, PhD, JD)

5. What is your current employment status?

1. Working for pay at a job or
Business

2. Looking for work, not
currently employed

3. Not currently working and not looking for work

6. In 2017, what was your total family income from all sources? Was it:

1. Less than N50, 000. 00

2. N100, 000. 00

3. N200, 000. 00 or more

4. N500.000. 00?

7. Does anyone in your family or household have breast cancer or any other kind of cancer?

1. Yes

2. No

8. What was the time frame between when you first noticed breast changes and the when you reported in the hospital?

Less than five months

Five to less than ten months

Ten to less than 15 months

More than two years

9. What is your religious affiliation? -----

Appendix 4.A.2: Participant Interview Guide in the English Language

Good morning/ afternoon. How are you today? How is your health condition? Let me start by thanking you again for agreeing to take part in this study.

My name is Agatha Ogunkorode. I am a graduate student from the University of Saskatchewan. As I explained to you earlier on, I am carrying out a study on the health-seeking behavior of women presenting with advanced stages of breast cancer in Southwestern Nigeria, and the factors that influence women in engaging in any health-seeking activity for the treatment of advanced stages of breast cancer in Southwestern Nigeria. This study is part of my PhD. Requirement. The aim of this study is to explore your health-seeking behavioral patterns, and any other factors that may be influencing health-seeking behavior for breast cancer among women. The goal of the study is to render an effective and comprehensive management of the disease to women. You have been purposely selected for this study.

I ask you to take this task seriously by sharing your opinions and ideas candidly and openly on the subject as this will facilitate the development of relevant interventions related to breast cancer in women.

The information collected will be confidential and it will be used for only the intended purpose of providing an integrated, comprehensive, and total management of breast cancer to women in Southwestern Nigeria.

To keep a more accurate record of our discussions and to ensure that it is accurately transcribed for my study as I explained to you before, I am proposing that we use a digital recorder. Do you mind if I use a digital recorder? (observe for any objection and if there is none, proceed). I can see that there is no objection to our using a digital recorder for this interview. I will also be jotting down some points in my notebook for the same reasons I discussed with you

before. I thank you again for your cooperation.

If you want, and you request it, I will provide you with a copy of the transcript of the interview. If you want me to turn off the digital recorder at any point during the interview process, please let me know, I will do so. You do not have to answer any questions that you are not comfortable with. You are also free to stop the conversation at any time and withdraw from the interview without any consequences. Do you have any questions about the whole process before we proceed? (Participant will now be given the demographic form to fill out).

This interview should take about 30-45 minutes.

- 1) Describe for me in as much detail as possible how you learned about your illness?
 - i. Probe for the full story.
 - ii. What were the signs that you saw? Probe for an explanation.
 - iii. How did you respond to the observation?
 - iv. What was your explanation of the signs and symptoms?
 - v. Did you consult other people about your signs and symptoms?
 - vi. If yes, who are these people that you consulted?
 - vii. What advice did they give you?
- 2) Before you were diagnosed with breast cancer, did you know that you might be suffering from the disease?
 - i. If no
 - ii. What then motivated or pushed you to seek for care in the hospital?
- 3) When people are diagnosed with breast cancer, they respond in different ways.
 - i. Tell me how you responded
 - ii. What steps did you take?

- iii. Tell me in detail what you did?
 - iv. What activities did you engage in to manage the illness?
- 4) What does breast cancer mean to you?
- i. In your opinion, is breast cancer treatable?
 - 1. If yes, how? If no, why not?
 - 2. Is breast cancer curable?
 - 3. If yes, how? If no, why not?
- 5) How long did it take between the time you noted the signs and symptoms of the illness and the time you decided to seek health care in the hospital?
- i. Did you seek health care elsewhere before you decided to go for treatment in the hospital?
 - ii. If yes, where did you go to seek for health care?
 - iii. What reasons made you to go there?
 - iv. Tell me about the kind of treatment you were given there?
 - v. Was the treatment helpful?
- 6) What would you say was a major factor that influenced your decision to seek for health care in the hospital?
- i. After initiating treatment at the hospital, did you seek for health care elsewhere?
 - ii. If yes, where
 - iii. What was your main reason for doing so?
- 7) What are the complications one is likely to get if one is not treated for breast cancer on time?
- 8) What in your understanding should a person do for the successful treatment of breast

cancer?

9) Who has the final say on when and where you should take treatment when you are ill?

10) Do you have a particular person or place where you go to take treatment when you are ill?

- i. What motivates you to go there for treatment?
- ii. What other factors make you go there for treatment?
- iii. Tell me in detail the nature of the care you obtain there?
- iv. How pleased were you with the care and attention given to you?
- v. What was helpful?
- vi. What was not useful?

11) What factors determine where you go for treatment?

12) How far is your home from the hospital?

- i. Does the distance from your home to the hospital affect your going there for treatment?

13) For how long on the average, do you usually have to wait at the hospital before seeing a doctor?

14) What can you say about the answers and explanations you get from nurses and other healthcare workers to all the questions and issues related to your illness?

- i. How would you describe your relationship with the nurses?

15) What support do you get from your family and friends in taking care of your illness?

- i. Who would you say provides most of your care/ support?
- ii. What do they do?
- iii. What should be done to assist you?

16) What would you say are the major challenges you have been facing in taking care of your illness?

i. How have you been addressing the challenges?

17) What have you learned from this illness?

18) What advice do you have for women having this kind of illness?

19) What can health care providers particularly nurses do to care more adequately for people with this kind of illness?

20) Do you think I should know anything else to understand the health-seeking behaviors you practice?

21) Towards the end of the interview, I will explain to the participant that I will transcribe the recorded interview, think, and reflect about it. I will ask if I can contact her again should I think I have any other questions. By the time the interview has been analyzed, several questions may have occurred to me. I will write down the questions. The second interview may help in the clarification of issues and points raised during the first interview.

22) Is there anything you would like to ask me or tell me?

Thank you very much for your participation.

Appendix 4.A.3: Participant Interview Guide in The Yoruba Language

ATÓKA ÌBÈÈRÈ ÒRÒ FÚN ÌPÀDÉ ÌWÁDÌÌ ÒRÒ LÓRÍ ÀWỌN OBÌNRIN TÍ N WÁ
ÌWÒSÀN ÀRÙN ỌMÚ TÓ TI WỌRA NÍ GÚSÙ-ÌWỌÒRÙN NIGERIA.

Atóka Ìwádíí Òrò Náà

È kú ikàlẹ̀ o. Òní áá san wá o. Šé ara le? Ara áá yá o. Šíwájú jẹ́ kí n dúpẹ̀ lówọ̀ yín tí ẹ̀ gbà láti kópa nínú ẹ̀kọ̀ yíi.

Orúkọ mi ni Agatha Ogunkorode. Èmi jẹ́ akẹ̀kẹ̀kọ̀ ẹ̀gbà láti University of Saskatchewan. Gégé bí mo ti šàlàyé šíwájú, èmi n ẹ̀ ìwádíí ẹ̀kọ̀ lóri àtíṣe àwọn obinrin alárùn ọmú tó ti wọra ní Gúsù-ìwọ̀òrùn Nigeria, pẹ̀lú àwọn ohun tí àwọn obinrin bẹ̀ẹ̀ n ẹ̀ láti wá ìmúláradá. Ìwádíí ẹ̀kọ̀ yíi jẹ́ apá kan pàtàkì nínú iṣẹ́ PHD tí mo n ẹ̀ lówọ̀. Ohun tí ẹ̀kọ̀ yíi n lépa ni láti wo àwọn ọ̀nà tí ẹ̀ n gbà fún itọ́jú, àti àwọn ọ̀nà miíràn tí àwọn ènìyàn n gbà wá iwòsàn àrùn ọmú lááárín àwọn obinrin. Ohun tí ẹ̀kọ̀ yíi n lépa ni láti fun àwọn obinrin ní itọ́jú tó kúnjú fún àisàn náà. A si mọ̀mọ̀ yàn yín fún ẹ̀kọ̀ yíi ni.

Mo n rò yín kí ẹ̀ gba iṣẹ́ yíi ní ọ̀kúnkúndún, kí ẹ̀ sọ tinú yín àti irísí yín ní kedere lóri òrò yíi, nítorí ṣíṣe bẹ̀ẹ̀ la ẹ̀ lè ṣíṣe borí àrùn ọmú obinrin.

Òrò aṣoṣo wa yíi wà ní àṣírìbò, ilépa àṣekápá àrùn ọmú obinrin ní apá Gúsù-ìwọ̀òrùn Nigeria nìkan ni a ó ló ó fún.

Kí òrò aṣoṣo wa yíi lè wà ní pípé mo dábáá kí a lo ẹ̀rọ agbòròsilẹ̀ (digital recorder). Šé kò sèni tó lòdi sí lílò ó? (Šàkíyèsí eni tí kò bá fẹ́. Bí kò bá sí, máa bá òrò lo). Mo rí i pé kò sèni tí kò fẹ́ bẹ̀ẹ̀. Èmi náà yóò máa kọ kókò òrò wa sínú iwé ọwọ̀ mi fún idí kan náà ti mo ti bá yín sọ tẹ̀lẹ̀. Mo dúpẹ̀ fún isowọ̀pọ̀ yín.

Bí ẹ̀ ba n fẹ́, tí ẹ̀ bá bèèrè fún un, èmi yóò fún eni bẹ̀ẹ̀ ní àdàkọ̀ àbájáde ìwádíí tí a n ẹ̀ yíi. Bí ẹ̀ bá n fẹ́ kí n pa ẹ̀rọ agbòròsilẹ̀ bí a tí n bá ìwádíí òrò wa lo, kí ẹ̀ jẹ́ kí n mọ̀. Èmi yóò sì ẹ̀ bẹ̀ẹ̀. Ẹ̀ kò ní láti dáhùn ibèèrè tí kò rọ̀rùn fún yín. Àyé sì wà láti dānu òrò dúró nígbà kúùgbà, àní láti jáde nídíí òrò láisí ohun tí yóò tẹ̀yìn rẹ̀ wá. (Wáyíi ni a ó fún àwọn tó wà ní ipídé ní iwé iye ènìyàn láti kọ ohun tí a bèèrè níbẹ̀).

ìwádíí òrò yíi yóò gba àsikọ̀ àádòrùn-ún (90) iṣẹ́jú (wákàtí kan àti iṣẹ́jú mēēédógún).

1. Šàlàyé ní kíkún fún mi ohun tí ẹ̀ ti mọ̀ nípa àisàn yín.

- i. Šé ìwádíí gbogbo itàn náà.
- ii. Àwọn àmì wo lẹ̀ rí? Wádíí fún àlàyé.
- iii. Kí ni ẹ̀ ẹ̀ nígbà tí ẹ̀ rí àwọn àmì náà?
- iv. Kí ni ẹ̀ ka àwọn àmì náà kún?
- v. Njẹ́ ẹ̀ fi irírí àwọn àmì náà lo eni kẹ̀ni?
- vi. Bí ó bá jẹ́ bẹ̀ẹ̀ ni, àwọn ta ni ẹ̀ fi lẹ̀?
- vii. Kí ni imọ̀ràn tí wọ̀n fún yín?

2. Kí a tó ɛ̀ ibèwò yín wò fún àrùn ọ̀mú, nǵé ẹ̀ mò pé ó ɛ̀ ɛ̀ ɛ̀ kí ó jẹ̀ pé àrùn ọ̀mú ló wà lára yín?
 - i. Bí bẹ̀ẹ̀ kọ̀
 - ii. Kí ló mú yín wá sí ilé iwòsàn fún ìmúláradá?

3. Lẹ̀yìn ɛ̀ ɛ̀ iwàdíí tí a sì mò pé àrùn ọ̀mú ló n ɛ̀ àwọn ènìyàn kan, oríṣíríṣi ọ̀nà ni ọ̀kàn wọn fi n gbà á.
 - i. Sọ fún mi bí ọ̀kàn yín ti gbà á.
 - ii. Àwọn ọ̀nà wo ni ẹ̀ gbà?
 - iii. Sọ fún mi lẹ̀ṣelẹ̀ṣe ohun tí ẹ̀ ɛ̀.
 - iv. ɛ̀ ɛ̀ wo ni ẹ̀ ɛ̀ fún itọ́jú àìlera náà.

4. Kí ni àìsàn ọ̀mú já sí fún yín?
 - i. Nǵé ẹ̀ rò pé àrùn ọ̀mú ɛ̀ wòsàn?
 - ii. Bí bẹ̀ẹ̀ ni: Báwo? Bí bẹ̀ẹ̀ kọ̀: Nítórí kí ni?

5. Báwo ló ti pé tó kí ẹ̀ tó wá fún itọ́jú ní ilé iwòsàn lẹ̀yìn ìgbà tí ẹ̀ ti rí àwọn àmì àìsàn náà?
 - i. Nǵé ẹ̀ lọ ibòmíṛàn fún itọ́jú kí ẹ̀ tó pinnu láti wá gba itọ́jú ní ilé iwòsàn?
 - ii. Bí bẹ̀ẹ̀ ni: Níbo ni ẹ̀ ti lọ gba itọ́jú náà?
 - iii. Kíló mú yín lọ ibè?
 - iv. Sọ fun mi, irú itọ́jú wo ni ẹ̀ rí gbà lẹ̀hùn-ún?
 - v. Nǵé itọ́jú náà ɛ̀ yín lánfààní?

6. Kí ni ìdí pàtàkì tí ẹ̀ lè sọ pé ó mú yín wá fún itọ́jú ní ilé iwòsàn?
 - i. Lẹ̀yìn ibèrè itọ́jú ní ilé iwòsàn nǵé ẹ̀ tún lọ ibòniṛàn fún itọ́jú?
 - ii. Bí bẹ̀ẹ̀ ni: Níbo?
 - iii. Kí ni ìdí pàtàkì tí ẹ̀ fi ɛ̀ bẹ̀ẹ̀?

7. Àwọn ilọ́júlẹ̀ra wo ló lè ɛ̀lẹ̀ bí a bá pé láti gba itọ́jú fún àrùn ọ̀mú.

8. Kí ni ẹ̀ mò tó yẹ kí a ɛ̀ fún itọ́jú tò péye fún àrùn ọ̀mú?

9. Ta ni aláṣe ibi tó yẹ kí ẹ̀ ti lọ gba itọ́jú nígbà tí ara yín kò bá dá?

10. Nǵé ẹ̀ni kan tàbí ibi kan wà pàtò tí ẹ̀ ti n gba itọ́jú nígbà tí ara yín kò bá yá?
 - i. Kí ló fà á tí ẹ̀ fi n lọ ibè fún itọ́jú?
 - ii. Kí ni àwọn ohun miṛàn tó n mú yín lọ síbè fún itọ́jú?
 - iii. Sọ fún mi lẹ̀ṣelẹ̀ṣe irú itọ́jú tí ẹ̀ n rí gbà lẹ̀hùn-ún?
 - iv. Báwo ni itọ́jú ọ̀hùn-ún ti tẹ̀ yín lórùn tó?
 - v. Nǵé ó ɛ̀ràn lówó?
 - vi. Kí ni kò wúlò níbè?

11. Àwọn ohun wo ló lè mú yín mọ̀ ibi tí ẹ̀ ti lè lọ gba itọ́jú?

12. Báwo ni ibùgbé yín ti jìn sí ilé iwòsàn tó?
 - i. Nǵé ọ̀nà jínjìn ibùgbé yín sí ilé iwòsàn jẹ̀ ohun idínà fún yín ní lílọ̀ gba itọ́jú níbè?

13. Báwo ni ẹ sáà ti n dúró pé tó kí ẹ tó lè rí Dòkítà ní ilé iwòsàn?
14. Kí ni irísí yín nípa ìdàhùn àti àlàyé àwọn Nòrsì pèlú èyí ti àwọn oníṣé ìtójú n fún yín lórí àwọn ọ̀rọ̀ tó jẹmọ̀ àìlera yín?
i. Kí ni ẹ lè sọ nípa ìṣesí àwọn Nòrsì pèlú yín?
15. Ìrànlowó wo ni ẹ n rí gbà láti ọwó idílé yín pèlú àwọn ọ̀rẹ̀ yín fún iwòsàn yín?
i. Ta ni ẹ lè pè ní agbáterù ináwó fún ìtójú yín?
ii. Kí ni wọn n ẹ?
iii. Kí ni a lè ẹ láti ràn yín lowó?
16. Kí ni ẹ lè sọ pé ó jẹ àwọn ìṣòro pàtàkì tó dojúkọ yín nínú ìtójú àìsàn yín yí?
i. Báwo ni ẹ ti ẹ n dojúkọ àwọn ìṣòro yín náà?
17. Èkọ wo ni ẹ rí kọ nínú àìsàn yí?
18. Ìmòrán wo ni ẹ ní fún àwọn obinrin tí àìsàn yí n ẹ?
19. Kí ni àwọn oníṣé iwòsàn, ní pàtàkì àwọn Nòrsì, kí ni wọn lè ẹ láti ẹ̀tójú tó gbéṣe tunbò sí i fún àwọn onírú àìsàn yí?
20. Njẹ ohun míràn wà tí ẹ rọ pé ó yẹ kí n mọ kí ẹsì yín nínú irú àìsàn yí lè yé mi dáràdàrà?
21. Njẹ ó ní ohun kóhun tí ẹ bá fẹ̀ bẹ̀rè lowó mi?
- Mo dúpẹ̀ púpọ̀ lowó yín fún ikópa yín nínú ọ̀rọ̀ yí.

CHAPTER 5: MANUSCRIPT 2

**THE SUITABILITY OF THE HEALTH BELIEF MODEL TO EXPLORE THE
HEALTH-SEEKING BEHAVIORS OF WOMEN WITH ADVANCED BREAST
CANCER IN AN AFRICAN CONTEXT**

THE SUITABILITY OF THE HEALTH BELIEF MODEL TO EXPLORE THE HEALTH-SEEKING BEHAVIORS OF WOMEN WITH ADVANCED BREAST CANCER IN AN AFRICAN CONTEXT

5.1 Relationship of This Manuscript to The Dissertation

The conceptual framework adopted for this study was the health belief model (HBM). In this manuscript, I discuss the suitability of HBM for my study on the health-seeking behavior and the factors influencing the health-seeking activities of women with advanced breast cancer in Southwestern Nigeria. There are wide divergences between the philosophical underpinnings of HBM, which are based on the ideologies of a male-dominated society in the developed regions of the Western world, and those of my study, which consider the reflections and perceptions of women from a developing country, in an African context. This manuscript will be submitted to Nursing Outlook Journal for consideration for publication.

THE SUITABILITY OF THE HEALTH BELIEF MODEL TO EXPLORE THE HEALTH-SEEKING BEHAVIORS OF WOMEN WITH ADVANCED BREAST CANCER IN AN AFRICAN CONTEXT

5.2 Abstract

Breast cancer is the most common cancer in women in both more and less developed regions of the world. In more developed regions, breast cancer is the second cause of cancer-related death after lung cancer (Ferlay et al., 2015). In developing regions, breast cancer is the leading cause of cancer-related deaths in women, with 324,000 deaths in 2012, representing 14.3% of all cancer-related deaths (Ferlay et al., 2015). The empirical literature on Nigeria indicates that women present with the advanced stages of the illness. It is therefore essential to explore and understand the health-seeking behaviors of women with breast cancer from the time they notice a breast abnormality to their eventual presentation at the hospital for the management of the illness. In this paper, I discuss the suitability of the health belief model (HBM) as a construct for exploring the health-seeking behaviors, and factors influencing the health-seeking activities of women with advanced breast cancer in Southwestern Nigeria, an African context. The sample for the study consisted of 30 women who presented with advanced stages of breast cancer in a Southwestern Nigerian urban, university-affiliated hospital. Components of the original HBM: perceived susceptibility, perceived seriousness (perceived threat), perceived benefits, perceived barriers, and cues to action were identified to explore the health-seeking behaviors and factors that women believed influenced and motivated their health-seeking activities.

Findings indicated that the participants viewed breast cancer as a definite threat- both as a spiritual attack and as a killer disease. They perceived some benefits to both traditional and

medical treatment options and barriers to engaging in health-seeking behavior, such as the stigma attached to breast cancer and the association of hospital with death from cancer. Many of their perceptions appeared to be culturally based, while others were based on their individual experiences.

The findings are consistent with the hypotheses of HBM. Interventions that address people's perceptions of susceptibility, seriousness (threat), benefits, and barriers when supported by effective cues to action could be effective in managing the advanced stages of breast cancer in Southwestern Nigeria.

Keywords: Women, breast cancer, Health Belief Model, Southwestern Nigeria, Nigeria.

THE SUITABILITY OF THE HEALTH BELIEF MODEL TO EXPLORE THE HEALTH-SEEKING BEHAVIORS OF WOMEN WITH ADVANCED BREAST CANCER IN AN AFRICAN CONTEXT

5.3 Health Belief Model (HBM)

The Health Belief Model (HBM), a social psychology model was developed by Hochbaum, Rosenstock, and Kegels (1952), to explore why individuals failed to participate in relatively free health preventive services (Rosenstock, 1974). The model has been described as one of the most widely used conceptual frameworks in health behavior. Although there are several other health-related behavioral models, none approaches HBM regarding research attention (Janz & Becker, 1984). Notwithstanding its wide use for almost four decades, the major components of the model have remained unchanged. The model has avoidance orientation. Diseases or illnesses are perceived as unpleasant situations to be avoided (Rosenstock, 1974a). Health belief model specifies several variables that seem to contribute to an understanding of health-seeking behaviors. The variables involve an individual's subjective world, and the model aims to connect the current subjective status of a person with his or her current health behavior (Rosenstock, 1966).

5.4 The Philosophical Underpinnings of the HBM and the African Context

The philosophical underpinnings of HBM are based on the principles and ideas about behavior in a male-dominated society. Such principles include freedom to act without consulting anyone and adherence to one's own ideas and desires. In the HBM, subjective beliefs are regarded as motivators for undertaking a health-related behavior (Rosenstock, 1966). In the African context, women's autonomy is limited. Autonomy is defined as the freedom to act independently or make independent decisions without consulting others, or seeking their

permission at act (Santow, 1995). In many developing countries, including Nigeria, male domination is still the norm in some quarters. However, since few studies have been done about women's autonomy in Nigeria, little is known about their freedom to make health-related behavior choices and control of financial resources in the households.

5.5 The HBM and the African Context

A significant number of studies using the HBM as a framework have focused almost exclusively on samples whose illness situations have been shaped by the Western biophysical model of medicine. Among the 46 studies reviewed by Janz and Becker (1984), none was carried out in a non-Western culture. Similarly, in a meta-analysis conducted by Harrison, Mullen, and Green (1992), none of the studies analyzed were conducted with participants from a non-Western culture. However, Elvis and Francis (2015) conducted a literature review exploring the application of the HBM in HIV prevention, in a subdivision of rural Cameroon. In another study based in Africa, Onoruoiza, Musa, Umar, and Kunle (2015) used the HBM as an intervention framework to explore non-compliance with guidelines for hypertension among hypertensive patients in Northern Nigeria. Akhigbe and Akhigbe (2012) also used the HBM as a framework to study the effects of health beliefs and cancer fatalism on the practice of breast cancer screening among Nigerian women. Although this last study investigated the cultural beliefs and attitudes towards breast cancer screening, it did not seek in-depth information from women with breast cancer about their healthcare decisions. None of these authors discussed the degree to which the model was deemed appropriate as a conceptual framework for their studies. The current study used components of the HBM: perceived seriousness, perceived threat, perceived benefits, perceived barriers, and cues to action, to explore the health-seeking behavior, and factors that affect it from the perspectives of the women themselves. It is noteworthy that, women who

already have breast cancer are susceptible.

5.6 The Assumptions of the HBM

The assumptions of the HBM indicates that (1) individuals take actions related to their health if they are convinced they are at risk for contracting an illness and if the action can either remove the illness or reduced its impact on some aspects of their lives; (2) they are likely to accept, take, and maintain the action if they see benefits in the specific health-related behavior and conversely, not to accept, take, and maintain the action if they see no benefits; (3) individuals take health-related action provided its positive aspects outweigh the negative and they are confident in their skills and resources to undertake the action or health-related behavior (Rosenstock, 1974; Rosenstock et al., 1988).

5.7 Methods

5.7.1 study setting. The study was conducted in a large urban-based tertiary hospital in Southwestern Nigeria. The hospital was chosen because of the diversity of the patient population that visit the hospital. It has a well-equipped oncology section where patient from near and far receive high-quality oncology care.

5.7.2 study design. The researcher used the interpretive description design. Interpretive description (ID) is a qualitative methodological approach that is flexible and creative in generating knowledge to inform clinical understanding (Thorne, 2016). The logic framework of ID is based on the reasoning and logic applied at each decision-making point in the research process (Thorne, 2016). Interpretive Description is well-suited for exploring how people give meaning to their lived experiences. It is an inductive analytic approach that acknowledges both the constructed and contextual nature of human experiences (Thorne et al., 1997). Through ID, researchers identify patterns and themes in human experiences.

5.7.3 study participants. The study participants were women with advanced breast cancer. They were all in different stages of breast cancer management. Appointed gate-keeper nurses and oncologists assisted in identifying and approving prospective participants. A trained research assistant, who was employed for the purpose, obtained the prospective participant's informed consent to participate in the study.

5.7.4 sampling and sample size. Thirty women with advanced breast cancer were purposively selected to participate in the study. The inclusion criteria included women with advanced breast cancer, who can take part in an interview and are willing to participate in the study.

5.7.5 data collection. The data collection was undertaken in two phases. The first phase consisted of participants completing a personal demographic information form, while the second phase consisted of participation in one-on-one, face-to-face, semi-structured, audio-recorded interviews, guided by open-ended questions, conducted by the researcher. Broad topics on the interview guide included the participants' health-seeking behaviors after they noticed a breast abnormality and the factors that influenced their health-seeking behaviors. The interview guide was pilot tested before using it to collect the data. All data collection occurred in a private room previously arranged for the purpose in the hospital. Each participant had the opportunity of choosing the language in which they were interviewed. That is, either in the local or the English language. During the interviews, clarifications were sought as deemed necessary.

The researcher transcribed the interview audio-recordings verbatim. The researcher also translated the interview transcripts needing to be translated from the local language to the English language. The interview transcripts were read and reread while listening to the audio-recordings. All necessary corrections were made. The translations were back-translated by

another independent translator to ensure the meanings of the interviews were maintained.

5.7.6 data analysis. The participants' demographic questionnaires were analyzed using descriptive statistics, while the interview transcripts were analyzed inductively using thematic analysis. The interview transcripts were read and reread for familiarization. The interview transcripts were uploaded into N'VIVO 12 software (QSR, International, 2018). The first cycle coding identified broad-based codes. During the second phase coding, similar codes were grouped into categories. The categories were refined into themes. Intraparticipant comparison of data was carried out. Themes were supported and verified by direct quotes from the participants' statements.

5.8 Methodological Rigor

Four criteria suggested by Lincoln and Guba (1985) for judging the trustworthiness of research findings include credibility, dependability, confirmability, and transferability. In this study, credibility was ensured by using member checking to confirm the researcher's understanding of participant's shared experiences by a) summarizing the participants' discussions during and at the end of the interviews, b) consultation with the researcher's supervisors, and c) maintaining an audit trail of the decisions made during the research process. Transferability was ensured by providing "thick descriptions" of the research process from the beginning to the end (Lincoln & Guba, 1985). Dependability was ensured through consultation with experts throughout the research process. Member checking minimized the researcher's personal biases. Confirmability was ensured through validation of the initial findings with the participants, personally transcribing the interviews, using participants' exact quotes, and maintaining a reflexive journal to express the researcher's own biases and personal thoughts.

5.9 Ethical Consideration

The University of Saskatchewan Behavioral Research Ethics Board (REB) granted ethical approval to conduct the study. Operational approval was granted by the authorities of the hospital where the data for the study were collected. Efforts were made to ensure the participants' rights as study participants were protected. All participants were informed that their participation in the study was voluntary and they were assured of their rights to withdraw from the study at any time if they wish to do so without any penalty. They were informed of their rights not to answer any questions with which they were not comfortable. Written informed consent was obtained from all study participants, following informed consent procedures, before participation in the study. Every attempt was made to ensure the study participants' anonymity and confidentiality of the information provided.

5.10 Findings and Discussions

5.10.1 Study participants' demographic information. The analyses of the participants' demographic information indicated they have a varied level of education, employment, and economic status. They have different family histories of breast cancer. Their age range was 29-68 years. Most of the participants were between 40- and 50 years. Their mean age was 47 years.

5.11 Constructs of the HBM

This section presents the ways in which the constructs of the model predicted the health-seeking behavior of women presenting with advanced breast cancer, starting with the first time the women noticed breast changes to their engagement in definitive treatments for breast cancer, such as chemotherapy, radiation, and surgery. As noted above, the HBM addresses an individual's perception of the warning and the danger of a health issue and appraises health-seeking behavior in preventing or managing the health problem (Carpenter, 2010). Below is a

discussion of the five concepts of HBM —perceived susceptibility, perceived severity, perceived barriers, perceived benefits, and cues to action (Rosenstock, 1966, 1974b) and how they were used in my study.

5.11.1 perceived susceptibility. Perceived susceptibility involves a person’s belief in the risk for contracting an illness (Rosenstock, 1966). This construct was not directly a part of the focus of the current study because risk for contracting the illness in women already diagnosed with late-stage breast cancer is no longer a concern (Carpenter, 2010). However, all the participants in the study were aware of having contracted an illness that kills whosoever is afflicted by it, resulting in their heightened level of perceived threat. This finding is consistent with the notions of the original HBM.

5.11.2 perceived seriousness. Perceived seriousness concerns a person’s belief in the severity of an illness. The degree of perceived seriousness is often influenced by the strength of the psychological arousal created by the illness when individuals think about it and the perception of the kinds of difficulties they believe a given illness would cause for them (Rosenstock, 1966, 1974b). The perception of severity plays a role in decision-making about a health-seeking behavior. In the current study, advanced breast cancer was considered severe because of the cultural perceptions of breast cancer as a spiritual attack and the personal perception of breast cancer as a killer disease. In addition, some manifestations of breast cancer, including painful and embarrassing breast changes, aroused emotions related to the perceived psychological and physical consequences of the illness. The awareness of having contracted such an illness also heightened levels of threat, triggering participants’ decision-making processes about engaging in health-seeking behaviors. This observation is consistent with the notions of the original HBM.

5.11.3 perceived benefits. Perceived benefits relate to an individual's judgment of the worth of an action; in other words, how beneficial a person judges an action to be (Rosenstock, 1966). According to Rosenstock (1974), for the individual to engage in the action for managing health-related issues, the perceived benefits of the action must be judged to be higher than the perceived barriers. Thus, an African woman with advanced breast cancer must believe that it is worth overcoming hurdles to accept chemotherapy, radiotherapy, and surgery for the management of her breast cancer. If she believes that a treatment could prevent complications, such as cancer metastasis or death from occurring, she would be more inclined to engage in this treatment. However, if she believes that going through chemotherapy, radiotherapy, and surgical removal of her breasts would not be beneficial, she may be less likely to engage in the health-seeking behavior. In the current study, the wish for positive change and the desire to live were judged by the study participants, at least in the advanced stage of their illness, to be more beneficial than any barriers, including stigma, and other unwarranted side effects of treatment. This finding is consistent with findings from a mixed method study conducted by Aduayi, Onayade, Aduayi, and Ijadunola (2015) to explore whether women in some rural and urban communities in Southwestern Nigeria would accept preventive bilateral mastectomy. The findings indicated that the decision to remove both breasts through preventive bilateral mastectomy among high-risk individuals transcended social and spiritual boundaries. The findings from Aduayi et al. (2015) and those of the current study are, consistent with the notions of the original HBM.

5.11.4 perceived barriers. Perceived barriers relate to the adverse aspects, and impediments to undertaking health-related actions. Perceived barriers could be emotional, psychological, and material in nature. They concern the extent to which an action is

inconvenient, expensive, painful, unpleasant, and upsetting (Rosenstock, 1966). In the current study, the barriers identified were as follows: the financial difficulties of breast cancer treatment, the effects of the illness on participants' social and marital relations, and the unpleasant side effects of breast cancer treatments such as skin changes, and fear. The women did not perceive these barriers as outweighing the benefits and the expected outcome of breast cancer treatments. That is, the participants' desire to become breast cancer survivors was greater than their desire to avoid unpleasant treatments and other negative effects of the disease. This observation is consistent with the notions of the original HBM.

5.11.5 cues to action. Cues to action are either internal or external triggers that could trigger a decision-making process to engage in a health-related action. Internal cues to action include the signs and symptoms of illness, while external cues include media communications, social interactions, and the influence of significant others (Rosenstock, 1966). In the current study, breast changes such as hardness and breast discharge, worsening of symptoms, and pain were identified by the women as signs that compelled them to engage in health-seeking behaviors. These signs could be regarded as internal cues to action. In line with Rosenstock (1966), if cues to action are forceful and intense, they might convince a woman who recognizes neither that she is in the advanced stages of breast cancer nor the severity of the situation, to adopt a curative health-seeking behavior, notwithstanding her initial impression and belief. The participants in the current study found encouragement and support to engage in health-seeking behaviors in the influence and roles played by their family members, friends, church affiliations, and other social networks systems, which could be regarded as external cues to action for these participants. These findings are consistent with the notions of the original HBM.

5.11.6 the concept of perceived threat. The concept of perceived threat is a combination of perceived susceptibility and perceived seriousness. This concept was mentioned by Rosenstock (1974), but it was not defined separately. A heightened level of threat can trigger a decision-making process to engage in health-seeking behavior. It can also motivate a person to accept, adopt, and maintain a health-related action (Rosenstock, 1974b). The current study participants manifested signs of threat.

The perceived threat was likely influenced by any or a combination of the following factors: the experience of breast changes, the individual's appraisal of the breast changes, worsening of symptoms, the individual's perception of breast cancer as a killer disease, and the cultural perception of breast cancer as a spiritual attack. These, in turn, influenced the participants' health-seeking behaviors, as well as, cues to action, which are regarded as triggers and strategic reminders such as the supportive role of family members, friends, church members, and other social networks. Thus, the participants felt they were supported and encouraged by their significant others to engage in health-seeking behavior to manage their breast cancer.

As observed in the study, a woman's perception of threat alone was enough to predict her likelihood of engaging in specific health-seeking behavior. Perceived benefits and perceived barriers also could predict behavior. For instance, in the study, the participants considered the benefits of chemotherapy, radiotherapy, and mastectomy in preventing cancer metastasis to outweigh their perceived barriers, which they perceived as minimal. They were also positively influenced by their significant others such as their families, friends, and other social networks. Therefore, they engaged in health-seeking behaviors such as coming to the hospital for the management of their breast cancer. The findings are consistent with the notions of the original HBM.

5.12 The Assumptions of the HBM and those of the Study

The assumptions of this study are parallel to those of the HBM. The assumptions of this study are that a Southwestern Nigerian woman will take health-related action if she: a) perceives that she has contracted a serious health condition (advanced breast cancer); b) has a confident expectation that the available treatment options could cure the advanced stage breast cancer; c) believes that the benefits of the health-related behaviors outweigh the challenges or difficulties inherent in the health-related action; and d) enjoys the support and favor of her significant others, friends, and other social network systems.

The health-seeking behaviors of women presenting with advanced breast cancer in Southwestern Nigeria were influenced by the following: the perceived threat of breast cancer as a life-threatening illness (an illness that few people survives or as a killer disease); the perceived benefits of the treatment options (prevent death); the perceived barriers to engaging in the health-related action (e.g. stigma, not enough money, side effects of breast cancer drugs, and fear), and their available cues to action (supportive and encouraging roles of family, friends, church members, and their other social network support system).

As mentioned, an assumption of the study was that the HBM is a suitable framework to guide this study. The basis of this assumption are as follows: first, HBM's successful use as a framework in many studies; second, the empirical studies of HBM variables; third, the conception and presentation of the HBM added to the prediction of mammography screening behavior in African American women (Champion et al., 2008); the predictive nature of HBM constructs for increasing mammography screening behavior in African American women, particularly, the perception of susceptibility, benefits, and barriers (Champion & Skinner, 2003). Forceful and intense cues to action could convince a woman who does not recognize her breast

changes to be severe, to accept available therapeutic options, notwithstanding her initial impression and belief (Rosenstock, 1966).

It must be recognized, however, that the population for which the HBM was initially developed had been provided with valuable and essential health information, urging them to use the available health-seeking resources. This population also had access to preventive, diagnostic, and health care through the provision of health insurance. Cues to trigger action were also available. Some African countries, including Nigeria, lack access to these essential health care benefits. Breast cancer treatments and care are paid for through individual out-of-pocket payments (Ezeome & Aranada, 2007; Ezeome, 2010). Notwithstanding a lack of both resources and essential cues to action, the current study participants engaged in health-seeking behaviors to manage their breast cancers because of they had a strong desire to live.

Perceived benefits and barriers have been identified to significantly and consistently predict behavior when the goal is the prevention of an adverse health outcome (Carpenter, 2010). Southwestern Nigerian women presenting with breast ill-health, have the desire to live. They also face many challenges and difficulties, which prevent them from presenting earlier for optimum care. Some such barriers include the financial burden and side effects of breast cancer treatments. In a developing country like Nigeria, other sociocultural barriers, such as stigma and misconceptions about breast cancer care, constitute barriers to seeking professional breast cancer care. To encourage earlier presentation of breast cancer, the obstacles and barriers that prevent women from seeking timely medical care first need to be identified and addressed.

Perceived threat (perceived susceptibility plus perceived seriousness), perceived benefits, perceived barriers, and cues to action constructs of the HBM are better aligned with this study. Literature: Carpenter (2010); Champion, Skinner, and Menon, 2005; Janz and Becker, (1984);

Rosenstock, (1966) support their consistency in predicting behavior.

5.13 Implications for Nursing Practice

Nurses clinicians, nurse researchers, nurse educators, and other healthcare providers are in ideal positions to identify and counter perceived barriers to early presentation of breast cancer. By using the HBM construct to identify individuals' perceived barriers (e.g. fear of death, fear of embarrassment, fatalistic views of breast cancer, side effects of breast cancer treatments, and stigma), the nurse can plan, develop, and implement strategies to address the identified issues. For example, the nurse can design programs and strategies that acknowledge and address the personal, cultural, and community factors that influence the perceptions of breast cancer and its management. Engaging community and public health approaches to address breast health education and breast cancer awareness could increase understanding of breast cancer-related issues, thereby, leading to changes at the individual, institutional, and community levels. Findings from the study also indicated the need to use multi-sectorial approaches through collaboration with various stakeholders, such as government, the civil society, and private sectors, in addressing culture-specific breast cancer-related issues and providing culturally sensitive services.

5.14 Proposed Additions to the Health Belief Model Constructs

5.14.1 cultural perception. The cultural background of the Yorubas influences their views of an illness and the health-seeking remedies employed in managing the illness. The Yoruba people believe that illness does not occur by chance. Therefore, a Yoruba person will explore why she or he became ill by consulting the traditional healer, who will consult the Ifa Oracle- “an ancient secret knowledge system” (Ogundele, 2017, p. 129). The traditional healer will also prescribe the necessary remedies for the illness (Adepoju, 2012). In the Yoruba culture,

it is believed that illnesses have three origins: preternatural, natural, and supernatural (Ademuwagun, 1969; Jegede, 2002; Adegoke, 2007).

The preternatural origin relates to the magical practices of witches, sorcerers, and curses. This source of an illness reflects hostility and jealousy within the community (Ademuwagun, 1969). Illnesses resulting from a faulty diet, the excessive use of drugs, and the infringement on social values like stealing are said to have natural origins. The supernatural cause of illness is attributed to the wrath of God and ancestors. Such wrath may result from the violation of certain taboos. The Yorubas also believe that some illnesses such as those originating from preternatural and supernatural origins can only be treated and managed through their traditional healing methods, which are usually carried out by the native doctor, the herbalist, or the spiritualists. Typically, the native doctor would consult the oracle to inquire about the source of the illness and prescribe the necessary remedies (Ademuwagun, 1969; Jegede, 2002; Adegoke, 2007).

Therefore, the perception of individuals about the cause of their illness will trigger a decision-making process to choose a health-seeking behavior that the individual perceives will be the most effective and appropriate method from the available health-seeking options. If individuals believe that their illness has a supernatural or preternatural origin, they are more likely to seek health by engaging the services of a traditional or native healer. Thus, cultural perception plays an essential part in appraising the seriousness of an illness such as breast cancer, as well as the health-seeking decision-making process. It is, therefore, proposed that cultural perception be incorporated into the constructs of the HBM.

5.15 Conclusion

In this study, the HBM has been used to successfully explore and understand the health-seeking behaviors and factors that impact these health-seeking activities of women presenting

with the advanced stages of breast cancer in Southwestern Nigeria, an African context. Individual perceptions, cultural perceptions, and symptom interpretations all influenced the health-seeking behaviors of the study participants. The influence and supportive roles of family members, friends, and other social network members not only encouraged the participants to engage in health-seeking activities, it also lessened the degree of their emotional reactions to their perceived barriers: fear, stigma, side effects of breast cancer treatments, and the financial burden of breast cancer treatments. The participants' perceived benefit of engaging in health-seeking was the desire to live, which outweighed all barriers. The decision to engage in health-seeking behavior was made, in most cases, at the family level. The study findings indicated that the HBM appears suitable for exploring and providing insights into the health-seeking behaviors and factors that influenced the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria, an African context. The incorporation of cultural perception to the HBM variables has been proposed.

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CHAPTER 6: MANUSCRIPT 3

**HEALTH-SEEKING BEHAVIORS OF WOMEN WITH ADVANCED BREAST
CANCER IN SOUTHWESTERN NIGERIA: AN INTERPRETIVE DESCRIPTION
STUDY**

HEALTH-SEEKING BEHAVIORS OF WOMEN WITH ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA: AN INTERPRETIVE DESCRIPTION STUDY

6.1 The Relationship of Chapter 6 Manuscript 3 to the Dissertation

In this chapter, I present a discussion of the study's findings in relation to one of the research questions and relevant empirical literature on the health-seeking behavior of women with advanced breast cancer in Southwestern Nigeria. Interpretive description, a qualitative approach, proposed by Thorne et al. (1997) was adopted for this research. This approach allowed both an in-depth exploration of the study participants' perceptions and an interpretive naturalistic approach to their world. It also enabled me to engage the study participants in describing their health-seeking behaviors and the factors they believed influenced these behaviors. The conceptual framework adopted for the study was the Health Belief Model proposed by Rosenstock et al. (1952). The impact of personal and cultural perceptions on the women's health-seeking behaviors were identified and discussed. This manuscript will be presented to the International Journal of Nursing Sciences for consideration for publication.

HEALTH-SEEKING BEHAVIORS OF WOMEN WITH ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA: AN INTERPRETIVE DESCRIPTION STUDY

6.2 Abstract

Background: Breast cancer is the most common cancer in women in both more and less developed regions of the world. In developed countries, breast cancer is the second cause of cancer-related death after lung cancer, while in less developed countries, breast cancer is the leading cause of cancer-related death in women. In Nigeria, 70 to 79% of women present with the advanced stages of breast cancer. Empirical evidence indicates that young and middle-aged women, who are in the active phases of their social, physical, reproductive, and economic developments, are affected by the illness, resulting in remarkable social, economic, and psychological consequences. In this paper, I present part of the findings of a study that explored the health-seeking behaviors and factors that influenced the health-seeking activities of women, with advanced breast cancer in Southwestern Nigeria from the participants' perspectives.

Methods: The research methodological approach adopted for the research was Interpretive Description (ID), while The Health Belief Model (HBM) was the conceptual framework. The study participants were women presenting with advanced stages of breast cancer in Southwestern Nigeria. Data were collected in two phases. Phase one consisted of participants filling a personal demographic information form; the second phase consisted of the conduct of audio-recorded one-on-one, face-to-face semi-structured interview guided by open-ended questions by the researcher. Data analysis was inductive.

Findings: Many participants did not interpret their breast changes as breast cancer, and they engaged in self-care until their symptoms had worsened. Some women engaged in seeking information and explanation about their breast changes from their families, internet, and social

networks. The themes that emerged from the thematic analysis of the interview data revealed the women's health-seeking behaviors to include engaging in self-care, seeking divine intervention, and seeking evidence-based knowledge and care.

Conclusions: A comprehensive approach to improving breast cancer treatment outcomes must address breast cancer public awareness, etiology, misconceptions, and care. Any form of financial assistance would go a long way in assisting women to manage their breast cancer.

Keywords: Advanced stages of breast cancer, health-seeking behavior, health belief model, interpretive description, women, Southwestern Nigeria, Nigeria.

HEALTH-SEEKING BEHAVIORS OF WOMEN WITH ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA: AN INTERPRETIVE DESCRIPTION STUDY

6. 3 Statement of Problem

Universally, the most common malignancy in women is breast cancer (WHO, 2017; 2018). In 2012, worldwide, 1.67 million new cases of breast cancer (25% of all cancers) were diagnosed (Ferlay et al., 2015), and in 2018, about 2.1 million cases of breast cancer were diagnosed (Globocan, 2018). Breast cancer ranks fifth among the causes of cancer-related death worldwide with 522,000 deaths estimated to have occurred in 2012 (Ferlay et al., 2015). In more developed countries, breast cancer is the second most common cause of cancer-related deaths in women, after lung cancer, accounting for 15.4% (198,000 deaths) of all cancer-related deaths in 2012 (GLOBOCAN, 2012; WHO, 2017). In developing regions, breast cancer is the leading cause of cancer-related death in women with 324,000 deaths in 2012; 14.3% of all cancer-related deaths (Ferlay et al., 2015; WHO, 2017). The mortality from breast cancer is becoming a public health issue with devastating consequences in developing countries (Bray, Jemal, Grey, Ferlay, & Forman, 2012; Soerjomataram et al., 2012).

Breast cancer is the most common malignancy affecting Nigerian women with 27,304 cases diagnosed in 2012 (GLOBOCAN, 2012). It has been calculated that this number will increase to 33,666 cases in 2020. The cancer-related death from breast cancer in Nigeria in 2012 was 13,960 deaths. It has been estimated that this number will increase to 16,908 deaths in 2020 (GLOBOCAN, 2012, WHO, 2017). It has been projected that the number of Nigerian women who are at risk for developing breast cancer will rise from about 24.5 million in 2010 to about 50 million in 2020 (Akarolo-Anthony et al., 2010). The incidence and the mortality rates of the illness are projected to continue to increase due to a low level of awareness, presentation and

diagnosis at the advanced stages of the disease, and a lack of adequate technology to address the sickness (Akarolo-Anthony, Ogundiran, & Adebamowo, 2010; Anyanwu, Anyanwu, & Yakubu, 2016; El Saghir et al., 2011). The subtypes of breast cancer often presented for medical care in Africa are mostly the aggressive types characterized by low survival rates (Akarolo-Anthony et al., 2010). The illness affects young and middle-aged women, who are in the active phases of their social, physical, and reproductive lives, resulting in enormous social, economic, physical, and psychological consequences (Akarolo-Anthony et al., 2010). In Nigeria, mortality from breast cancer is causing traumatic effects on both individuals and communities.

In this paper, I present one of the findings of a study that explored the health-seeking behaviors of Southwestern Nigerian women presenting with advanced stage breast cancer and the factors the women believe influence their health-seeking activities. Identifying and addressing the problematic areas of delays within the context of Southwestern Nigeria may contribute to improving breast cancer treatment options and outcomes. Reducing the illness stage at diagnosis may contribute significantly to improving the survival rate of the illness in the region.

6.4 Significance of the Study

No study was identified in which the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria from the women's perspectives has been discussed. It is essential to understand the women's health-seeking activities, defined as activities in which women engage to manage breast-ill-health, with the aim of identifying areas of delays in seeking medical care, after becoming aware of breast cancer symptoms. This understanding can inform the addition of specific information about breast health and ill-health, importance of early detection, and treatment of breast cancer in health promotion programs.

6.5 Research Question

The research question that guided the portion of the research presented here was: How do women with advanced breast cancer in Southwestern Nigeria describe their health-seeking behavior?

6.6 Methodology

Interpretive description (ID), proposed by Thorne et al. (1997), was identified for this study. Interpretive description is a qualitative approach developed from an understanding of nursing philosophical and theoretical foundations (Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, Stephens, & Truant, 2016). Interpretive description was developed by nurse researchers to answer the kind of questions that emanate from within nursing (Thorne et al., 1997; Thorne et al., 2016). The goal of ID is to identify themes and patterns among subjective perspectives while at the same time, accounting for variations between individuals (Thorne, 2016). Interpretive description is aligned with a naturalistic orientation to an inquiry (Hunt, 2009; Thorne, 2016). The philosophical orientation of the ID indicates that realities are multiple, local, socially, and experientially-based, and must be studied holistically (Guba & Lincoln, 1982; Thorne, 2016). The researcher and the research participant are closely related, influence each other, share ideas, and co-create understanding and knowledge (Guba & Lincoln, 1982; Thorne, 2016). The health belief model (HBM) developed by Rosenstock et al (1966, 1974) was the conceptual framework adopted for the study.

6.7 Ethical Considerations

Before starting to conduct the study, a letter of support was obtained from the University College Hospital Ibadan, Nigeria. Ethical approval was obtained from the University of Saskatchewan's Behavioral Research Ethics Board and the University of Ibadan/ University

College Hospital Institutional Ethics Review Board to carry out the study. Operational approval was also obtained from the management of University College Hospital Ibadan, Nigeria, to gain access to the institution to collect data. The aim and objectives of the study and all the study procedures were explained to prospective participants in plain and straightforward language that they could understand. Participation in the study was free and voluntary. Each participant was aware she could withdraw her consent from participating in the study at any time without any penalty. Issues relating to confidentiality of the data collected, the anonymity of study participants, audio-recordings of the interview, and note-taking during the interview were all explained to the participants. Informed consent procedure to participate in the study was conducted and the informed consent was obtained by a trained research assistant employed for the purpose.

6.8 The Context of the Study

This study was conducted in a large teaching hospital located in Southwestern Nigeria. The teaching hospital is a referral care center. The teaching hospital runs oncology clinics where breast cancer patients referred from other hospitals receive quality, comprehensive, and specialist treatment and care for breast cancer twice weekly.

6.9 Research Participants

The study participants were women presenting with advanced stages of breast cancer, defined as stages III and IV of the illness. The study participants were in different stages of breast cancer treatments and care. Identified gate-keeper oncologists and nurses assisted in participants' identification and approval for participation the study.

6.10 Sampling Technique and Sample

By using a purposive sampling technique, 30 women with advanced breast cancer, who

expressed willingness to participate in the study, were selected as the study participants.

Purposive sampling enables the selection of information-rich participants, people who have a great deal of knowledge about a health issue and are willing to share their knowledge to inform the phenomena under consideration. The study sample size was guided by the principle of saturation (Thorne, 2008), that is when no new data or information that could influence and enhance the emerging pattern from the data was forthcoming from the study participants.

6.11 Data Collection and Procedure

Data were collected in two phases. Phase one consisted of asking study participants to complete a personal demographic form, while phase two consisted of the researcher conducting semi-structured, in-depth face-to-face, one-on-one interviews, guided by open-ended questions with each study participant. One-on-one interviews were adopted for the study because it could provide the researcher insight into how an individual interprets and manages observed body changes while taking into consideration the sociocultural context of the study (Creswell, 2007). The interview protocol was designed by the researcher based on the information obtained from the literature review. The interview protocol was translated into the local language, and back-translated by an independent translator to ensure consistency with the original meaning. Two experienced breast cancer oncologists, who had carried out many research studies in the area of breast cancer in the local setting, were supplied with copies of the interview protocol to assess for adequacy and suitability for collecting the required data in the local setting. A pilot testing of the interview protocol and procedures was also conducted, in the same location as the study, engaging similar oncology patients apart from the study participants.

Interviews were conducted in private rooms already prepared for the exercise between February and May 2018. Study participants were interviewed in the languages of their choice

either Yoruba or the English language. All interviews were audio-recorded, saved as a digital file to a password protected laptop, and personally transcribed verbatim by the researcher. The transcribed interviews were read while listening to the audio recordings, and all necessary corrections were made. Those interviews that needed to be translated from Yoruba into the English language were translated. The translated interviews were back-translated by an independent translator, after he had signed the confidentiality agreement, to ensure the accuracy of the translation. The data collection and analysis transpired concurrently.

6.12 Data Analysis

Descriptive statistics (mean, median, and simple percentages) were used to analyze and illustrate the study participants' characteristics. Interview data analysis was inductive and data-driven (Thorne, 2016). Individual participant's interview transcripts were uploaded into NVivo 12 (QSR, International, 2018). The software was used at the initial stages of the data analysis to organize the data into "nodes." Interview excerpts considered relevant to the research question were identified and coded. Codes relevant and in harmony were combined, grouped, regrouped, and formed into themes to reflect the data. The themes represented the similarities study participants described in their different individual interviews, as their health-seeking behaviors. The subthemes represented the perceptions that were common across interviews. The subthemes are essential to understanding participants' health-seeking behaviors.

6.13 Findings and Discussions

6.13.1 sample characteristics. All the study participants were women with advanced breast cancer. They were in different stages of breast cancer management. The 30 participants recruited for the study had different levels of education and employment status. Thirty percent (n=9) of the study participants had noticed breast changes two years before presenting, 10% (n=

3) for about 11-15 months, 23% (n= 7) for 5-10 months, and 36% (n=11) for less than 5 months. Analysis of the sample by age, revealed the mean age of the study participants was 47 years. This finding is consistent with findings in the empirical literature (Akarolo-Anthony et al., 2010; Azubuike et al., 2015; Okobia, 2006), that breast cancer in Nigerian women affects those who are relatively young and in the active phases of their physical, social, and economic developments.

6.13.2 thematic analysis of interview data. A thematic analysis of the data relating to the health-seeking behaviors of the participants were condensed into three themes: 1) women with troubling breast symptoms engaged in self-care before seeking medical interventions, 2) women with troubling breast symptoms sought divine intervention before seeking medical attention, and 3) women with breast symptoms sought evidence-based knowledge and care. No previous study exploring the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria was identified in the literature. However, there are themes common to breast cancer health-seeking behaviors in the literature that were used to compare to the findings of this study.

Themes Relating to the Participants' Health-seeking Behaviors

6.14 Theme 1: Women with Troubling Breast Symptoms Engaged in Self-care before Seeking Medical Interventions

In this study, self-care was defined as an informal care process through which an individual engages in activities that promote health, prevent illness, ameliorate the effects of illness, treat the disease, and cure the disease. It involves self-diagnosis, self-prescription, self-medication, purchasing drugs without prescription, consulting local pharmacy or drug store, and using home remedies. The participants in this study described self-care as involving many

behaviors, including: using herbal remedies, and purchasing drugs from the pharmacy and local drug stores. This theme was supported by two subthemes: engaging in self-treatment and using nutritional remedies.

6.14.1 women with breast symptoms practiced self-care by engaging in self-treatment. “I went to buy those tablets for infection that are being sold from the chemist shop” (a 40-year-old participant). For the purposes of this study, self-treatment involves individuals treating their breast ill-health without the direct involvement of a healthcare professional or a traditional healer. Self-treatment differs from self-care in that it refers to treatments that are applied directly to the changes in the breast, whereas self-care is a more general term, including promoting overall good health. Factors influencing self-treatment in this study were breast changes, the interpretations of breast changes, and the perception of the severity of the illness. In this study, most participants, who considered that their condition was not serious, managed it through self-treatment. If symptoms worsened or showed no positive changes, individuals in this study usually sought assistance, either by consulting with the local pharmacist, the traditional healer, or by going to the hospital.

Some study participants described the self-treatments they engaged in as a response to their breast changes. A sixty-year-old participant described rubbing a lesion that she thought was a boil with Vaseline ointment and Shea butter. A forty-year-old participant also recounted engaging in self-treatment in response to the breast changes. Thinking the changes were not serious and indicated infection, she bought tablets that are being sold at the chemist. When describing pain, she was beginning to feel in her arm close to her breast, a 45-year-old participant applied a balm.

These findings are congruent with those of Jegede (2002) from a qualitative study in

which he sought to understand the Yoruba ethnic group's cultural perception of health and illness. Jegede (2002) observed in his study that on perceiving they have any illness, the Yoruba people initially engaged in self-care. It was only after these self-care attempts failed that they went to the hospital. The findings of the current study are also consistent with findings from Agyepong and Manderson (1994) in a qualitative study on the diagnosis and management of fever at the household level in the greater Accra region of Ghana, where it was observed that self-treatment for managing fever was the first option of 90 percent of their study participants. The current study's findings are also consistent with findings from a critical review of the literature (Facione, 1993) on patient versus provider delays in patients presenting with breast cancer. The review findings indicated that women applied antibiotics ointment to cure breast and nipple ulcerations, changed their bras to relief pain under the breast, washed their nipples to clear secretions, rubbed the hardened areas of the breast to soften the tissue, and applied heat to hardened and painful parts of the breast before presenting for medical care at the hospital.

6.14.2 women with breast cancer engaged in self-care by using nutritional remedies.

“I do take vegetables and tomatoes. Tomatoes seeds seem to assist it” (a 60-year-old participant). Some study participants recounted that they were using nutritional remedies to enhance and hasten the cure of their breast cancer. Several participants said that, since their diagnosis, they had been drinking the liquid from heated soursop leaves. Some had been eating fruits and vegetables; other planned to do so once the wound from their surgery had healed. One participant observed that tomatoes were helping her condition. Omogbadegun (2013) has provided a list of local medicinal plants that are being used by cancer patients in Nigeria. In a review, Shareef, Ashraf, and Sarfraz (2016) also identified different types of plants being used for medicinal

purposes as well as for food. However, scientists have pointed out that some herbal remedies can interfere with chemotherapy.

6.15 Theme 2: Women with Troubling Breast Symptoms Sought Divine Intervention before Seeking Medical Attention

“When I discovered the problem, I prayed to God about it ... at the beginning of the problem, I trusted in God and even now, I trusted in the Lord” (a 29-year-old participant). Sixty-seven percent (n=20) of the current study participants sought divine interventions to manage their breast changes and breast cancer. This finding is similar to findings from Ibrahim and Oludara (2012) qualitative study of the socio-demographic factors associated with delay in breast cancer presentation in Nigerian women. Findings from their study indicated that 61.6% of their study participants engaged in alternative, spiritual, and herbal medicine to manage their breast cancer. In the current study, seeking divine intervention to manage breast cancer was supported by two subthemes: going the traditional way by visiting the herbalist and praying or visiting praying centers.

6.15.1 women sought divine interventions by visiting the herbalist. “I went to traditional healer, the herbalist. ... They only gave me the ones that I can be rubbing on it” (a 42-year-old participant). This understanding refers to the use of traditional medicine for the treatment of breast cancer. Three categories of traditional medicine men and women are identified among the Yorubas: diviners, also known as Babalawo; herbalists; and the shrine priests. The diviners “diagnose and counsel about the causes of illness or misfortune and they prescribe the necessary sacrifice” [remedy] (Ademuyiwa, 1969, p. 1086). The herbalists cure and prevent illness or misfortune using herbs, roots, barks, incantation, talisman, therapy, and immunization. They also diagnose, counsel, prescribe, and treat ailments (Ademuyiwa, 1969).

The function of the shrine priests is to perform rituals. The Shrine priests offer sacrifice to the gods, either for appeasement or for thanksgiving. One person can serve in the dual role of a diviner and herbalist, but not all herbalists are diviners. The medicine men and women share the same cultural beliefs and values with the people. They are well accepted and trusted in the community. Due to cultural beliefs and influence, the Yorubas have faith in the efficacy of these traditional practitioners whose services they perceive to be more culturally acceptable, seemingly affordable and do not involve surgery (Ademuyiwa, 1969; Borokini & Ibrahim, 2014; Hughes, 1976; Jegede, 2002).

The Yorubas believe that some illnesses like breast cancer are caused by supernatural forces (Adegoke, 2007; Ademuwagun, 1969, Borokini et al., 2014; Jegede, 2002). The Supreme God, the Almighty, has given some people the gifts of recognizing the sources of illnesses using instruments such as the Ifa Oracle. Through consultation with Ifa, the diviner identifies the source of the illness and prescribes the necessary remedies. In this study, a 54-year-old participant had consulted with a diviner: “She told us that it was a spiritual attack... We paid money there. ... She gave us various things. Since that time, in spite of all her efforts, there was no change, no cure...”. Other participants used traditional herbal remedies. A forty-eight-year old participant describes that people in the village brought her herbal solutions “black medicines” from the village, advising her to “rob them on her breast to make the cancer disappear.” As she further explained “it did not disappear. I rubbed an herbal mixture on it ... but, there was no change I then came back to Lagos.” A thirty-four-year-old participant had a similar experience. She found that the herbal solution given to her caused her body to swell. The herbalist then advised her to seek medical attention.

These women’s disappointment with herbal remedies is consistent with findings of

Ezeome and Anarado (2007), who conducted a cross-sectional study of the use of complementary and alternative medicine by cancer patients at the University of Nigeria teaching hospital Enugu, Nigeria. These authors observed that 68% of patients in the study expressed disappointment with traditional healing methods and therefore were, reluctant to recommend them to others or use them in the future for cancer treatment.

The experiences of the participants in this study suggest that not all diviners and herbalists correctly diagnose illness and recommend appropriate remedies. Findings also indicated that herbalists have specializations. A fifty-year-old participant said she is an herbalist by profession. Her specialty is in childhood diseases for which she prepares herbal solutions. She explained, “I do not know anything about it [breast cancer]. If I know anything about it [breast cancer], I could have helped myself. I would not have come here.”

The participants’ tendency to use traditional healers for the treatment of breast cancer could be related to the cultural perception of breast cancer as a supernatural illness, which, for some, is beyond the competence of biomedicine (Ibrahim & Odusanya, 2009). This tendency could also be associated with the fear of biomedical treatment of the illness, such as the surgical management of breast cancer, in some cases, with mastectomy (Ajekigbe, 1991). A participant expressed people’s fear of surgery this way: “They are scared of the knife, so ... if they go the traditional way, it might work as it has worked for others,” but, she added, “They are forgetting that what [others] used the traditional treatment for is different from what they are facing.” In other words, traditional remedies work for some illnesses but not for all diseases for example, cancer.

The findings that some participants used traditional healers to manage their breast changes is consistent with those from Donkor et al. (2015) in a systematic review of late breast

cancer presentation in Africa. Donkor et al. (2015) observed that women with breast cancer in Africa use alternative medicine to cure or treat breast cancer, and the highest use of alternative medicine was identified in West Africa. In another systematic review of breast cancer in Malaysia, Yip, Pathy, and Teo (2014) also observed that traditional medicine was used by Malaysian women presenting with breast cancer. Also, findings from the current study are congruent with those from Clegg-Lamptey (2009) in a qualitative study of the psychosocial aspects of breast cancer treatments in Accra Ghana. The study findings indicated that women diagnosed with breast cancer utilized herbs in attempts to cure their breast cancer. These findings are also consistent with findings from a qualitative study of the socio-cultural determinants of health-seeking behavior on the Kenyan coast (Abubakar et al., 2013), which indicated that traditional healers were consulted for various reasons such as the treatment of illnesses perceived to be caused by supernatural forces.

According to Hughes (1976), the Yoruba people usually patronize the services of the indigenous medicine men and healers before coming to the hospital. The hospital is usually their last resort in health-care seeking. Findings from the current study also suggest that initial consultation of some participants with traditional healers had contributed to delays in presentation for medical management of the illness at the hospital. These delays in illness presentation resulted in presentation with the advanced stages of the illness. This finding is similar to findings from Ezeome (2010); Ezeome and Anarado (2007).

6.15.2 women sought divine intervention by praying and visiting prayer centers.

“So, I ran to some pastors. I have been to prayer houses for God to intervene” (a 41-year-old participant). The diagnosis of breast cancer is often accompanied with huge psychological and emotional reactions, which can be overwhelming for an individual to handle alone. Many

participants used prayer as a source of strength to handle their illness. This opinion was emphasized by a 29-year-old participant:

I took it to God in prayer. So, after then, I rested my heart on God. And that is how God carried me through. Because it is a big challenge that ...except God help you to go through it, it is not a thing that human beings can, on his or her own, pass through it triumphantly except God help you.... I believe in God. Relying on faith. Believing He will not fail.

Participants reported using faith healing to handle their breast cancer. Faith healing is the practice of using prayers and other gestures such as fasting and using oils to ask for divine interventions during illness. Among the participants, it was the general belief that diseases can be cured through prayers and the practice of rituals. Faith healing is premised on the belief that God can do all things and that God is faithful. Forty-four-year-old participant 1 expressed her belief in faith healing this way: "Initially, I was praying on it... I went to praying center... I did fasting and praying... The pastor gave me anointing oil to be rubbing on it." A forty-one-year-old participant also had this to say: "I ran to some pastors. I have been to prayer houses for God to intervene. And I know that it is even God that is strengthening me on this issue. ... I went there for prayer and for fasting." Some participants expressed the belief in the ability of God to use all things and anything to bring healing. A forty-two-year-old participant expressed her belief when asked about how breast cancer could be cured: "By way of prayer, let them help me to prepare anointing oil so that I can be rubbing it on the breast. There is nothing the power of God cannot handle."

The findings of this study are like findings from Lagman, Yoo, Levine, Donnell, and Lim (2014) in a qualitative study of Filipina immigrant breast cancer survivors, who identified praying as the most common religious practice for coping with breast cancer. Praying helped participants to calm and soothe their fears. Praying also helped the migrants to derive definite meaning and strength from the experience of the illness. Prayer, according to the participants in

the current study, provided comfort during times of distress. Similar findings were identified by Levine, Yoo, Aviv, Ewing, and Au (2007) in a qualitative study of ethnicity and spirituality in breast cancer survivors. Finding solace in prayer helped this study participants to divert their attention from stressful thoughts and strong emotional responses to breast cancer. Similar findings were identified by Assaf, Holroyd, and Lopez (2017) in a qualitative study of Arab women diagnosed with breast cancer and in Akhigbe and Akhigbe (2012), who studied the effect of cancer fatalism on breast cancer screening. Also, findings from Clegg-Lampsey (2015) in a qualitative study of the psychosocial aspects of breast cancer treatments in Accra Ghana, indicated that women diagnosed with breast cancer utilized prayer camps in search of healing. However, the participants in this study indicated that women should not rely solely on prayer and praying as the only source of health-seeking for the cure of breast cancer. This opinion was expressed by a 47-year-old participant: “Prayer is very vital... you need to pray but at the same time, you need to come to the hospital for care.”

6.16 Theme 3: Women with Troubling Breast Symptoms Sought Evidence-based

Knowledge and Care

Another theme that emerged from the data analysis was the eagerness to seek evidenced-based knowledge and care. This theme was supported by two subthemes: Using the internet as a source of breast cancer information and seeking evidence-based care by going to the hospital.

6.16.1 women with breast changes sought information from the internet. “I browsed about it in the Internet” (a 47-year-old participant). Some study participants sought knowledge and information to understand their breast changes from the internet. A forty-eight-year old participant had this to say about her internet browsing:

I said that I have browsed on cancer and I know how it was, and I did not have any of the signs. The only difference I had was that I had a lump in my right breast and there were

no other signs of cancer... I now browsed and saw that soursop is used to treat cancer and hinder the spread....

Some women may not have had much information about breast cancer until they were directly affected by it, as indicated by a 42-year-old participant: "I do not know anything about it.

Because it has not happened to me before. This one just happened to me. This is its first time. It has not occurred in my family neither has it happened to any of my family members before."

For some participants, the Internet was an initial way of learning more about the illness and providing the individuals with information about cancer and its treatments. The Internet could also aid patients in selecting a specialist. A forty-four-year-old participant found out about UCH this way: "I went home, and I started doing some research online. You know, checking for hospitals in the country that really treat cancer patients. And so, that was how I got to know about UCH." A forty-two-year-old participant also had gone on the Internet to seek information on the management of breast cancer: "I started Google searching on how to treat cancer. What causes it, the food to eat? So, I started taking fruits, doing some things that I read on the internet."

These actions might be related to trying to understand their breast changes, as well, participants might also be interested in learning how to cope with the illness through the experiences of other patients. This study finding on participants' searching the Internet for information and knowledge about breast cancer is similar to findings from Valero-Aguilera et al. (2014). Other studies (Balka, Krueger, Holmes, & Stephen 2010; Fogel, 2004; Fogel, Albert, Schnabel, Ditkoff, & Neugut, 2002) have also found that breast cancer patients sought information from the Internet in response to their breast cancer. Findings from the current study also confirm that families are involved in searching the Internet on breast cancer diagnosis and care.

6.16.2 women with breast symptoms sought evidence-based care at the hospital.

“The only steps we took was to come to the hospital for treatment” (a 42-year-old participant). Going to the hospital was a subtheme identified in the participants’ descriptions of their health-seeking behaviors. These study participants were all recruited from the hospital, all had presented with advanced breast cancer. One of the reasons for why these women all presented with the advanced stages of the disease may be that many had tried other remedies and healing strategies before seeking care, thus delaying their diagnosis. In the current study, 30% (n=9) of the study participants had noticed breast changes two years before presenting, 10% (n= 3) for about 11-15 months, 23% (n= 7) for 5-10 months, and 36% (n=11) for less than 5 months. These findings could be related to observations from Jegede (2002) in a qualitative study on the definition of health and illness, and the implications of health definitions for preventive care and cure of illness. Jegede (2002) observed that a typical Yoruba person presents in the hospital for care only after other remedies such as self-care and consultation with the traditional healers have failed to cure the illness.

According to Jegede (2002), perceptions of the cause and definition of health and illness vary from culture to culture. Individual perceptions of the cause of illness influence health-seeking behaviors. The available options for engaging in health-seeking are self-care and self-treatment through home remedies; seeking the services of traditional healers and faith healers; seeking the services of private practitioners and going to either a federal or state-owned hospital. An illness that is common within a specific population might be perceived as normal. Home remedies can often be used to handle such an illness and can initially be used to handle body changes. Participants who perceived the cause of their illness to be supernatural might consider health-seeking though engaging the services of traditional and faith healers as the most

appropriate option. However, the current study revealed that when it became obvious that the remedies prescribed by the traditional and faith healers were ineffective or that symptoms were worsening, the participants usually presented for medical care and treatment at the hospital.

Figure 6.1 represents the health-seeking behaviors model of women presenting with the advanced stages of breast cancer in Southwestern Nigeria.

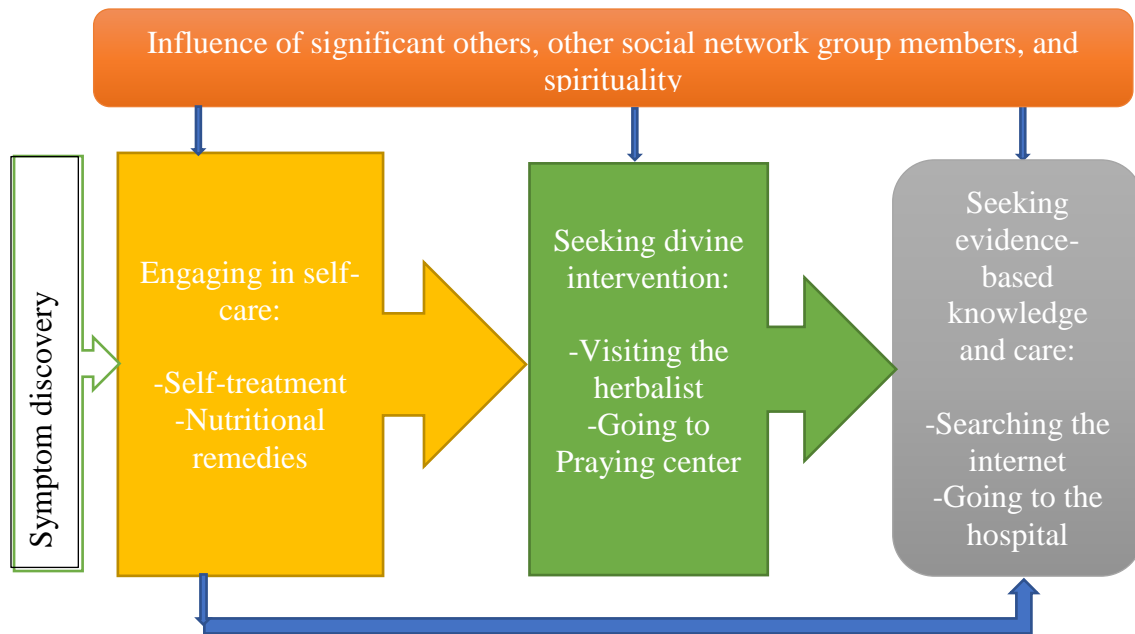


Figure 6.1 Health-seeking Behaviors Model of Women with Advanced Breast Cancer in Southwestern Nigeria
Source: The author

The model presents the pathways of the health-seeking behaviors as narrated by women with advanced breast cancer in Southwestern Nigeria. The model indicates that a woman will initially engage in symptom interpretation and self-care by applying home remedies, or buying drugs from the local drug store, and using nutritional remedies, following the experience of breast changes. Some participants did not understand the meaning of the changes and they, therefore, browsed the internet to acquire more knowledge about their breast changes. A few women recognized that something might be wrong, and they engaged in health-seeking by going to the hospital for medical attention. Some participants interacted with their social network

members who reinforced misconceptions, and suggested alternative explanations for symptoms, and prompted health-seeking in the traditional way, while some social network members motivated some participants to go to the hospital for the management of their breast changes. When the participants in general did not experience positive changes and cure for their breast ill-health, they resorted to coming to the hospital for the management of their illness.

6.17 Implications of the Findings

The habit of self-treatment can be problematic as it can lead to the use of inappropriate medications to manage an illness, which can worsen the symptoms and illness condition, as experienced by some of the current study participants. Perhaps more concerning is that self-treatment can lead to delays in seeking proper medical care, which increases a woman's risk of presenting with a more advanced stage of cancer.

Finding from the current study implies that a lack of knowledge and understanding of breast changes meant that breast cancer patients either ignored or misinterpreted their symptoms. The misinterpretation of symptoms can lead to delay in engaging in timely and appropriate health-seeking behaviors. Positive and early symptom interpretation can initiate timely appropriate health-seeking. Accurate early breast cancer identification can contribute significantly to timely seeking of specialist breast cancer care, which could improve survival rates. Given the value that breast cancer patients attach to Internet use, healthcare professionals should ensure the best use of this resource, so to ensure that patients are obtaining quality information from the internet.

6.18 Contributions to Nursing Knowledge

The outcomes of the study incorporating the HBM and the ID qualitative research approach to explore the health-seeking behavior of women with advanced breast cancer in

Southwestern Nigeria will hopefully enhance the understanding of the phenomenon under investigation. This understanding could enhance the provision of evidence-based, holistic management of breast cancer for the population. The HBM is based on improving the cognitive appraisal of health-related behaviors to encourage people to take action (like an early presentation for breast cancer screening, diagnosis and management, and performing breast self-examination). Using the health-seeking behavior model developed in this study, nurses can plan, structure, and provide evidence-based relevant comprehensive breast cancer education and counseling sessions that address the perceptions and beliefs of their patients. The model's constructs could provide an ongoing evidence-based structure for nurses to reassess patient's health-seeking behavioral patterns and their developmental, cognitive, and physical health needs within their socioeconomic, and their sociopolitical contexts.

6.19 Policy Implications

The findings from this study suggest the need for community-based educational interventions to educate people about the etiology, signs and symptoms of breast cancer, and the actions to take when breast changes are observed.

6.20 Limitations

The scope of the study was limited to one geopolitical zone in Nigeria. The view of the participants may not necessarily reflect that of patients from the remaining five geopolitical zones. However, the results show consistent pattern of breast cancer health-seeking behavior among African women. Also, the perceptions of the healthcare providers could have helped to widen the scope.

6.21 Conclusion

Women in Southwestern Nigeria typically present with advanced breast cancer. Low

level of breast cancer signs and symptoms awareness delayed the women's decision to seek professional attention to manage their breast changes. The health-seeking behaviors described by the women include: engaging in self-care, seeking divine interventions, and seeking evidence-based knowledge and care. Ignorance of the nature of the participants' breast changes, the use of home and herbal remedies and spiritual healing were the leading causes of delayed presentation of women with advanced breast cancer in Southwestern Nigeria. The participants sought medical care after trying other types of remedies to manage and resolve their breast symptoms. Planning and providing comprehensive information and education sessions about breast cancer signs and symptoms, teaching and encouraging the practice of breast self-examination, and presentation for clinical examination could lead to earlier breast cancer identification, diagnosis, and timely initiation of breast cancer professional care in the hospital. All these actions could impact the treatment outcomes of breast cancer among women in Southwestern Nigeria.

6.22 Recommendation

One of the key findings of this study is that patients engaged in self-care. Nurses can support their patients to engage in self-care by actively listening to their patients' perceptions of self-care and engaging in health promotion communications with them. Nurses can use every opportunity to replace their patients' misconceptions with evidence-based alternative explanations and teachings. Nurses can plan and provide healthy life-style promotion interventions with their patients.

Given the resilience of the patients in patronizing the services of the alternative breast cancer care providers, a situation whereby the alternative breast cancer care providers and the modern Western type of medicine practitioners function cooperatively might be beneficial to the health of the people. Policy regulating the activities of all alternative breast cancer care

providers, as well as, integrating the traditional and the modern healing systems might significantly impact the treatment outcomes of women with advanced breast cancer in Southwestern Nigeria.

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Chapter 7 MANUSCRIPT 4

**FACTORS INFLUENCING THE HEALTH-SEEKING BEHAVIORS OF WOMEN
WITH ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA: AN
INTERPRETIVE DESCRIPTION STUDY**

FACTORS INFLUENCING THE HEALTH-SEEKING BEHAVIORS OF WOMEN WITH
ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA: AN INTERPRETIVE
DESCRIPTION STUDY

7.1 The Relationship of this Manuscript to the Dissertation

In this manuscript, the author presents a discussion on the factors the study participants believe influenced their health-seeking behaviors, representing part of the findings of this study. Knowledge of these factors may enable nurses and other healthcare providers to communicate with their patients from the patient's point of view. The knowledge generated in this way may empower nurses and other healthcare providers to better understand how their patients perceive and experience breast cancer, how they react to its discovery, and the factors that motivate their responses. This manuscript will be presented to the International Journal of Nursing Sciences for consideration for publication.

FACTORS INFLUENCING THE HEALTH-SEEKING BEHAVIORS OF WOMEN WITH
ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA: AN INTERPRETIVE
DESCRIPTION STUDY

7.2 Abstract

Background. The World Health Organization (WHO) records indicate the survival rate from breast cancer in Nigerian women is 48.9%. Little is known about the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria. This paper presents the factors influencing the health seeking activities of women with advanced breast cancer in Southwestern Nigeria. It is part of the findings of the study that explored the health-seeking behaviors and factors influencing the health seeking activities of women with advanced breast cancer in Southwestern Nigeria.

Methods. The researcher adopted the health belief model (HBM) as its conceptual framework, while the methodological approach was interpretive description (ID). The University Human Ethics Review Board (REB) approved the study, while operational approval was granted by the authorities of the hospital where the data collection took place. Thirty women with advanced breast cancer were recruited for the study using purposive sampling technique. Data were collected by engaging the participants in audio-recorded, semi-structured, face-to-face, one-on-one interviews guided by open-ended questions, conducted by the researcher and filling of a demographic questionnaire by each participant. The interview transcripts were analyzed using thematic analysis, while the demographic information was analyzed using descriptive statistics.

Findings. The study identified motivating and enabling factors as well as factors acting as barriers to engaging in specific health-seeking seeking behaviors. Breast changes, interpretation of symptoms, the financial challenges of breast cancer treatments, some sociocultural factors,

and a desire to live influenced the participants' health-seeking behaviors.

Conclusion. The knowledge of these factors may help nurses and other healthcare providers approach their patients with the patients' health beliefs and perceptions, thereby empowering nurses to provide more relevant and efficient care to their patients. Interventions should include strategies to raise breast cancer awareness and reduce the stigma associated with the illness.

Keywords: Advanced breast cancer, factors influencing health-seeking behaviors, health belief model, Interpretive description, Southwestern Nigeria, Nigeria.

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7.3 Statement of Problem

Breast cancer is the most common malignancy affecting women worldwide (Ferlay et al., 2015). In developed regions, breast cancer is the second most common cause of cancer-related death after lung cancer, while in developing countries, breast cancer is the leading cause of cancer-related death in women (Ferlay et al., 2015; WHO, 2017). Breast cancer is a serious health issue, accounting for 53% of all other types of cancer and claiming the lives of Nigerian women than any other form of cancer (GLOBOCAN, 2012; WHO, 2017). The incidence of breast cancer in Nigeria is increasing. The World Health Organization (WHO) records estimates suggest that in 2012, 27,304 cases of breast cancer were diagnosed among Nigerian women, while in 2020, 33,666 cases would be diagnosed. Also, WHO records showed that in 2012, 13,960 Nigerian women died from breast cancer, while in 2020, it is estimated that 16,908 women would die from the illness (Ferlay et al., 2015; WHO, 2017). Empirical literature indicate that women delay seeking evaluation long enough to adversely affect their chances of long-term survival (Adebamowo et al., 2008; Adesunkanmi, Lawal, Adelusola, & Durosimi, 2006; Adisa et al., 2012; Akarolo-Anthony, Ogundiran, & Adebamowo, 2010; Akinkuolie, Etonyeaku, Olasehinde, Arowolo, & Babalola, 2016). Delays in seeking medical care after becoming aware of breast symptoms may lead to an advanced stage of the illness at diagnosis and has been associated with shorter survival time. There is need to explore and find ways to encourage women to seek prompt medical evaluation and management of breast cancer. The purpose of this paper is to present part of the findings of a study that explored the health-seeking behaviors and

factors women with advanced breast cancer in Southwestern Nigeria believe influence their health-seeking activities from the women's perspectives because in some contexts, personal beliefs and practices may influence health-seeking behaviors.

7.4. Factors Influencing Health-seeking Behaviors

Health-seeking is a social behavior influenced by various factors in people's everyday living. Factors influencing health seeking in this study are defined as circumstances or elements that play significant roles in health-seeking decision making of women with advanced breast cancer. Empirical literature indicate that various factors influence the health-seeking behaviors of women. In a systematic review of the literature on the factors influencing early presentation and diagnosis of breast cancer among Sub-Sahara African women, Akuoko et al. (2017) identified socio-cultural factors and fear among other factors as influencing the health-seeking behaviors of African women with breast cancer.

7.4.1 socio-cultural factors. Findings from Akuoko et al. (2017) indicate that the association of stigma with breast cancer causes trauma to African women and impacts their health-seeking behaviors. In a related review of the literature conducted by Tfayli, Temraz, Abou Mrad, and Shamseddine (2010), findings indicated that stigmatization of metastatic breast cancer isolates women from pertinent and essential resources and debars them from accessing the medical and social support that are crucial to their survival. In an enquiry into cancer-related knowledge, understanding, and health-seeking behaviors of Tshwane women, Maree and Wright (2010) also identified sociocultural factors such as the influence and encouragement of husbands and partners, as important factors in determining early detection and management of breast cancer among the participants. In another qualitative study among breast cancer survivors in Uganda, Meacham, Orem, Nakigudde, Zujewski, and Rao (2016) identified social pressure from

social networks as a factor influencing the utilization of health services among their study participants.

7.4.2 access to care. Women in rural settings are more likely to seek help from traditional healers due to non-availability of healthcare facilities in the rural settings (Akuoko et al. (2017).

7.4.3 socio-demographic factors. The degree to which socio-demographic factors such as age and literacy levels are associated with screening behavior among Tshwane women living in resource poor community in South Africa were described in detail by Maree, Wright, and Lu (2013). In a descriptive cross-sectional study of the knowledge and practice of breast self-examination among traders in Ibadan Nigeria, Balogun and Owoaje (2005) discussed in detail the influence of education on the health-seeking behaviors of their study participants.

7.4.4 poverty. In a systematic review of the literature on barriers to breast cancer care in developing countries, Sharma, Costas, Shulman, and Meara (2012) identified poverty as the most significant factor influencing health-seeking behavior of women with breast cancer in developing countries. Poverty, Sharma et al. (2012) argued, is reflected in lower economic status, lesser education level, rural residency, and lack of access to healthcare delivery. In a population-based study of breast cancer patients in Chicago, Rauscher et al. (2010) observed that misconceptions about breast lumps, which were more common among women with lower socioeconomic status, influenced medical presentation of urban breast cancer patients. Okobia, Bunker, Okonofua, & Osime, 2006; Shulman, Willett, Sievers, and Knaul (2010) argued that the cost involved in the diagnosis and treatments of breast cancer among African women compels them to seek for alternative source of breast cancer care, including traditional healers and or herbalists. High cost of transportation according to Akuoko et al. (2017), is also associated with greater distance and

living in rural area.

7.4.5 fear. Fear relates the fear of breast cancer diagnosis and the fear of some of the outcomes of breast cancer treatments such as a mastectomy among African women (Ajekigbe, 1991).

7.5 Significance of the Study

Very little is known about the factors influencing the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria. This paper presents part of the findings of a study that explored the health-seeking behaviors and factors influencing the health seeking activities of women with breast cancer in Southwestern Nigeria from their perspectives, with the aim of encouraging women to present early, to improve breast cancer treatment outcomes.

7.6 Research Question

The research question that guided this section of the study was: What factors do Southwestern Nigerian women with advanced breast cancer believe influence their health-seeking behaviors?

7.7 Methods

The study was a qualitative study. According to Creswell (2007), qualitative methods provide a holistic way to understand health phenomena and to capture the varied dimensions of human experiences. This study adopted interpretive description (ID) Thorne et al. (1997), as the research methodology. Interpretive description was developed by nurse researchers as a feasible alternative way of generating knowledge for nursing and other applied healthcare practices (Thorne, 2016). Interpretive description is a pragmatic approach. The logic framework of this approach is based on the reasoning applied at each decision-making point in a research process (Thorne, 2008). In ID, subjective and experiential knowledge are acknowledged as acceptable

legitimate sources of data. Truth is approximated by considering multiple realities. Knowledge is co-created by the researcher and the research participant (Thorne, 2016).

The conceptual framework adopted for the study was the health belief model (HBM) proposed by Hochbaum, Rosenstock, and Kegels (1952). The HBM focuses on the belief that health-seeking behaviors are influenced by a person's perception of the threat posed by a health condition and the value associated with actions aimed at reducing the threat (Rosenstock, 1974). The constructs of the model relate to a person's perception of susceptibility to and seriousness of disease, as well as the perceptions of benefits and barriers to taking preventive action, the availability of effective cues to action, and modifying factors (Rosenstock, 1974).

7.7.1 setting. The setting of the study was a large urban-based tertiary hospital in Southwestern Nigeria.

7.7.2 sampling and sample size. The purposive sampling technique was used to recruit 30 participants who took part in the study. Appointed gate-keeper nurses and oncologists assisted in identifying and recruiting the participants who met the inclusion criteria for the study. All the participants were women with advanced breast cancer, defined as stage III or IV of the illness.

7.7.3 data collection. A letter of information was sent from the chairman of the medical advisory committee to the oncology section of the hospital where data were collected, explaining the study and eliciting their assistance with participant recruitment. Data were collected in two phases. The first phase was the collection of participants' demographic information. For this phase, each participant personally completed a researcher-designed demographic questionnaire. The second phase was the participants' participation in one-on-one, face-to-face, semi-structured interview, guided by open-ended questions, conducted by the researcher. The interviews were audio-recorded. The participants were interviewed in the language of their choice. Either the

local language of the English language. All interview transcripts were transcribed verbatim by the researcher.

7.7.4 data analysis. The participants' demographic information was analyzed using descriptive statistics. The interview data analysis was inductive. The interview transcripts were cleaned as necessary. The interview documents were read, reread, and corrected to ensure their accuracy and for familiarization with the data. The interview transcripts were uploaded into N'VIVO 12 (QSR International, 2018). Initial data analysis identified broad-based codes. During cycle two coding, similar codes were grouped into categories. The categories were later refined into themes. Intraparticipant comparisons of data were carried out. The emergence of recurrent themes in the analysis indicated that saturation was achieved.

7.8 Ethical Consideration

This study was reviewed and approved by two institutional review boards: The University of Saskatchewan Research Ethics Board and University of Ibadan/ University College Hospital Research Ethics Committee. Operational approval was obtained from the hospital where the data collection took place. Prospective participants were offered verbal, followed by written information about the study. The information sheet outlined the research aims, procedures, special peculiarities, some ethical considerations, and how the researcher could be contacted if the participants had questions. All the participants were aware of their rights as study participants before taking part in the study. A trained research assistant conducted the procedure for and obtained written informed consent from each consenting prospective participant.

Anonymity of the study participants was achieved by removing names from the interview transcripts and replacing them with codes. Initials were used to replace the names of any third party whose name was mentioned during the interview process. All research data were digitally

stored on a computer secured with password and stored in a locked cabinet in the researcher's office. Validation of themes involved sharing sections of the interviews with the researcher's supervisors.

Rigor was enhanced by maintaining an "audit trail" that described the decision-making processes of the study. Findings were confirmed through member checks with participants who indicated they wanted to be involved, and consultation with the researcher's supervisors.

7.9 Findings and Discussions

7.9.1 study participants' demographic characteristics. The analyses of the participants' demographic data indicated their mean age was 47 years. They all had varied levels of education ranging from junior secondary to post-graduate level. The period between the initial identification of breast changes and presentation in the hospital ranged from less than five months to 2 years. A greater majority 87% of the participants were from the Yoruba ethnic group, 3% were Edo, 3 Efic, and 6 % were Ibo.

7.9.2 thematic analyses of the participants' interview transcripts. From the analysis of the participants' interview transcripts, the factors the participants believe influence their health-seeking behaviors were clustered into five themes: 1) breast cancer, a life-threatening illness that few people survive, 2) breast cancer, a disease inflicted by the enemy, 3) support from family, friends, and social network system members, 4) Major barriers and difficulties in managing breast cancer, and 5) Making decisions about when and where to engage in breast cancer health-seeking behavior. These themes are also supported by subthemes.

7.10 Theme 1: Breast Cancer, a life-threatening Illness that Few People Survive

"It is a death sentence" (a 40-year-old participant). Many of the current study participants perceived breast cancer to be an illness that few people survive. A forty-two-year-

old participant expressed it like this: “Once somebody gets it, if they don’t treat it on time, she or he will die. Or, either they treat it, or if she or he do not treat it, there is no cure for it.” Other participants described breast cancer as “a deadly disease... that no one survives,” “life-threatening,” “a death sentence,” “death,” “a terrible” and “very bad illness,” and “the end of the world.” The perception of the seriousness of an illness as a killer disease can influence the decision to engage in a health-seeking behavior for so many reasons such as the desire to live and the desire to look after the children.

Fatalism is a belief that situations like an illness or other misfortunes happen because they have been destined for the individual. It may result in feelings of powerlessness, social despair, and hopelessness (Powe, 1997). These feelings could impact an individual’s health-seeking behavior decision-making process. The breast cancer fatalism identified among the current study participants has been identified in other studies. In a descriptive correlational study of the effects of health belief and cancer fatalism among Nigerian women, Akhigbe and Akhigbe (2012) identified cancer fatalism as part of an average Nigerian’s worldview. The study identified a high level of cancer fatalism, a helpless resignation to accepting whatever the “death sentence” of breast cancer brings to the individual, among their participants. In a qualitative study on the influence of sociocultural factors on breast cancer screening behaviors in Lagos Nigeria, Elewonibi and BeLue (2017) reached similar conclusions about breast cancer fatalism. In a similar research, Ezeome and Anarado (2007) found that breast cancer is considered a death sentence, and that its cure, in many cases, has been considered beyond the capability of modern

Western medicine. Cancer fatalism has also been identified as a barrier to participation in cancer screening among African Americans (Powe, 1997). Interestingly, however, the current study deviated from the above-mentioned research in one way. After describing their initial fatalism towards their diagnosis, the participants expressed hope that they will not die from breast cancer. This theme was supported by six subthemes: a) the experience of breast symptoms led to anxiety, b) interpretation of breast symptoms suggests the direction of health-seeking activities, c) worsening of symptoms led to a heightened level of threat, d) breast cancer treatments necessitate spending money, e) the desire to live prompts breast cancer health-seeking behavior, and f) women handled the emotional reactions to breast cancer with spirituality.

7.10.1 the experience of breast symptoms led to anxiety. “I was afraid when I heard it. Because they said it kills” (a 53-year-old participant). This subtheme relates to the ways participants experienced the central theme. For many, breast changes led to uneasiness and anxiety which triggered a search for knowledge and understanding. Thus, experiencing breast changes often initiated the decision to engage in health-seeking. A forty-four-year-old participant described her decision to seek medical opinion: “When I saw something on my breast, I went to my doctor. The doctor touched it and then said I should go and do a scan.” A forty-two-year-old participant described a similar reaction: “My hand accidentally touched my breast, and it ached me, and the fluid came out again from my nipple. My daughter ... said we should go to the hospital. She now took me to the hospital.” A forty-nine-year-old participant related a similar experience:

I was just feeling a lump in my breast. So, I discussed with my neighbor... She told me that she had one friend that such a thing had happened to before that later came out to be

cancer. I say haa cancer! Let me start going to the hospital. That was how I went to the hospital the first time.

The experience of the breast changes often initiates the decision to engage in health-seeking.

This finding is similar to those of Meechan, Collins, and Petrie (2003), who indicate that initial emotional arousal from breast changes drives health-seeking decision-making to initiate and engage in health-seeking behavior.

The current study findings are consistent with those of Lierman (1988). In a retrospective descriptive study, Lierman (1988) examined the responses of women to the discovery of breast symptoms and observed that some women ignored the symptoms. The study also revealed that the observation of breast changes provoked anxiety and agony in some women, who struggled to understand the meaning of the changes. The way they responded to the changes influenced their decision about their health-seeking and treatment options.

7.10.2 interpretation of breast symptoms suggests the direction for health seeking.

“I thought it was a boil so I was rubbing it with Vaseline. I also rubbed it with Shea butter” (a 60-year-old participant). This subtheme relates to symptom appraisal. A forty-two-year-old participant thought the lesion on her breast was a boil and was using antibiotics to handle it:

I discovered it last year, but I thought it was a boil...So, I had been feeling the pains. So, I went to my doctor... but, I thought it was a boil. So, I started using boil medications. I was using Amoxine.

A thirty-one-year-old participant had a similar experience she said:

I told my doctor that see, I am having pains on the nipple of my right breast... So, he said maybe it is an infection. So, he gave me Ampiclox. That he wrote Ampiclox by Beecham for me that I should go and buy it.

Interestingly, both these participants were prescribed antibiotics by their doctors, who clearly missed the diagnosis of breast cancer. Other women made decisions to treat themselves with no medical direction. These women were not alarmed by their breast changes, so did not seek health

care. A fifty-year-old participant thought she had an infection or boil, so she drank an “herbal solution” and “rubbed it with ointment. A sixty-year-old participant rubbed Vaseline and Shea butter on what she thought was a boil. A twenty-year-old participant: explained why she had not been alarmed about finding a lump two years earlier: It was “small,” “painless,” and “hard.” Since she “thought it was part of my body,” she “did not do anything about it.”

A fifty-year-old participant was similarly unconcerned by a small lump. She consulted with her sister and both agreed that it was “a breast vein,” so they took no action. A forty-three-year-old participant also thought her breast change was normal, saying “I thought maybe it was just a breast pain. Maybe that is how the breast pains someone.” And explaining that was the reason for not going to the hospital. A forty-six-year-old participant had a related experience, indicating as well: “We thought maybe it was just an ordinary breast problem. It was when we saw that the breast did not heal. It was getting bigger and more and more painful, we went to the hospital.”

Ayaz, Ayaz, and Farrukh (2016), in a cross-sectional survey of the reasons for delayed presentation of women with breast cancer in Islamabad, similarly showed that women who delayed their reports of first breast cancer symptoms did so because they were unaware of the gravity of these symptoms. Also, findings from Ibrahim and Oludara (2012) in a qualitative study of the socio-demographic factors and reasons associated with delays in breast cancer presentation in Lagos Nigeria indicated that ignorance of the nature of the illness was among the leading causes of delay in breast cancer presentation. Likewise, in a qualitative study of delay in seeking health by women reporting symptoms of breast cancer, Gould et al. (2010) found that women delayed reporting symptoms of breast cancer when their symptoms deviate from their knowledge of breast symptoms. Some women in the same study acted promptly as soon as they

perceived the potential seriousness of their breast changes. The study concluded that symptom interpretation influences help-seeking.

7.10.3 worsening of breast symptoms led to a heightened level of illness threat. “it was getting bigger and the pain became more throbbing” (a 46-year-old participant). After the initial appraisal of breast changes and the initiation of health-seeking behaviors, some participants observed they were not experiencing positive changes. For some of them, the symptoms worsened. A forty-year-old participant shared the following: “I saw that my breast was becoming harder and bigger. It started aching me. I used medications for infection. I saw that the drugs did not help the situation... I then went to the hospital.” A thirty-seven-year-old participant went to the hospital after, “... until I think I started seeing some discharges from [her] nipple.” Worsening of symptoms also convinced a 54-year-old participant to consult a physician: “Before, it was not aching me. But now, it is giving me a lot of discomforts. It was aching me.” In a similar qualitative study exploring why women delay seeking assistance for metastatic breast cancer, Gould, Fitzgerald, Fergus, Clemons, and Baig (2010) found that participants contracted the health care provider because their symptoms had worsened. Signs of worsening of symptoms were growing hardness and thickening of the breast as also observed in the current study.

The current study also found that the women whose symptoms of breast cancer were unrelated to a lump were less likely to attribute them to signs of breast cancer. This finding is congruent with findings from Burges, Ramirez, Richards, and Love (1998), who conducted a qualitative study to determine who and what influences delays in the presentation of breast cancer. In the study, the authors observed that patients with non-lump symptoms are less likely to attribute their symptoms to a definitive cause and are less likely to engage in breast cancer

health-seeking behaviors.

7.10.4 breast cancer treatments necessitate spending money. “They say the illness will eat you until you die. I say that it is not the illness that must kill a person. If one has the money to look after herself” (a 60-year-old participant). The idea portrayed by this subtheme is that breast cancer treatment demands spending money. As a 43-year-old participant revealed, “Money is a big issue,” adding that “although most women want to continue with their breast cancer treatment, the cost of treatment is too high.” A thirty-five-year-old participant shared her experience: “After we left the theatre, my sisters withdrew N50,000.00. It is all spent. The doctors, and the nurses asking us to buy this, buy that.” A forty-nine-year-old participant talked about a similar experience as she related part of her conversation with an oncologist: “He asked me if I can pay the bills... He said because, most times, they ask you people, to pay money, you people just beg and beg and beg. They tell you this amount. You will beg everything down.”

When the cost of treatment is high, patients may find it difficult to pay. The cost of breast cancer treatment and care may constitute major challenges in seeking health care. In a systematic review of barriers to breast cancer care in developing countries, Sharma, Costas, Shulman, and Meara (2012) found that the high costs of treatment resulted in delayed patient presentation. Sharma et al. (2012) indicated that poverty is the most significant factor influencing health-seeking behavior.

7.10.5 the desire to live prompts breast cancer health seeking. “I have to endure because of my children. I want to live long” (A 42-year-old participant). Participants expressed their motivation for engaging in health-seeking as a desire to live, because according to some of the participants nobody wants to die. When a 44-year-old participant was asked why she came to the hospital for care, she responded: “Do I ever have an alternative? ... I want to have a solution.

It can spread to other parts of the body. When it spreads, it can be dangerous. It can affect the organs. Then, the next thing is death.” Similar responses were given by other participants, who wanted to live for the sake of their children. A forty-two-year-old participant said, “I have to endure because of my children,” and a 41-year-old participant, “all that I want is that I should follow my children or take care of my children ...”

7.10.6 women handled the emotional reactions to breast cancer with spirituality.

“But I belief God. One thing I said was that the illness will not kill me” (a 60-year-old participant). This subtheme expressed the women’s optimism that breast cancer will not kill them. It is an indication of hope and relates to their spirituality. Spirituality has been defined as the way people find meaning and purpose in life. It embraces cultural beliefs and practices. Spirituality involves the inner life of a person and how an individual connects with the divine or sacred (Puchalski, 2012). Spirituality is a fundamental aspect of human beings and it has been identified as a critical factor in an individual’s health and wellbeing (Puchalski, 2012).

The perception of breast cancer as a disease that kills aroused in the participants emotional reactions, which they were handling with faith, optimism, and belief in God. In expressing her belief in God, a 60-year-old participant revealed, “The illness will not kill me. I will see your end. You will not see my end.” A forty-two-year-old participant expressed similar optimism: “But I have said that I shall not die I shall live. Death is not my lot.” A fifty-three-year-old participant expressed her fear and emotions on being told she had breast cancer. Her expression was a kind of strong faith that the illness will not kill her: “I was afraid when I heard it. Because they said, it kills. But, I believe that it will not kill me. I will be the one to kill it.” Fifty-four-year-old Participant 24 expressed similar sentiments: “But, if one believes that this illness will not kill one, then it will not kill that person.” All these women were expressing

optimism in the face of a disease that they knew could kill them.

Religious and spiritual beliefs can influence health-seeking behaviors and many other health-related decisions. Many of the current study's participants seemed to understand the significance of their spirituality. They expressed a firm belief in God, as well as optimism that God will not allow breast cancer to kill them.

7.11 Theme 2: Breast Cancer, a Disease Inflicted by the Enemy

“Mostly, people believe it is an attack from the enemy” (a 44-year-old participant). This theme relates to the cultural perception of breast cancer as a disease mete out to another person by the enemy. Many participants perceived breast cancer as a spiritual attack, also called an arrow. When a 44-year-old participant was asked about the perception of the local people about breast cancer, she said, “Some believe that it is an attack ... arrow like my own issue because there are no traces of breast cancer in my family history.” A Forty-two-year-old participant said, “I believe it was an arrow. I believed it was an arrow. Because at that time, there were many bad birds flying in our surrounding and they were making all sorts of noises.” A forty-four-year-old participant elaborated more on this perception, saying: “Mostly, people believe [breast cancer] is an attack from the enemy. That is why they do not come to the hospital.” A sixty-year-old participant also elaborated on the perception of breast cancer as an attack: “To me, it is a spiritual attack. If you are ... somebody that is up and doing ... somebody can just be jealous of you. Spiritually, they can attack you.” A sixty-eight-year-old participant also thought it was an attack: “I saw that the thing looked like two lumps. I was told it might be an attack. That it was an attack. When it started worrying me, I decided to come to the hospital.” When asked why she did not tell anybody about her diagnosis, a 43-year-old participant said: “The illness may not have a natural cause. It may be a spiritual attack. If you now tell people about your illness, do you know

where the spiritual attack (arrow) is coming from?”

The general belief in some quarters is that a spiritual attack is a deliberate act of malice. It could also be inflicted by a traditional practitioner at someone else’s request. Traditional healers and spiritualist also have the power to counter a spiritual attack. Such practitioners would return the arrow to the sender through prayers and other remedies. A sixty-eight-year-old participant said, “After the prayers that were said on my behalf that if it was an attack, that God should return it to the sender, I came to eh hospital.” A forty-six-year-old participant recounted the following about praying for the attack to end: “We went for prayers maybe it was a kind of war ... other pastors prayed for the attack to be resolved.” The findings from this study are similar to those of Ezeome and Anarado (2007) who found that many patients perceived cancer to be caused by spiritual forces, which can only be cured by traditional healers because Western medicine has been seen to be ineffective in managing such illnesses. This perception was often fueled by the fact that most of cancer patients die even after receiving orthodox Western medical care. Therefore, to secure all the possible benefits and make sure they are not losing out on anything that might help in managing their breast problems, the people try alternative treatments first or use them in combination with Western biomedical practice.

7.12 Theme 3: Support from Family, Friends, and Social Network Members

“With the help of the church, my family, and my friends, I did the operation” (a 60-year-old participant). The participants revealed that their families had been extremely supportive in helping them to face and handle their breast cancer. A forty-two-year-old participant said, “My brother and my family and my husband’s brothers. All of them joined hands together to bring me here.” Also, a 54-year-old participant saw her supporting family as a favor: “The favor I have received is that I thank my brothers. In fact, [her brother] he is the one who forced me to come

here ... He said I should just go to the hospital.”

Support from family members. A fifty-three-year-old participant expressed gratitude to her husband who, “has been very supportive.” A Forty-two-year-old participant thanked her whole family: “My husband’s family, my family, my junior ones.” A forty-four-year-old participant was also grateful to “[her] husband and [her] siblings.” All family members were involved in the supportive role as shared by a 42-year-old participant who spoke of her daughter’s support: “My daughter ... was the one that started the movement ... During one of my operations, she was there. After I finished the chemo, I told her to go back to school.” The supportive role and connectedness of the family observed in this study are similar to those observed in Bentur, Stark, Resnizky, and Symon’s (2014), phenomenological study of Israeli patients with advanced cancer. The findings from the study indicated that family connectedness enabled advanced cancer patients to cope with existential and spiritual concerns by providing comfort and support. The findings from this study about the supportive roles of participants’ significant others are similar to findings from Majaj et al. (2015) in a qualitative study of the health-seeking behaviors of Palestinian women in the Occupied Territories, which indicated that the study participants’ significant others were instrumental in enabling the women to engage in health-seeking behaviors by offering encouragement, support, and assistance.

Support from friends. A forty-two-year-old participant related the contributions of her friends in her health-seeking activities: “When it was getting bigger, we started telling our friends and relations, asking for assistance, explanation, and help to diagnose what it was. Different people gave different suggestions.” A forty-four-year-old participant also said of her friends: “They looked after me. They visited me in the hospital. They counsel me. They prayed for me. They bought me gifts.” A forty-six-year-old participant and a 37-year-old participant

spoke of the help and encouragement they had received from their friends.

Support from church members. A sixty-year-old participant expressed: “With the help of the church, family, and friends, I did the operation.” A thirty-five-year-old participant expressed the supportive role of her church members: “You know, they will console me... no problem, God is on your side. God will do it. We will pray. We will do this, we will do that.” The supportive roles of church members were not limited. For example, the pastors were also involved as a forty-two-year-old participant revealed: “I talked to my shepherd. I said, please pray for me. We prayed. He was among the people that even said go that it needs medical attention. That don’t think it is spiritual.” A twenty-nine-year-old participant narrated a similar experience: “They prayed with me, they prayed with me, pray for me, pray for me and not only that, my pastors entered into prayer for me. Members said a prayer, prayer for me.” Similar findings about the support of church members were identified by Sabado, Tanjasiri, alii, and Hanneman (2010) in a qualitative study of the role of spirituality in coping with breast cancer among Samoans.

Findings from Sabado et al. (2010) indicated that spirituality and prayer enabled breast cancer survivors to cope with breast cancer. Spirituality provided considerable emotional strength to them. The church provided financial assistance and social support programs for women with breast cancer. Findings from Maree and Molunda (2015) qualitative study of Zambian women with advanced breast cancer indicated that some of the women received support from church while others did not.

7.13 Theme 4: Major Barriers and Difficulties in Managing Breast Cancer

“The major difficulty is stigmatization and all other jests that people will make of you” (a 41-year-old participant). Women diagnosed with breast cancer encounter many challenges. Some

of these challenges could be devastating emotionally, impacting relationships with partners and friends. Other challenges relate to the shock of a cancer diagnosis; fear of treatment outcomes; physical side effects of treatments such as loss of hair, skin changes, nausea; and costs of treatments. These study participants shared some of their challenges or difficulties: stigma, financial difficulties to breast cancer treatments, experience of breast cancer treatments, and fear.

7.13.1 stigma, a barrier to seeking medical attention for breast cancer. Stigma is defined as the attachment of negative connotation to a diagnosis (Mutebi & Edge, 2014). Stigma was experienced by some of the study participants. A forty-one-year-old participant shared her experience: “The major difficulty is stigmatization and all other jests that people will make of you.” A forty-four-year-old participant had a particularly difficult experience with stigma from her own husband: “When I told my husband that I will undergo surgery, his behavior toward me... changed ...I agreed that they should cut [my breasts] off ... We came here together when ... But after four days, he abandoned me, and he ran away.”

When a 44-year-old participant was asked to explain how the village people were reacting to her, she said: “They will be laughing at me. They will say, I have only one breast. They will be looking at my chest, and they will be saying I am not complete.” Similar findings about stigma have been identified in the literature: in two qualitative studies, one (Assaf et al., 2017) on the experience of Arab women with breast cancer and one (Maree & Mulonda, 2015) on the experience of Zambian women with advanced stages of breast cancer, and a survey (Clegg-Lamprey, Dakubo, & Attobra, 2009) of the psychosocial aspects of breast cancer treatment in Ghana. All these studies observed that stigma was associated with the diagnosis of breast cancer. The women in the studies reported that they lost their social relationships and their friends, and their family stopped visiting them. These reactions led them to isolate themselves

from people who according to the women, do not understand the disease.

The stigma experienced by breast cancer patients in the current study could be related to the cultural myths and taboos surrounding the illness, as observed by Daher (2012). Such taboos and myths include the perception that breast cancer is always fatal; that mastectomy mutilates the human body and renders a woman incomplete; the concern that if cancer is cut into, the cancer will spread immediately to other parts of the body; and that those whose breast is cut off will die within a short time.

7.13.2 financial difficulty, a barrier to seeking medical attention for breast cancer.

“Ha, with money, money was my main difficulty” (a 46-year-old participant). “The cost of treatment is too high” (a 43-year-old participant). This subtheme expresses the financial hurdle women encounter in treating and handling their breast cancer. In a country like Nigeria, where the financial implications of breast cancer are borne through out-of-pocket payments, the burden of breast cancer treatment can become enormous. These participants expressed their difficulties with comments such as: “my difficulty is that I do not have enough,” “the medication was very expensive,” “Money was my main difficulty.” A sixty-year-old participant delayed seeking medical attention in the hospital until the cancer had metastasized, because of a lack of money. A forty-one-year-old participant exclaimed, “I am a clerk. My husband is a teacher. Where will I get the money?” A fifty-four-year-old participant explained what could happen to people with not enough money to treat the disease: “If one does not have capital and one does not have anybody to give financial support, that is what kills a person who has this illness.”

A forty-two-year-old participant told of other breast cancer patients who did not return to the hospital because of lack of money and explained that her family searched for money even to the extent of “selling some of their possessions and properties to pay for her treatment.” A forty-

four-year-old participant believed that cancer does not kill a person who “has the money to look after herself.” Similar findings were identified by Pruitt et al. (2015) in a qualitative study of the social barriers to the diagnosis of breast cancer in a teaching hospital in Nigeria and in an earlier study by Ajekigbe (1991). As observed by Ezeome and Anarado (2007), the indigent patients who must pay for their conventional breast cancer treatment out of their own pockets are more likely to seek alternative ways to manage their breast cancer.

7.13.3 women experienced increased suffering with some breast cancer medical treatments. “It was the chemotherapy water that made my body to look like this. I cannot eat, my throat is dry and sore” (a 42-year-old participant); and according to a 53-year-old participant, “the chemo is worrying me.” This subtheme relates to the side effects of breast cancer treatments such as chemotherapy and radiotherapy. Many participants spoke of the severity of these treatments. The effects of the drugs made a 43-year-old participant feel afraid and she added, “The illness is not as severe on the body as the drug.” Some participants described how they felt after chemotherapy. “if I take that chemo three days ... I will be feeling as if the end has come (a 42-year-old participant); and “I have some reactions ... like vomiting, fatigue, unable to eat, unable to pooh, and just that” (a 49-year-old participant). These findings are consistent with findings from Maree et al. (2015) which indicated that the side effects of chemotherapy resulted in negative experiences associated with various side-effects, which added to the women’s sufferings.

7.13.4. fear, a barrier to seeking medical attention for breast cancer. “When they said they will cut off my breast, I was afraid” (a 44-year-old participant). Women who have had a breast cancer diagnosis and are undergoing breast cancer treatments experience fear. Participants in this study felt fear related to their perception of breast cancer, as expressed by a

42-year-old participant: “Who can be given a death certificate and will not be afraid, that will not be sad.” Fear of the mastectomy was expressed by a 37-year-old participant: “Yes, they are scared of the operation. That is the mentality.” A forty-four-year-old participant said, “When they said they will cut off my breast, I was afraid ... When they said that those people whose breast is cut off will die.” The fear of breast cancer treatment such as mastectomy found in this study is similar to the fear found in Ajekigbe (1991).

7.14 Theme 5: Making Decisions about When and Where to Engage in Breast Cancer Health-seeking Behavior

“Myself and my husband decide” (a 60-year-old participant). This theme relates to the decision-making to engage in health-seeking behavior. It investigated who makes the final decision about when and where to engage in a health-seeking behavior. A greater majority of the participants said the decision to engage in health-seeking was made at the family level. A forty-six-year-old participant, a 40-year-old participant, and a 60-year-old participant said that they made joint decisions with their husbands. A forty-four-year-old participant said, “I need to tell him that I am sick, I need to go to the hospital. I am no longer a baby.” For a 44-year-old participant, the decision was made at the larger family level. It involved the participant’s brother. The involvement of the family in decision-making on important issues within the family is typical of Nigerian families. Similar findings are found in Hobbs et al. (2015) in a research and surveillance consortium to explore the involvement of patient’s families in decision making regarding cancer treatments. Hobbs et al (2015) identified that family involvement in oncology visits is associated with better satisfaction with care and understanding of cancer related information. Similar findings are also identified in Hawley et al. (2009), who in a study to explore the decision to accept mastectomy among racially and ethnically diverse breast cancer

patients, indicated that the involvement of family and friends contribute to a more favorable acceptance of mastectomy by breast cancer patients.

The decision to engage in health-seeking at an individual level was reported by a thirty-seven-year-old participant, when asked about who makes the final decision for her as to when and where to engage in health-seeking, she responded, “myself.” The same response was given by a forty-nine-year-old participant, a young undergraduate living by herself. Speaking of her husband, a fifty-four-year-old participant said the following:

Sometimes I tell him. At other times, I do not tell him. I just think that each person will carry his or her own cross. I don't like to put unnecessary stress on people. I don't like to disturb other people. Each person has what she or he is facing.”

For a 41-year-old participant, it was her husband who decides: “He is the one.”

These findings indicate the role of the family in decision-making participially on health issues. In the current study, most of the participants indicated that health-seeking decision-making was not an individual affair, but a responsibility of the whole family. This shows that the individual in the Southwestern Nigerian context is an active member of a family system, thereby, reinforcing cooperation, collective responsibility, and interdependence.

Figure 7.1 presents a model depicting the factors the participants believe influence their health-seeking behaviors. The experience of breast changes triggered an emotional response in the participants. The experience of worsening of symptoms increased the participants' physical and psychological reactions. The individual and cultural perceptions of having contracted a serious illness led to heightened level of threat, triggering participants' decision-making process to engage in health seeking. The more severe a person perceives the situation to be, the greater the chance that the individual will take action against it. The perceived benefits of health seeking – the desire to live – outweighed the perceived barriers: stigma, fear, side-effects of drugs, and the cost of treatment. The pressure and supportive role of the participants' significant others,

friends, and other social networks members, as well as the participants' own spirituality also lessened the degree of their emotional reactions to their perceived seriousness and perceived barriers and provided encouragement to engage in health-seeking. In many cases, the family, friends, and other social-network members provided financial assistance for the participants.

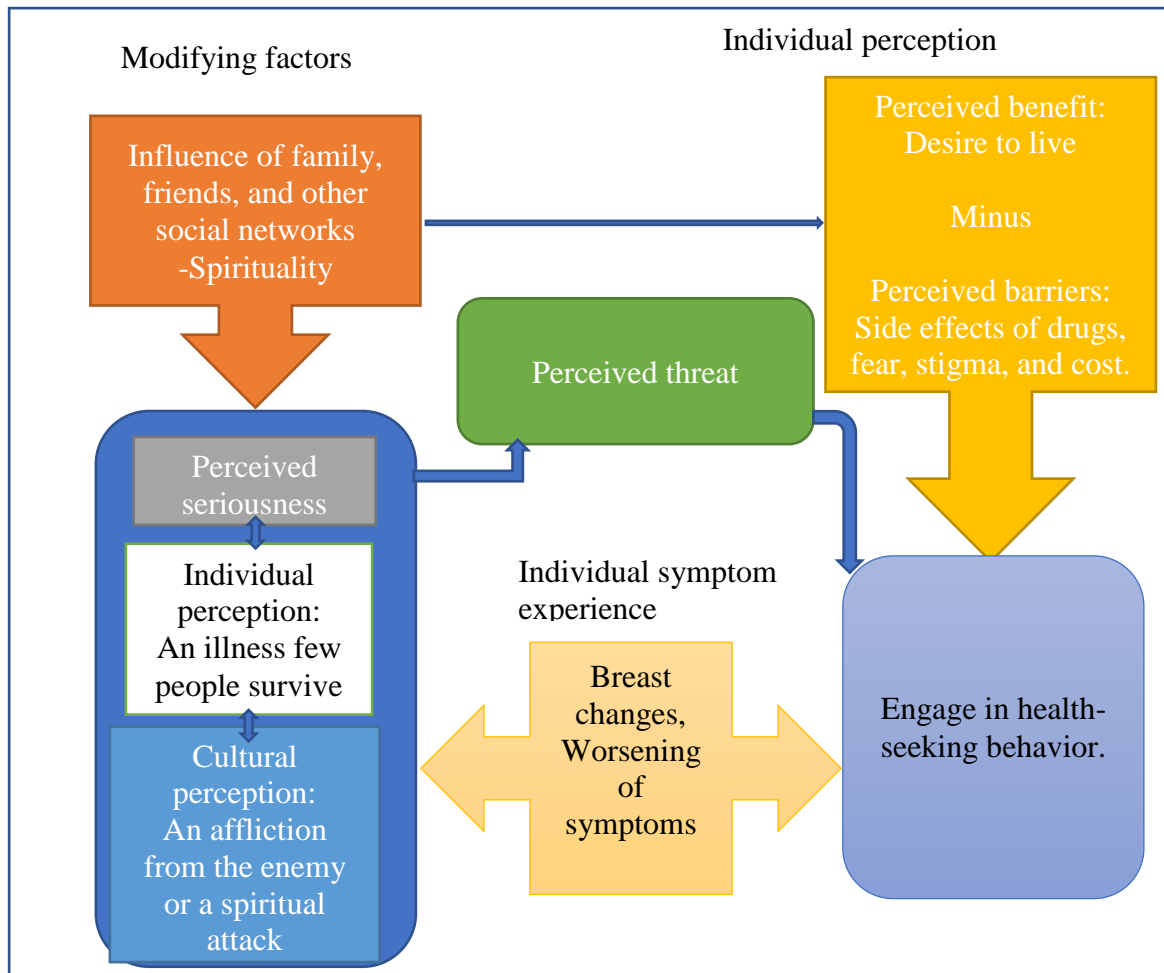


Figure 7.1 Factors Influencing Health-seeking Behaviors Model for Women with Advanced Breast Cancer in Southwestern Nigeria.

7.15 Implications of the Findings

Findings from this study suggest the need to address individual and cultural perceptions and misconceptions about breast cancer etiology in Southwestern Nigeria in a culturally sensitive manner. The findings from this study indicate that some participants experienced stigma. Some

participants described how family and friends disappeared after their breast cancer diagnosis and how they dealt with the illness in private and isolation. Nursing interventions might be focused on supporting the individuals affected while at the same time addressing breast cancer stigmatization in the general public. Such supportive interventions could aim at enhancing empathy for the women, providing relevant information about breast cancer and its treatment outcomes, and connecting the patients with appropriate social support services.

Interventions targeting the general public might aim at addressing the misconceptions, myths, and fears associated with breast cancer. Different outlets such as social gathering, town meetings, and worship gatherings can all be used to disseminate comprehensive breast cancer information. Comprehensive public education about breast cancer might enhance a better understanding of the disease, and its treatment options which may help to dispel some of the myths and secrecy that surround the illness and enhance patient's earlier presentation for medical attention that, in turn, could result in better treatment outcomes. The fear of mastectomy can be addressed by planning and implementing programs that can help to dispel the misconception that link mastectomy to death and letting newly-diagnosed breast cancer patients meet breast cancer survivors. Funds for carrying out a nationwide breast cancer campaign may not be available, however, nurses can create awareness and empower the few people to whom they have access in their different clinics and work places.

The findings call for adequate counseling for women undergoing treatment for breast cancer. Nurses and health care professionals should create time and be available to listen to the patients, give them the opportunity to express and discuss their worries, and fears and, address these concerns. Nurses can also teach the patients what to expect before, during, and after breast cancer management procedures. There is the need for the creation of an insurance fund to assist

women presenting with breast cancer not only in Southwestern Nigeria but also at the national level.

Attending to the spiritual needs of patients presenting with advanced breast cancer could shift attention from the illness experience to higher values such as expressions of faith, trust, and hope in God. Paying attention to patients' spirituality and spiritual well-being could also help them to find meaning and live their lives to the fullest throughout their breast cancer trajectory.

7.16 Study Limitations

The conceptual framework adopted for the study did not account for the potential influence that cultural beliefs may have on health-seeking behavior.

7.17 Contributions to Nursing Knowledge

The factors influencing the health-seeking behavior of women with advanced breast cancer in Southwestern Nigeria model could enable nurses to carry out a systematic exploration and assessment of patient's beliefs, motivations, and barriers that influence their health-seeking behaviors. Based on the outcomes of the investigation, nurses can plan and implement culturally sensitive, contextually relevant, evidenced-based nursing care that address the peculiar needs of their patients.

The factors influencing the health-seeking behavior of women with advanced breast cancer in Southwestern Nigeria model constructs could be used to focus and guide patients' interviewing. By obtaining health information from all the model constructs to present a complete historical picture of the factors influencing the patient's health-seeking behaviors, nurses can help patients initiate the most appropriate steps to take in seeking to promote health, ameliorate, and prevent illness. Using the factors influencing the health-seeking behavior model developed from this study as a tool to guide health assessment and history taking, nurses can

structure and provide comprehensive breast cancer education and counseling sessions within their socioeconomic, and sociopolitical contexts.

7.18 Conclusion

Women in Southwestern Nigeria typically present with advanced breast cancer. Low level of breast cancer signs and symptoms awareness delayed the women's decision to seek professional attention to manage their breast changes. The factors influencing the women's health-seeking behaviors were: personal perception of breast cancer as a life-threatening illness and cultural perceptions of breast cancer as an affliction from the enemy or spiritual attack, breast changes, interpretations of breast changes, and worsening of breast symptoms. The women's major challenges were related to the financial difficulties they encounter during their breast cancer trajectory, handling the cultural misconceptions associated with breast cancer, and the side effects of some breast cancer treatment modalities. The findings also indicate the need to support women who have this illness and to educate the community comprehensively about issues relating to breast cancer etiology and its treatments. Family members, friends, and other significant network systems encouraged and supported the women to engage in health-seeking activities.

By identifying and addressing the ways in which cultural beliefs, social interactions, and the costs of breast cancer treatments impact Southwestern Nigerian women's health-seeking behaviors to manage breast ill-health, nurses and other health care providers can design and implement interventions that can enable holistic management and care delivery of breast cancer in the region, thereby improving the treatment outcomes of the illness.

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Chapter 8 MANUSCRIPT 5

**SEEKING DIVINE INTERVENTION FOR THE MANAGEMENT OF ADVANCED
BREAST CANCER IN SOUTHWESTERN NIGERIA**

SEEKING DIVINE INTERVENTION FOR THE MANAGEMENT OF ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA

8.1. Relationship of Manuscript 5 to the Dissertation

In this manuscript, I discuss the implications of one of the key findings of this study. Generally, among the participants in the current study, religion and spirituality played significant roles. The analysis of the data showed that 67% (n= 20) engaged in seeking divine intervention to manage their breast changes. When the participants observed their breast changes, they experienced bewilderment and stress over the changes being observed in their bodies. They turned to religion and expressed strong faith in God's ability to see them through this phase of their lives. This turning to religion could be regarded as a coping mechanism to handle the emotional, psychological, social, physical reactions, and experiences accompanying advanced stages of breast cancer.

Findings from this study indicate that those who sought comfort in religion approached it by asking their pastors and church members to pray with and for them, a practice which indicates that both the healer and the patient together actively participated in the healing process. Relating this observation to the current study context, religion as part of the Yoruba culture has played significant roles in influencing health-seeking behaviors among the people. Prayer and spirituality have been associated with high levels of faith, hope, and optimism among the current participants. This manuscript will be presented to Cancer Nursing, for consideration for publication.

SEEKING DIVINE INTERVENTION FOR THE MANAGEMENT OF ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA

8.2 Abstract

In this paper, the author presents part of the findings of a research study that explored the health-seeking behaviors and factors influencing the health-seeking activities of women presenting with the advanced stages of breast cancer in Southwestern Nigeria, from the women's perspectives. The study participants were 30 women, showing up with the advanced stages of breast cancer in a large tertiary, referral, and university-affiliated Southwestern Nigeria hospital. Study participants were purposively selected. Data were obtained through participants personally filling out a researcher-designed demographic information form and participation in in-depth face-to-face, one-on-one, semi-structured interview guided by open-ended questions, conducted by the researcher. The Health Belief Model (HBM) was the conceptual framework adopted for the study, while the methodological approach was the interpretive description (ID). Data analysis was inductive. Thematic analysis of interview transcripts revealed that one of the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria was seeking divine intervention for the management of the illness. Findings emerging from this study indicate the need for health-care policy-makers to address alternatives to health care deliveries. It is recommended that the alternative health care providers should be given some trainings on breast cancer recognition and the appropriate time to refer their clients for more specialist and professional management of the illness.

Keywords: Advanced stages of breast cancer, Health-seeking behavior, Divine intervention, Southwestern Nigeria, Interpretive description, women.

SEEKING DIVINE INTERVENTION FOR THE MANAGEMENT OF ADVANCED BREAST CANCER IN SOUTHWESTERN NIGERIA

8.3 Statement of Problem

Globally, breast cancer is the most common cancer in women in both more and less developed regions. It is the second cause of cause of cancer-related death after lung cancer in more developed regions. In developing regions, breast cancer is the leading cause of cancer-related mortality among women (Ferlay et al., 2015). In Nigeria, 70 to 80% of women with breast cancer present with the advanced stages of metastatic breast cancer (Akarolo-Anthony, Ogundiran, & Adebamowo, 2010; Ezeome, 2010; Jedy-Agba et al., 2012). The World Health Organization (WHO, 2017) reports predict an increase in breast cancer incidence in Nigeria from 27,300 cases in 2012 to 33,660 cases in 2020. It has also been predicted that the mortality from breast cancer in Nigeria will increase from 13,960 cases in 2012 to 16,900 cases in 2020 (Ferlay et al., 2015; GLOBOCAN, 2012). Data analysis from cancer incidence and mortality for 16 European countries indicated that the recent declines in mortality from breast cancer could be related to earlier detection and presentation of the illness (Botha, Bray, Sankila, & Parkin, 2003). In preparation for the predicted increases in the incidence and mortality rates of breast cancer in Nigeria, it is essential to understand the health-seeking behaviors of women presenting with the advanced stages of the illness.

In this paper, the implications of seeking divine intervention for the management of the advanced stages of breast cancer in Southwestern Nigeria will be presented and discussed. Understanding women's health-seeking behaviors and the factors influencing them could help policy makers and health care providers formulate and implement practical strategies and treatment options that can contribute to the holistic management of breast cancer, by encouraging

early presentation, and reducing breast cancer-related mortality.

8.4 Traditional Medicine

The World Health Organization (WHO) defines traditional medicine as “the knowledge, skills, and practices based on theories, beliefs, and experiences indigenous to different cultures to promote, maintain, prevent, diagnose, and treat physical and mental illness” (WHO, 2013, p. 15). Traditional medicine includes the use of products such as herbs, herbal materials, herbal preparations, combinations of plants, prayers, religious signs, symbols, rites and rituals, spiritual therapies, and other locally available resources to prevent and cure diseases, and maintain health (Adefolaju, 2014; WHO, 2013). Traditional medicine is used all over the world. For many people, traditional medicine is the primary source of healthcare; for others, it is the only source. Traditional medicine is close to homes, accessible, affordable, culturally acceptable, and trusted (Olasehinde, 2013; WHO, 2013). In Nigeria, the most commonly used traditional healing methods are herbal preparations, followed by faith and prayer-house healing (Ezeome & Anarado, 2007).

8.5 Traditional Healers

Traditional healers are individuals who use traditional medicine and other remedies to promote the psychological, physical, and spiritual well-being of their clients. These healers offer guidance and counseling services to individuals in the pursuit of holistic health (Olasehinde, 2013). In Nigeria, traditional and indigenous healing methods include consultation with the spirits, also called divination; the performance of rituals to establish harmony between the living and the spiritual worlds; the offering of sacrifices to ancestors to request favors and healings; traditional psychotherapy or counseling; the use of words or incantations, and religious or faith healing ceremonies (Olasehinde, 2013).

The traditional healers' role is to preserve the well-being of the entire community, as well as individuals in it, by monitoring spiritual well-being and the flow of life within the community (Day, 2014). According to Day (2014), the traditional healers are always available and rarely say no to anyone who seeks their services. She adds that they are considered to be visionaries who “play important cultural and spiritual roles by helping those who are seeking healing and traditional knowledge to live good lives” (p. 38). Day (2014) goes on to write that the healers are kind, respectful, devout, and firm individuals, who share beautiful stories that must be passed down from generation to generation.

Because life depends on good health, most societies provide for the well-being of their citizenry through the development of their traditional medical system. The traditional and indigenous healing system is thriving in Nigeria, with about 95% using the traditional healing system concurrently with modern Western medicine (Adefolaju, 2014). Nigerians see the traditional healing system as affordable, easily accessible, and effective (Adefolaju, 2014).

Nigerians have deep faith and confidence in the traditional healing system because they hold the belief that the traditional healing practice treats the whole person and it considers the socio-cultural background of the people (Adefolaju, 2014). Nigerians believe that traditional medicine sustained their forefathers, who lived longer and stronger lives (Adefolaju, 2014). The trust the Yoruba people of Southwestern Nigeria have in traditional healers is partly based on their provision of physical, spiritual, and psychological support for people suffering from chronic conditions (Adefolaju, 2014). It is also based on shared experiences: the healers live in the same community as the people they care for, share the same value system, and go through similar socialization processes (Ademuwagun, 1969).

8.6 Risks Associated with Traditional Healing Methods

The practice of traditional medicine is not without some challenges and potential risks. The WHO (2013) cautioned against the risks associated with the use of traditional healing methods. These include the use of poor quality adulterated or counterfeit products, unqualified practitioners, misdiagnosis, delayed diagnosis, or failure to use effective conventional treatments, exposure to misleading or unreliable information, direct adverse effects, side effects, and unwanted treatment interactions.

8.7 The Purpose of the Study

The aim of the study was to explore and understand the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria from the women's perspectives, as well as the factors the women believe influence these behaviors.

8.8 Context and Setting

The focus and context of this study was Southwestern Nigeria. The Yoruba, the second most populous ethnic group in Nigeria, dominate the Southwestern part of the country. Southwestern Nigeria comprises six states: Ekiti, Lagos, Ogun, Ondo, Osun, and Oyo. Although the region is mainly Yoruba-speaking the people speak different Yoruba dialects. All the states in Southwestern Nigeria share a common climate and weather conditions: a period of rain from March to November and a dry season from November to February. The people's primary occupations include trading, farming, fishing, blacksmithing, pottery, and indigenous medical practices (Borokini & Ibrahim, 2014).

The setting for the study was a large tertiary, university-affiliated, referral hospital in Southwestern Nigeria. This treatment center was chosen for several reasons: the diversity of the patient population; its reputation for good quality medical assessment, treatment, care, and

equipment; and its role as a referral center for patients with various diseases. People travel from rural and urban areas of Nigeria to be assessed and to receive treatment in the hospital. The oncology section and the radiotherapy department of the hospital operate a twice weekly breast cancer outpatient clinic. The patients seen in the oncology section are there either for surgical intervention or for chemotherapy treatments for the management of various malignancies including breast cancer, while the patients seen in the radiotherapy department are normally referred by other clinics in the hospital, where other treatment modalities such as surgery or chemotherapy have already been carried out. At the clinic, patients with different stages of breast cancer are assessed, diagnosed, and counseled about breast cancer and its treatment options. For the current study, participants were recruited from the oncology section of the hospital.



Figure 8.1 Map of Southwestern Nigeria 2

Retrieved from <https://www.naija.ng/1117167-south-west-states-nigeria.html#1117167>

8.9 Research Questions

The two research questions that guided the conduct of the study were as follows: 1) How do women presenting with the advanced stages of breast cancer in Southwestern Nigeria describe their health-seeking behaviors? 2) What factors do women presenting with the advanced stages of breast cancer in Southwestern Nigeria believe influence their health-seeking behaviors?

8.10 Methodology

8.10.1 study design. A qualitative research approach was used, including the interpretive description methodology proposed by Thorne, Kirkham, and MacDonald-Emes (1997). The interpretive description approach is suitable for generating knowledge that can be applied in clinical settings (Thorne, 2016).

8.10.2 sampling technique and sample. The purposive sampling method was used to select 30 information-rich participants, who consented to take part in the study. Information-rich participants are individuals who have much knowledge about the phenomenon under investigation and who are capable and willing to share this knowledge with the researcher. The researcher can learn a great deal from such participants (Patton, 2014). Inclusion criteria for this study were the following: a) being of a female gender, b) presenting with the advanced stages of breast cancer: that is, stage III or stage IV, c) ability to take part in an interview, d) having the ability to communicate either in English or the Yoruba language, and e) being an in-patient in the hospital.

8.10.3 study participants. The study participants were women with advanced breast cancer. They were in the hospital at different stages of breast cancer care and management and they were all symptomatic at the time of the study. They were all aware of their ethical rights as study participants.

8.11 Ethical Consideration

A letter of support was applied for and obtained from the hospital where the data collection exercise for the study took place. Ethics permission to conduct the study was obtained from the University of Saskatchewan Research Ethics Board (REB) and the Joint Research Ethics Committee of the hospital and the university to which the hospital where the data

collection for the study occurred was affiliated. Operational approval was obtained from the Chief Medical Director of the hospital where the data was collected. Participation was completely voluntary.

The objectives and goals of the study were explained to the participants in straightforward language that they could understand. Participants were enlightened that they were free to withdraw their participation from the study at any time. They were also told to answer only the questions they were comfortable answering. Issues relating to the confidentiality of the data and anonymity of participants' identities were discussed, as well as the audio-recording of the interview and the use to which the collected data would be put. All participants' questions were answered, and they were given ample time to decide on their participation in the study. Those who indicated their willingness to take part in the study signed the consent form.

8.12 Data Collection

Two methods of data collection were used: a researcher-designed demographic information form completed by individual participants; and participation in a one-on-one, face-to-face, semi-structured interview, guided by open-ended questions, conducted by the researcher. In the interviews, participants were asked questions on their symptom experiences, perceptions about breast cancer, knowledge of breast cancer, health-seeking behaviors, and treatment challenges. The interview protocol was translated into the local language and participants were given the opportunity of being interviewed in the language of their choice: the local language or English language. The interviews lasted for between 10-40 minutes, depending on the experiences each participant wished to share. Interviews were audio-recorded.

8.13 Data Analysis

Data collection and analysis occurred concurrently. The demographic data of the

participants were analyzed using descriptive statistics (mean, median, mode, and simple percentages). Audio-recordings of the interviews were transcribed verbatim by the researcher. Data were cleaned by removing all potentially identifying information. The transcribed interviews were read and corrected for errors. The interviews conducted in the local language that needed to be translated into the English language were translated by the researcher. The translations were back-translated by an independent translator after this individual signed the confidentiality agreement form. The researcher engaged in thematic analysis of the interview transcripts. Constant comparison was used during data analysis (Thorne, 2000). Commonalities and variations in the data were identified. A thematic framework was developed to depict the findings from the thematic analysis. The researcher frequently met with the research supervisors to discuss the emerging interpretations.

8.14 Methodological Rigor

Methodological rigor was ensured by engaging 13 participants who consented in a second interview to confirm and authenticate the initial themes developed by the researcher and to share any new information. The participant's setting was described to enhance transferability. As suggested in the literature by Lincoln and Guba (1985), an audit trail, including interview transcripts, reflexive journals, and field notes, was maintained to support dependability and confirmability.

8.15 Findings and Discussions

The data analysis revealed that the study participants' ages ranged from 29 to 68 years, but the clear majority were between 40- and 50-years-of-age. Their mean age was 47 years. The data analysis also showed that 30% had noticed breast changes two years before presenting, 10% for about 11-15 months, 23% for 5-10 months, and 36% for less than 5 months. The study

findings revealed that some study participants (67%, n=20) engaged in health-seeking behaviors ‘the traditional way,’ in other words, the participants’ responses revealed three options of health-seeking behaviors directed to traditional care: visiting the traditional healer, visiting the herbalist, and praying or visiting the prayer center for faith healing.

8.16 Health and illness in the Yoruba culture

Because, healing in the Yoruba culture depends on one’s relationship with the Supreme God, the deities, and the ancestors, it is believed to have a religious dimension, (Adepoju, 2012). The Yorubas have the following beliefs: a) a single supreme God, known as Olodumare, who is the creator, controller, and leader of all things; b) spirits comprising of superhuman beings and ancestral spirits; c) human beings including those who are living and those who are yet to be born; d) the biological life of animals and plants; and e) extraordinary occurrences without biological life (Jegade, 2002). The Yorubas also believe that vital forces, energy, and power exist and permeate the universe. Every plant, animal, and natural occurrences is a carrier of the divine force, energy, or power (Borokini & Ibrahim, 2014; Jegede, 2002). There are deities or smaller gods, who are intermediaries, and who act as messengers between God and man. Moreover, some human beings have been gifted with knowledge and the ability to tap, manipulate, control, influence, and use the vital forces in nature (Ademuwagun, 1969; Borokini et al., 2014; Jegede 2002). Such human beings include medicine men, witches, priests, and rainmakers. Some use the gifts for the good and benefits of their communities and fellow human beings. Others use the gifts to harm other human beings and their communities. The attitudes and thoughts of the Yorubas are powerfully shaped by their traditional religious beliefs, as evidenced in their day-to-day interactions, despite the advent of Christianity and Islam (Jegade, 2002).

In the Yoruba worldview, health and illness are two opposing phenomena: health is

regarded as a blessing, while ill-health is considered as an abnormal situation and sometimes a misfortune, which requires corrective measures (Ademuwagun, 1969). Ill-health and other misfortunes do not occur accidentally. Among the Yorubas, the diagnosis of an illness is influenced by the cultural background of the people (Ademuwagun, 1969). Illnesses are explained by way of ancestral spirits, witchcraft, sorcery, and alien spirits (Adegoke, 2008). The perception of illness among the Yoruba people is based on three significant etiologies: preternatural, supernatural, natural/ unknown (Adegoke, 2007; Ademuwagun, 1969; Jegede, 2002). These etiologies of illness are not mutually exclusive but are linked together in a particular case. These perceptions often influence the choice of health-seeking behaviors (Adegoke, 2008). The biomedical germ theory of Western medicine is not always wholly acceptable to an average Yoruba person (Ogundele, 2007).

8.16.1 the preternatural origin of illness. The preternatural etiology of illness is related to the magical practices and activities of witches, sorcerers, enemies, and curses. Some people believe that some illnesses can be inflicted on individuals by people with mystical powers, who bear grudges against the sufferer. This source typically reflects jealousies and hostilities within the community (Ademuwagun, 1969; Jegede, 2002). This idea was expressed by a 60-year-old participant when she was asked about the cause of breast cancer: “to me, if you are eh eh somebody that is up and doing ... somebody can just be jealous of you. Spiritually, they can attack you. They put it there.” Some Yorubas believe that such an illness can only be treated through their traditional healing methods, which are usually carried out by the native doctor or traditional healer, who consults with the Oracle — an ancient secret knowledge base system to inquire about the source of the illness and recommended solutions or cures (Ademuwagun, 1969;

Ogundele, 2007)). When a 43-year-old participant was asked for the reasons why she did not tell anybody about her illness, she replied,

Haa, is it in this life that one will broadcast about her illness? They may add more to it. You know that the illness may not have a natural cause. It may be a spiritual attack or an arrow. If you now tell people about your illness, do you know where the spiritual attack (arrow) is coming from?

When a 44-year-old participant was asked about the perception of local people of breast cancer, she responded, “Mostly, people believe it is an attack from the enemy. That is why they do not come to the hospital. When they don’t come on time, they present at advanced stages. That is why some of them die.” A fifty-four-year-old participant related a similar opinion when she said,

After the prayers that were said on my behalf that if it was an attack that God should return it to the sender. When I did not have any issues with anybody. I did not have any quarrels with anybody. Why will anyone attack me?

Thus, it is not uncommon for a Yoruba person to be suspicious or to consider another person as a potential enemy who could attack him or her through extraordinary powers.

8.16.2 the supernatural origin of illness. The supernatural origin of illness involves offenses to some divinities or the violation of some taboos, and the subsequent wrath of the gods and the ancestors (Ademuwagun, 1969). The Yorubas believe that the gods could inflict a person who offends them with illness (Ademuwagun, 1969). Such illness could only be treated by traditional healers who would consult with the gods through divination to know the cause of the illness and the appropriate remedy for it (Ademuwagun, 1969). To prevent an illness caused by the gods and ancestors, one should avoid offending them (Addemuwagun, 1969). When the gods are offended, people must make sacrifices and engage in rituals, usually performed by the shrine priests, to appease the gods and avert the anger or the displeasure of the supernatural beings (Jegade, 2002).

8.16.3 the natural origin of illness. The natural etiology of illness relates to sociocultural issues such as the infringement of a social value like stealing, rudeness to an older

person, excessive use of drugs, and involvement in other anti-social behaviors (Jegade, 2002). The Yorubas believe that natural illnesses can be prevented by counseling, obeying the rules of healthful living, avoiding some kinds of foods, and avoiding excessive exposures to heat, and cold conditions (Jegade, 2002).

In Yoruba society, illness resulting from heredity and unknown sources must be accepted as they are. There are no known preventive measures for hereditary and diseases of unknown etiologies (Jegade, 2002). Praying to the Supreme God (Olodumare) is a crucial and essential part of the Yoruba health-seeking and healing processes. The details of how prayer works are within the realm of the supernatural codes of the Yoruba people (Ogundele, 2007).

8.17 Medicine Men and Their Roles in Yoruba Healing Tradition

Medicine men in the Yoruba healing tradition consist of diviners, herbalists, shrine priests/priestesses, and spiritual healers.

8.17.1 the diviner. The diviner “understands and responds to the supernatural beings through divination with Ifa Oracle- an ancient secret knowledge system” (Ogundele, 2007, p. 129). The Diviners diagnose the cause of illness through consultation with the Oracle, who then prescribe the necessary, and appropriate remedies to cure the illness (Ogundele, 2007). For a Yoruba person, nothing happens by chance. Events and occurrences must have meaning and purpose. The Yoruba person endeavors to explore the reasons for why something happened, either by appealing to a human or spiritual agency for explanation and understanding. Divination with the Ifa Oracle reveals the meaning and purpose of all occurrences in an individual’s life and prescribes the solemn ceremonies and series of actions to control them (Ray, 1993). This notion was attested to by a fifty-four-year-old participant when she said,

When I first got the result of the tests, ... they said it was cancer, I called my junior brother, ... He then said we should go somewhere (Traditional healer). In that place, the

woman told us that it was a spiritual attack.... She gave us a lot of things... see... She said it was an attack.... Since that time, despite all her efforts, there was no change, no cure....

The performance of divination and rituals require the construction of sacred places for prayers, offerings, and sacrifices. “The Yoruba person goes to these sacred places to seek cures for their illnesses, answers to their questions, and guidance in their lives” (Ray, 1993, p. 268).

8.17.2 the herbalists. The herbalists diagnose and prescribe remedies either to cure or to manage an illness. They treat, cure, and prevent illness through using extracts of medicinal plants such as roots, barks of trees, leaves, and other natural ingredients, including animal sources (Ademuwagun, 1969; Adepoju, 2012; Ogundele, 2007). The Yoruba people believe that trees and herbs are empowered for medicinal purposes by the spirits living in them (Borokini & Ibrahim, 2014). Every plant has its original name, given to it by God at the time of creation. Only the herbalists know the original names of a plant that have therapeutic and medicinal potential. It is only when the herbalist calls the plant by its original name that its medicinal and therapeutic properties become manifested (Borokini & Ibrahim, 2014). A person may function in the dual roles of diviner and herbalist. However, not all herbalists are diviners (Ademuwagun, 1969). A thirty-four-year-old participant shared her health-seeking experience with an herbalist:

... I took an herbal solution and mixture. The herbal solution that I drank, I noticed that, as I was drinking the herbal solution, I was getting bigger. My legs, my hands, body, everywhere. All my body parts were getting bigger. I was getting fat. I called the woman herbalist who gave me the herbal solution. I said ha, the herbal solution that you gave me, I am getting bigger. The next thing she said was that she does not know what she can do. That I should go to the hospital. That was when I made up my mind to go to the hospital.

A forty-eight-year-old participant shared a related experience when asked about her health-seeking behaviors:

In the village, some people brought black medicines for me to drink, like herbals solutions, saying that when I drink them, the cancer will disappear. But nothing happened. It did not disappear. I rubbed the herbal mixture on it. I should not tell you a

lie. I rubbed it but, there was no change I then came back to Lagos.

8.17.3 the shrine priests and priestesses. The shrine priests and priestesses perform rituals, solemn ceremonies, and offer sacrifices either to appease the gods for offenses committed against them or to offer thanksgiving for the favors received (Ademuwagun, 1969).

8.17.4 the spiritualists. In response to the perception of illness causation by supernatural forces, a great number of Nigerians patronize the services of spiritual healers, to fight the wrath of witchcraft or sorcery (Adepoju, 2012). Spiritual healing churches include Christ Apostolic Church (CAC), Celestial Church of Christ (CCC), Cherubim and Seraphim (C&S), Christ Apostolic Faith (Adegoke, 2007). The Spiritualists believe in God, Jesus Christ, the Holy Spirit, and the Holy Angels, whom they regard and take as their spiritual associates, collaborators, and helpers. The spiritualists accept the reality of malicious spirits, evil-minded individuals, and witches. They believe in the efficacy of prayers in defeating, overthrowing, and subduing evil forces (Adepoju, 2012). When a 46-year-old participant was asked about what she did after noticing her breast changes, she responded,

Initially, before we went for the operation, we first of all, went for prayers maybe it was a kind of war. We were thinking it was a kind of war from somewhere. However, when all that did not help, we decided to go to the hospital... Ha by prayers. Not by the Seraphim alone, but other pastors pray for the attack to be resolved. However, when we tried it all, and they did not work, we went to the hospital.

The spiritualists reject the methods of handling the activities of evil spirits, and malicious individuals through divination and sacrifices formally used to handle them. They cope with these harmful and destructive forces by engaging in fervent prayers to God. A forty-two-year-old participant shared,

but in my church, I prayed, I prayed, and I talked to my pastor, my shepherd. I am a Celestial member. I talked to my shepherd. I said, please pray for me. We prayed. He was among the people that even said go that it needs medical attention. That don't think it is a spiritual problem.

According to Ray (1993), “Gaining access to God ... require a proper ritual context, namely, the construction of a sacred place, which is the meeting place between a man and God” (p. 270). While the diviner makes sacrifices to appease the gods, the spiritualist engages in religious activities such as fervent prayers, fasting, use of anointing oils, a revelation in dreams and visions, prophecy, and use of holy water. They also engage in body cleansing (Ray, 1993). This idea was corroborated by Participant 1 when asked about her health-seeking activities she said, “I initially started praying on it. I went to praying center... I did fasting and prayer.”

Forty-one-year-old Participant 30 also shared a similar health-seeking behavior when she was asked about how she had been managing her illness, she responded,

So, I ran to some pastors. I have been to prayer houses for God to intervene. Moreover, I know that it is even God that is strengthening me on this issue. I went to churches to my pastor. I went there for prayer and fasting... That Jesus Christ healed all manner of diseases. He healed all manner of diseases. He did not have a specific disease. So, I place my faith in it that it is all manner of diseases which include the cancer the doctors are talking about...

In some spiritual healing churches, the healing procedure also involves singing, dancing, declaration of sacrifice or therapeutic fasting, to be carried out by the client. “This type of faith healing sometimes involves complete abstinence from orthodox medicine” (Borokini & Ibrahim, 2014, p. 24). A thirty-one-year-old participant described her experience with a pastor:

So, ... one of my brothers called one of his friends a pastor to pray for me. The pastor now told me that ... that is when I wanted to do the surgery. He now told me I should not do any surgery. That he will pray for me and the lumps will get out of there. He said did I have faith? I said I yes now. He prayed for me that day. He said around 12 in the afternoon; I should press it. I should call him back to tell him what I see... I now called him, and he asked me what I see, and I told him it is still there oh. He said I did not have faith.

When a 34-year-old participant was asked about the cure and treatment of breast cancer she said:

By way of prayer, let them help me to prepare anointing oil so that I can be rubbing it on the breast. There is nothing the power of God cannot handle. There is nothing Doctor Jesus cannot handle... Jesus raised Lazarus from death to life, raised him from the dead.

In a descriptive survey designed to explore the socio-cultural factors influencing the use of spiritual healing churches in Ibadan Metropolis Nigeria, Adegoke (2007) observed that those who go to spiritual healing churches for healing believe that these churches can handle specific categories of illness, particularly those inflicted by supernatural and mystical forces, more effectively than orthodox medical centers.

Culture impacts the labelling, interpretation of symptoms, and the options available to individuals in managing deviations from health (Angel & Thoits, 1987). Individuals' perceptions of the effectiveness of a healing outlet impacts their choices for health-seeking (Adegoke, 2007). According to Adegoke (2007), those who consult traditional healers in managing their illness believed that their illnesses have preternatural and supernatural origins. They probably perceived that the most appropriate places to seek remedies for their illnesses was through those outlets (Adegoke, 2007).

8.18 Implications of Seeking Divine Interventions for Managing Breast Cancer

People's perceptions influence their interpretation of ill-health and their choice of health-seeking behavior. Inaccurate attribution of the etiology of breast cancer might lead to an inaccurate and wrong diagnosis and treatment of the illness. Therefore, awareness needs to be created to alter people's beliefs about breast cancer etiology and management. This awareness is essential because, if people define breast cancer within the preternatural and supernatural context, they are likely to present in the hospital with advanced and metastatic breast cancer. The mortality rate is unlikely to improve until women seek medical attention promptly when they first notice changes in their breasts. The findings from this study also indicate the need for collaboration between the traditional and faith healers, and healthcare professionals in the healthcare system.

The findings from this study demonstrate the need for population-based breast-health and breast cancer awareness education programs to enlighten people about breast health, the interpretation of breast changes, the etiology of breast cancer, and breast cancer treatment options. Educating the general population about the importance of early presentation of breast changes is essentially critical. The need to engage in breast self-examination, clinical breast examination, and regular screening for earlier detection of breast abnormalities also needs to be stressed. These practices might assist in identifying breast cancer earlier, thereby leading to early presentation, assessment, diagnosis, and initiation of breast cancer treatments.

8.19 Implications for Nursing Practice

Nurses should be encouraged to include breast health education in their regular women's clinic such as ante-natal, post-natal, and other health promotion activities. Parish nurses should also include breast health education in their different parish activities. Public health nurses should be mandated to include breast health activities in the different health centers where they practice.

8.20 Implications for Future Research

Future research could explore the roles of traditional and spiritual healers in breast cancer management. The collaboration with these healers could influence and encourage earlier detection and treatment of breast cancer.

8.21 Strengths and Limitations

A significant strength of this study is that it provides information on a topic area in which the empirical literature is scarce. The study took into consideration the socio-political background and context of the study participants. Another strength of this study is that the participants were interviewed in the language of their choice. Thus, they could describe their

experiences without difficulties. The researcher understands the local language therefore, there was no need for the services of an interpreter for those participants who wanted to express some ideas in the local language while continuing to communicate in the English language. By carrying out the study in the place and where research participants live, I was privileged to have direct interactions with the study participants. I was enabled to clarify and understand what the participants were sharing, and how the context was impacting the participants' experiences. Conducting the study in the place where the research participants live also allowed me to gain a direct information.

It is recognized that many Southwestern Nigerian women living with breast cancer never reached the referral hospital where the data for this study was collected. This study was carried out in just one geopolitical zone in Nigeria. As a result, the findings might have to be interpreted with caution. However, depending on the degree of similarities of settings and circumstances, transferability of knowledge from one situation to another might be possible.

8.22 Conclusions

This study revealed that the decision to use traditional and spiritual healing centers for managing advanced breast cancer, was a rational action taken by the individuals concerned. The decision-making process was influenced by each person's illness perceptions. The Yorubas hold a cultural perception that there are certain categories of illnesses that need the attention of the traditional and the spiritual healers. Such illnesses include those attributed to preternatural and supernatural etiologies. Thus, they believe that the most appropriate places to seek for health care are the traditional healing places, despite the availability of modern health care facilities and opportunities for the professional management of illnesses like breast cancer.

The participants believed that God holds the ultimate healing power. These observations

show the resilience of traditional and spiritual perception on health, illness, and healing among the Yoruba of Southwestern Nigeria. A common feature of the study participants, however, is that all of them presented with the advanced stages of breast cancer, with 30% having noticed breast changes two years before presenting, 10% for about 11-15 months, 23% for 5-10 months, and 36% for less than 5 months. The underlying reasons for this observation remain unclear. The most likely explanation could be that the participants delayed seeking help in the hospital due to a lack of knowledge and ignorance about the meaning and etiology of their breast changes, and the severity of breast ill-health. Their understanding of their breast changes led to their seeking to manage their illness by engaging in alternative methods of care in a bid to get well. There is, therefore, the need to research the scope of traditional, spiritual, and other alternative healing practices. Traditional and spiritual healers could be given basic education on the implications of breast changes and the need for them to refer their clients to medical caregivers without delay.

The study findings also indicate the need to provide population-based breast cancer education to enlighten people about the etiology, symptoms, and management of breast cancer. It is recommended that women be encouraged to make judicious use of the opportunities provided for them to engage in breast self-examination, clinical breast examination, and regular screening for the earlier detection of breast cancer. The government could also integrate the traditional and spiritual healing methods into the health care delivery system for the benefit of people.

8.23 Policy Recommendations

The findings from this study indicate the need to understand people's cultural health beliefs and practices. To achieve holistic management of breast cancer, management strategies, and interventions might need to consider and include a traditional method of health education component. This traditional component might enlighten people about the origin and management

of breast cancer.

Because the Yoruba people still consider some illnesses to be spiritual attacks and still patronize traditional and spiritual healers, strategies and interventions will likely need to officially recognize traditional and spiritual health care services, marrying some traditional practices with medical care. Additionally, the registration and monitoring of spiritual and traditional healers is essential: such a practice could indicate the specialization of each registered healer, allow health care planners to know the number of available traditional and spiritual health care providers, indicate the roles the healers can play in health care, and lead to the expulsion of charlatans from the registry. Knowing the identity and competencies of the healers would be critical in planning training programs for them.

Registration will also enable the policy makers to budget and plan adequately for training the traditional healers on the etiology, recognition, and treatment of breast cancer. Training might lead to quicker referral of breast cancer cases to the medical system. The managers of the spiritual health care centers and traditional healing houses could be mandated to encourage their clients to use conventional medical care outlets at the same time to avoid delays in presentation and worsening of symptoms, which could lead to complications in treatments. Hospital chaplains could assist in monitoring faith-based healing centers to encourage prompt referrals of breast cancer patients.

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CHAPTER 9: SUMMARY OF DISCUSSIONS, IMPLICATIONS FOR NURSING EDUCATION, PRACTICE, FUTURE RESEARCH, POLICY, STRENGTHS AND LIMITATIONS, RECOMMENDATIONS, AND CONCLUSIONS

9.1 The Relationship of Chapter 9 to the Dissertation

In this chapter, I present a summary of the study findings, together with its strengths and limitations. Also presented are the implications of the findings for nursing practice, education, research, and policy. The Chapter concludes with the dissertation recommendations.

9.2 Summary of Findings

This study explored the health-seeking behaviors of Southwestern Nigerian women with advanced breast cancer and the factors that influenced these behaviors. The health-seeking activities were investigated from the women's perspectives. The conceptual framework adopted for the study was the health belief model (HBM), proposed by Hochbaum, Rosenstock, and Kegels (1952), while the methodological approach was interpretive description (ID), proposed by Thorne, Kirkham, and MacDonald-Emes (1997). The Interpretive description research approach is a qualitative method that aligns with the naturalistic orientation of research methodologies. This method was chosen because qualitative research methods often allow an in-depth exploration both of participants' behaviors and the meanings of their experiences. In this case, little was known about the health-seeking behaviors of the study population, but it was thought that this research approach would encourage the participants to share their own personal experiences of the topic and perceptions of their illness. Through interviews, I was able to become close to the issues under investigation as expressed by the participants. Using semi-structured open-ended questions and non-leading prompts, I engaged the study participants in free discussions in which they described their health-seeking behaviors, and factors they believed

influenced and motivated them to engage or not to engage in specific health-seeking activities, for the treatment of breast ill-health. Prior to the interviews, a researcher-designed demographic form, which was personally completed by each participant, was used to obtain the participants' demographic information. The study participants were 30 women presenting with the advanced stages of breast cancer in a large tertiary teaching hospital in Southwestern Nigeria. The purposive sampling technique was used to select participants who both met the inclusion criteria and expressed willingness to take part in the study. All the participants were aware of their rights as study participants before the commencement of the data collection. Data were collected through the completion of a researcher-designed demographic form by the study participants and in-depth one-on-one semi-structured, audio-recorded interviews guided by open-ended questions, conducted by the researcher. To illustrate the demographic information of the participants, data were analyzed using descriptive statistics, while the interview transcripts were analyzed using thematic analysis.

The demographic information of the study participants was collected before each interview began. Thirty face-to-face interviews were initially conducted. Fourteen of these were conducted in the Yoruba Language, and 16 in the English Language. Three participants were interviewed a second time to validate study outcomes, bringing the total number of face-to-face interviews to 33. The interviews lasted from 10 to 40 minutes, depending on the experiences the participants were willing to share. The accuracy of all transcriptions and translations were confirmed before the data analysis began. As preliminary study findings were emerging, 13 telephone interviews were conducted with participants who had indicated their wish to remain engaged with the study. Altogether, then, 46 interviews (33 face-to-face plus 13 telephone) were conducted with 30 study participants. Rigor was adequately addressed throughout all the

different stages of the research process.

9.3 Study Participants' Demographic Information

The participants' demographic information was collected before each interview began as noted above. Table 9.1 presents the demographic information of the participants, all of whom were women presenting with the advanced stages of breast cancer. As can be seen, they identified with diverse cultural groups, with 87% belonging to the Yoruba ethnic group, 6% to the Edo group, 3% to the Ibo group and another 3% to the Efic group. Forty-three percent indicated that they could communicate in English, in addition to their primary language. Eighty percent of the women identified as Christian and 20% as Muslim. The table shows that the women's ages ranged from 29 to 68 years, but the clear majority were between 40- and 50-years-of-age. The mean age was 47 years. As also indicated in the table, all the study participants had some formal education, ranging from junior secondary to post-graduate education, with 33% having had secondary education, 36% college or technical education, 20% a bachelor's degree, and 10% post-graduate education. While 83% of the participants were employed, 6% were unemployed and were looking for a job, and 10% were unemployed but not looking for a job. For those participants who chose to declare their economic status, their income ranged from N50,000.00 to N500,000.00 (approximately \$150-1,500 CAD) in 2017.

As also seen in the table, the participants had different family histories of breast cancer, with less than a quarter having a family history of breast cancer. The last item recorded in Table 9.1 refers to time that elapsed between the participants' first noticing the breast abnormality and presenting to the hospital. Thirty percent had noticed breast changes two years before presenting, 10% for about 11-15 months, 23% for 5-10 months, and 36% for less than 5 months.

Demographic Information

Table 9.1 Presenting Participants' Demographic Information

Demographic Variables	Participants' Characteristics	N	%
Ethnic Origin	-Yoruba	26	87
	-Ibo	1	3
	-Efic	1	3
	-Edo	2	6
Primary Language	-Yoruba	26	87
	-Ibo	1	3
	-Efic	1	3
	-Edo	2	6
Specific other language	-English	13	43
Religious Affiliation	-Christian	24	80
	-Muslim	6	20
Age Group	-20-30	1	3
	-31-40	4	13
	-41-50	17	57
	-51-60	4	13
	-60+	4	13
Level of Education	-Less than primary 6	0	0
	-Secondary school	10	33
	-Some college, associate degree, - technical certificate	11	36
	-bachelor's degree	6	20
	-Graduate degree e.g. Masters, PhD	3	10
Employment Status	-Working for a pay or business	25	83
	-Not currently employed, looking for a job	2	6
	-Not currently working and not looking for job	3	10
Economic Status/ income sources in 2017	-Less than N 50,000.00	2	6
	-N 100,000.00	3	10
	-N 200,000.00	8	27
	-N500,000.00 and above	7	23
Family history of breast cancer	-Yes	7	23
	-No	23	77
Time frame between the discovery of breast changes and presentation in the hospital	-Less than five months	11	36
	-5-10 months	7	23
	-11-15 months	3	10
	-2 years +	9	30

9.4 Thematic Analysis of Interview Data

The health-seeking behaviors of the study participants were grouped into three themes: 1) women with troubling breast symptoms engaged in self-care before seeking medical interventions, 2) women with troubling breast symptoms sought divine intervention before seeking medical attention, and 3) women with breast symptoms sought evidence-based knowledge and care. The factors influencing the health-seeking behaviors of the participants were clustered into five themes: 1) breast cancer, a life-threatening illness that few people survive, 2) breast cancer, a disease inflicted by the enemy, 3) support from family, friends, and social network system members, 4) Major barriers and difficulties in managing breast cancer, and 5) Making decisions about when and where to engage in breast cancer health-seeking behavior. These themes were also supported by subthemes.

The subthemes helped to reveal how the study participants experienced the themes. The identified subthemes related to the interpretation of breast changes, worsening of symptoms which led to a heightened level of illness threat, the perception of breast cancer as an illness that necessitates spending money, handling breast cancer emotional response with spirituality and expression of optimism, and hope by the study participants that they would not die from breast cancer. Other identified subthemes related to the study included barriers perceived by the participants such as stigma, fear, the financial difficulties in managing breast cancer, and the side effects of breast cancer treatments.

9.5 Interpretation of Breast Symptoms

Findings from this study indicated that participants identified breast changes as the trigger for engaging in health-seeking behaviors. However, some participants were unaware of the signs of breast cancer, and many did not associate their breast changes with cancer. Had they

had more information about the meaning of changes in the breast, they might have sought professional care earlier. If women do not interpret their breast changes as signs of cancer, they are unlikely to present for breast cancer professional and specialist care. These findings are similar to findings from Donkor et al. (2015) systematic review on delays in breast cancer presentation in developing countries where it was observed that inaccurate symptom interpretations of breast abnormalities may lead to ignoring the symptoms and neglecting health-seeking activities while accurate symptom interpretation may result in timely decision making to engage in health-seeking behavior.

9.6 Individual and Cultural Perception of Breast Cancer

This study revealed a unique cultural perception of breast cancer as an illness inflicted by another person or a spiritual attack or arrow shot at another person by an enemy, which can only be remedied by traditional healing methods. The social construction and perception of breast cancer as a spiritual attack from an enemy assumes that breast cancer is viewed as not only a biomedical disruption but also as a disease with sociocultural origins and implication. As observed by Adegoke (2007); Ademuwagun (1969); Angel and Thoits (1987); and Jegede (2002), an individual's belief system influences the interpretation of symptoms and the type of treatment chosen to address the illness. This belief probably explains some of the participants' desire to engage in health-seeking behavior with traditional or spiritual healers, who they believe are more likely to cure such ailments than Western-oriented medical practitioners, who are perceived as being incapable of handling some categories of illnesses (Adegoke, 2007).

As observed in this study, the participants who identified the supernatural power as the cause of their breast cancer seemed more likely to believe that modern Western medicine could not cure them and sought healthcare from traditional spiritualist, herbalists, and prayer centers.

The study found possible adverse effects on women who had sought health care from some of these alternative providers. For example, some women were advised to fast. Fasting is one of the dominant practices advocated by alternative healers in curing illness (Borokini et al., 2014), but continuous fasting can weaken a sick person's condition. For example, one participant fainted after a period of prolonged fasting recommended by her pastor. The body requires energy for normal functioning, growth, and healing. Therefore, prescribing fasting for patients with advanced metastatic breast cancer may affect their energy levels. The fasting example is only one of many treatments suggested by traditional, spiritual, and faith-based healers. A key question raised in the study is how much of a role do these individuals play in encouraging women to delay seeking medical care?

In the same vein, those who believed in the biomedical explanation of breast cancer engaged in health-seeking from the modern Western healthcare facilities. These categories of peoples, with their different health-seeking avenues, probably perceived these places to be the best places for them to receive treatment and get cured of their breast cancer. This line of thought is consistent with those of Adegoke (2007) and Ray (1993). This perception provides insight for nurses, other healthcare providers, and other breast cancer stakeholders concerning the significance of cultural perception and definition of illness on an individual's health-seeking behaviors.

9.7 Seeking Divine Interventions to manage Breast Cancer

All the participants in this study who sought healthcare with traditional healers presented at a hospital or clinic with advanced metastatic breast cancer, suggesting that these healers' confidence in their ability to cure the illness influenced the women's health-seeking behavior. According to some of the participants, some healers even went so far as to dissuade them from

seeking professional medical care.

This study also found that some participants relied exclusively on prayer and faith as a means of curing their illness. The literature bears out this reliance – perhaps overreliance- on faith. In a cross-sectional study of the use of complementary and alternative medicine by cancer patients at the University of Nigeria teaching hospital Enugu Nigeria, Ezeome and Anarado (2007) observed that patients who had relied completely on prayers and faith, had usually presented with the advanced stages of metastatic breast cancer. Most of these patients die, but they also reinforce the belief that Western medicine is not effective in treating cancer. The findings from this study also concur with findings from Clegg-Lampsey et al. (2009) survey of the psychosocial aspects of breast cancer treatment in Accra Ghana, that breast cancer patients make use of prayer camps and herbs leading to delayed presentation for medical care.

The belief in faith alone as the magic bullet for healing can be traced to some religious leaders and pastors who proselytize that medication interfere with the purity of prayers and that medication or undergoing surgery signifies a lack of faith. Prayers, these religious figures insist must be constant and continuous, take a great deal of time, and women and their loved ones absorbed in prayer have little opportunity to seek professional health care. Although this study found that beliefs in witchcraft, spiritual healing, diviners, and herbalists prevented some women from seeking timely medical care, spirituality and religious beliefs also played a positive role.

Little has been documented in the literature about benefits of religion and spirituality as they relate to the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria. However, the participants in this study indicated that prayer and spirituality have given them a positive outlook on their condition. Thus, the activities and functions that traditional healers engage in to provide healthcare to Nigerian cannot be seen from

only a negative perspective. Diviners, herbalist, and spiritualist have been found to provide immense help to people suffering from various ailments. They provide physical, spiritual, and psychological support for people suffering from chronic conditions (Adefolaju, 2014). Donkor et al. (2015) also observed that cultural perception contributes to the reason why women would rather visit an alternative medicine practitioner for a cure after noticing signs of beast ill-health.

9.8 The Influence of Significant Others and Social Network Members

The current study participants indicated that family members were available to provide encouragement, financial support, psychological support, and emotional support. Family members also provided information and advice on when and where to engage in health-seeking behavior. For a greater majority of the participants in this study, health-seeking decision-making was not an individual affair but the responsibility of the whole family. This finding shows that the individual in the Yoruba context is part of a family system, indicating the communitarian principle of shared responsibility, loyalty, supervision, accountability to all members, and mutual help characteristic of the Yoruba people. These findings are similar to findings from Maree and Wright (2013) study of Tshwane women breast cancer screening practices which indicated that significant others do influence the health-seeking behaviors of their study participants'. These findings are similar to findings from Abubakar et al. (2013) qualitative study of the socio-cultural determinants of health-seeking behavior on a Kenyan coast where it was observed that significant others can influence when and where family members engage in health-seeking.

The finding from this study indicated that membership in a religious group influenced some study participant's health-seeking options and behaviors. Memberships in religious groups also appeared to provide support for these study participants. The understanding that religious community members are there to offer help and provide encouragement can be comforting and

reassuring. These aspects of religious support can also work against the stigma, fear, and anxiety often associated with the advanced stages of breast cancer and as observed in this study. The findings are also similar to findings from Pescosolido (1991) where it was indicated that social relations and networks influence health-seeking through support, influence, fellowship, caring, persuasion, information giving, and offering financial assistance.

9.9 Barriers to Seeking Medical attention for the Management of Breast Cancer

Findings from this study exposed the participants' challenges and difficulties, which they considered to be: stigma, financial difficulties, fear, and the side effects of breast cancer treatments. These findings are congruent with findings from Maree and Mulonda (2015) qualitative study of Zambian women with breast cancer where it was observed that women with breast cancer experienced stigma, financial difficulties, fear, and unpleasant side effects from chemotherapy medications. The fear of mastectomy identified in the present study is identical to those observed by Ajekigbe (1991) where it was concluded that fear of mastectomy was the most common factor responsible for late presentation of women with breast cancer in Nigeria and those who eventually accept to have mastectomy took some time to make up their minds thereby, giving the tumor cells more time to multiply. Similar findings relating to fear were identified in Clegg-Lamprey et al. (2009) survey of the psychosocial aspects of breast cancer treatment in Accra Ghana. In a systematic review, Sharma et al. (2012) identified poverty as the major factor contributing to delayed patient presentation of breast cancer in developing countries.

Contrary to findings from Powe (1997) quantitative study of the influence of spirituality on cancer fatalism and participation in cancer screening among African Americans, which indicated that spirituality played a role in the participants' resignation to death from cancer, findings from this study indicated that the study participants expressed optimism and hope that

they will not die from breast cancer. The participants' spirituality played a positive role in encouraging their participation in health-seeking activities to ensure that the illness does not kill them.

9.10 Access to medical Care and trust in the Healthcare Professionals

During my literature review, it came to my attention that empirical literature indicated that women with breast cancer do have problems with accessing medical care for the management of breast cancer and some even mistrust the health-care professionals. However, all the participants in this study accessed care from the hospital where they were recruited for the study. Findings from the study indicated that some participants accessed care only from the hospital. Other participants initially engaged in self-care, and they also sought treatment from traditional healers and healing houses prior to seeking medical attention in the hospital. Some participants sought medical care once it became apparent that the remedies they had been using in managing their illness had not been effective. These participants probably realized that their only option for surviving the illness was to seek care in the hospital. I was not able to meet with other women who did not access care from the hospital to explore why they did not do so.

9.11 Implications for Nursing

This dissertation research lends itself to understanding the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria. Although these findings are applicable to all the healthcare professionals providing frontline breast cancer care, I will focus more on their various implications for the discipline of nursing. Insights gained from this dissertation research will add to the knowledge base of the specialty of nursing in the areas of practice, education, and research.

9.12 Implications for Nursing Practice

The findings from this dissertation have implications for nurses in the practical settings. Individuals' health-seeking behaviors are determined by their beliefs. This line of thought is consistent with the conclusions of Adegoke (2007) in a socio-cultural study of the factors influencing the use of spiritual healing churches in Ibadan. Adegoke (2007) found that irrespective of people's educational background, they are keenly interested in using spiritual healing churches with the hope that these healing churches are more effective in handling certain cases of illness afflicted by supernatural and mystical forces than orthodox medical centers. They believe that the most appropriate places to go for remedy of their ill-health are spiritual healing churches. This is so because most of them attributed the origin of their ailments to supernatural forces and evil machinations.

Participants in this study who accepted biomedical explanations of breast cancer sought health care from modern Western healthcare facilities. Those that did not know about or accept these explanations put their faith in spiritual and traditional healers. The time spent using alternatives treatments to cure their ailments, which some did not associate with cancer, delayed their presentation in a hospital or clinic. Most patients presenting this late die (Ezeome & Aranada, 2007), and perhaps this fact has become known in wider Nigerian society. Thus, when patients with advanced metastatic breast cancer die in the hospital, the story circulates that medical science cannot help these individuals and may even hasten their death. Therefore, people who have breast cancer are advised not to go the hospital because they will die there. There is little understanding that if physicians using Western medical techniques can diagnose cancer at a much earlier stage, the disease is often cured, and hospital stay averted. These conclusions offer insight for physicians, nurses, other healthcare providers, and especially policy makers, who are

searching for means to reduce breast cancer mortality rates in Southwestern Nigeria.

If nurses learn, understand and appreciate the cultural context and surroundings within which they practice, they are more likely to provide culturally and contextually relevant breast cancer care that addresses the peculiar needs of the people. For example, knowing that breast cancer is perceived as a spiritual attack by Southwestern Nigerian women, nurses and other healthcare providers can strategically plan and implement breast cancer treatment plan that put into consideration the socio-cultural and sociopolitical peculiarities of the patient's environment. These programs could bring home to the people a better understanding of breast changes, breast disorders, their causes, and treatment options.

Knowing the collaborative roles played by family members in health-seeking decision making among the Yorubas, it is essential for nurses to involve the whole family where possible in the management, treatment alternatives, interventions, and the education programs designed for breast cancer patients.

The results indicated that religion and spirituality do relate positively to health and well-being and suggest that these factors are worthy of increased attention by the healthcare system at large. It is essential, therefore, for nurses, to include a spiritual dimension in the care and management of breast cancer patients. The spiritual dimension could involve the formation of a team of spiritual caregivers comprising a broadly-certified chaplain, spiritual directors, pastoral counselors, and specific religious providers such as the clergy, the pastors, and the alfas. Clinicians should be encouraged to refer patients to this team for spiritual caregivers. Patients' religious practices, such as yoga and other rituals, could be integrated into the patient's individual spiritual care plans. Patients could be encouraged to attend chapel and visit meditation rooms in the hospital, as well as attend religious services and events.

In this study, the participants expressed difficulties and challenges. These difficulties revolve around fear of death, mainly relating to the perception that those who undergo mastectomy will soon die. Other difficulties were lack of money, side effects from the drugs used for chemotherapy, and the experience of stigma.

Many practical strategies could reduce the stigma attached to breast cancer. These methods include public health initiatives such as increasing breast health awareness, increasing knowledge about breast cancer, and promoting earlier presentation and diagnosis of the illness. Information leaflets about breast cancer and its treatment could be made available. Breast cancer hotlines could enable women to ask questions, express their difficulties, fears, and challenges, and seek clarifications or encouragements. Patients could be encouraged to contact breast cancer support groups. Management teams for breast cancer could include clinical psychologists, psycho-oncologist, breast cancer survivors. Strategies should include the provision of a supportive environment for patients to share their thoughts and feelings about breast cancer illness experiences and consider enough time for adequate counseling, communication, and information giving.

Another strategy would be to encourage breast cancer survivors in the local area to present as role models. Contact with breast cancer survivors might convince women that not everybody with breast cancer dies from the illness. To alleviate their fears, women newly diagnosed with breast cancer could be given opportunities to express themselves to the survivors. A study of breast cancer survivors' contribution to the psychosocial adjustment of newly diagnosed breast cancer patients in a social support group revealed that breast cancer survivors provided more emotional and informational support than women who did not have the disease (Moon, Chih, Shah, Yoo, & Gustafson, 2017). The study also indicated that receiving emotional

support from breast cancer survivors contributed to a reduction in depression and an improvement in the quality of life of breast cancer patients. If survivors are not available, photographs of survivors of breast cancer from other localities could also be presented to the patients. All these strategies and more could be implemented to change the face of breast cancer in Southwestern Nigeria.

Another group of strategies would address the financial implications of a breast cancer diagnosis. Healthcare providers and policy makers in Southwestern Nigeria must understand as was reinforced in this study, the financial burden of breast cancer care. Many patients cannot afford the costs of the treatment. Nurses can help to locate in-kind donations and financial assistance programs for the women and initiate advocacy efforts that encourage health authorities to subsidize the cost of various breast cancer treatments.

Strategies to lesson women's fear of chemotherapy might mean they are more likely to seek medical care if they think they might have breast cancer. Preparing patients psychologically before they start chemotherapy could help them to accept the side effects of chemotherapy and the overall health outcomes for breast cancer patients. Nurses could explore with each patient her fears and concerns regarding chemotherapy. Health education programs and other breast cancer management approaches could be given to the patients receiving chemotherapy. The side effects of the different treatments approaches and ways of controlling the unwanted side effects could be discussed with the patients. Nurses could also help patients to locate wigs and scarves before the commencement of chemotherapy and before all their hair fall out. Knowing that they have a wig at hand before they need to use it might be comforting, and it might reduce any related anxiety. Such methods might help to allay fears about chemotherapy and assist the patients in coping with their condition.

Other strategies concern peer mentoring programs. Women presenting with the advanced stages of breast cancer could also be referred to peer mentoring programs, where they could connect with other women who have had mastectomies and similar treatment experiences. Peer support could normalize body image concerns and model positive adaptation. Women with pronounced body-image concerns for whom peer support is not sufficient could be referred to a professional psych-oncologist for further counseling services.

The continuous assessment of breast cancer patient's needs by nurses could indicate the need for further research to meet the healthcare needs of women presenting with breast cancer. Placing breast cancer on the national health agenda requires leadership. Nurses and other healthcare providers as opinion leaders could encourage breast cancer advocacy. The voices of women could be harnessed, not only to promote the agenda around breast cancer but generally for all the healthcare needs of all women.

9.13 Implications for Nursing Education

The findings from this dissertation have educational implications for nurses. The findings from this study has uncovered the perceptions of the study participants about breast cancer and the factors that influence them to engage in specific health-seeking activities. The knowledge of these perceptions could empower nurse educators and other healthcare professional educators to address the perceptions, attitudes, and myths that surround breast cancer. Findings from this study also suggest that some healthcare providers have limited knowledge of breast cancer signs and symptoms. Some thought the breast changes observed by their patients were signs of infection and therefore, prescribed antibiotics for them. Therefore, education of first line healthcare providers is essential. A comprehensive health education module about breast health and ill-health, could be incorporated into the academic curricular of the Nigerian nursing and

other healthcare profession training institutions. This module could address breast ill-health etiology, signs and symptoms, myths, individual and cultural perceptions, and treatment options, by providing evidence-based alternatives. Nurse educators and other healthcare professional educators should see it as part of their responsibilities to have prospective nurses and healthcare providers well prepared in this capacity. Thus, future nurses and other healthcare providers will be well equipped to educate their patients to differentiate between myths and facts regarding breast cancer, which could help to improve the treatment outcomes of the illness.

Nursing and other healthcare professional educators could also, get involved in individual and community education programs and informational sessions. Such education programs could increase the general knowledge concerning breast cancer, including its risk factors, etiology, screening recommendations, and treatment options. It is essential to include education about support groups, coping mechanisms, and post-mastectomy supplies because these could be beneficial information for those who already have been diagnosed and are receiving treatments.

9.14 Implications for Future Research

The dissertation research uncovered many possible future directions for nursing research. Findings from this study suggest the need for research to understand the roles of traditional and faith-based healers in the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria. Further study on the influence of patients' socio-demographic variables on their health-seeking behaviors might lead to a more detailed understanding of their health-seeking activities. Also, future research could explore the level of trust patients with advanced breast cancer in Southwestern Nigeria have in the conventional healthcare delivery system. A qualitative study that explores the health-seeking behaviors from the perspectives of both the health professional and the women affected with breast cancer could illuminate barriers to early

definitive treatment of breast cancer and possibly assist the health system in targeting areas that need attention.

Although breast cancer is not as common in men as it is in women, it might be essential to include men in future research studies. Men should be educated on breast cancer and the risk factors associated with the illness, not only for themselves but also, for their wives, mothers, sisters, and other female friends. A subject for further research could be the role of men in women's health-seeking behaviors, particularly in patriarchal culture. Other areas for further research are understanding the relationship between health-seeking behaviors of women with advanced breast cancer and their religious beliefs and practices because spirituality plays a significant role in the lives of people. All the participants in this study were recruited from the hospital. A future research might involve women who did not access healthcare from the hospital and explore where they engaged in health seeking to manage their illness and the factors that motivated their health-seeking decision. The participants for this study were recruited from an urban University-affiliated hospital. Future research on the health-seeking behavior of women with advanced breast cancer is needed with those living in geographically rural and remote areas.

The use of qualitative methods for data collection in this study brought to light the perceptions, beliefs, fears, feelings, and the health-seeking behaviors that helped me to understand the views of the participants. The acquisition of such rich data might not be readily available in quantitative methods of inquiry. Therefore, more qualitative research studies might better help to reveal the perceptions, beliefs, and attitudes that influence people's health-seeking behaviors, thereby enabling a better understanding of the issues under consideration.

The use of qualitative methods has also helped me, the researcher, to understand the health-seeking behaviors of women presenting with the advanced stages of breast cancer from

the participants' perspectives. Quantitative studies are usually based on the researcher's understanding of the issue under investigation and not necessarily done from the viewpoint of the participants. Therefore, more qualitative methods of research inquiry might be of more benefit in this regard.

9.15 Implications for Policy

In this study, it appeared that some participants opted for the use of traditional healing methods to manage their breast cancer. When these methods did not work, they opted for modern Western medical care in the hospital. A situation in which the traditional healing system and the modern Western healing systems complement each other might be an effective way of managing breast cancer in Southwestern Nigeria. The aim of integrating the traditional and modern Western medicines would be to provide health care that would be acceptable to the people, as proposed by WHO (2013).

As recommended by WHO (2013), various approaches could be put in place to integrate the modern and the traditional healthcare delivery systems. Some of these strategies include: 1) enhancing the sensibilities of medical doctor's, nurse's, and other modern breast cancer care stakeholder's sensitivities towards the role of the traditional healers; 2) encouraging the traditional healers to collaborate with modern medical breast cancer care providers. Such collaborative efforts could be in the form of prompt referrals of breast cancer patients for medical assessment, diagnosis, and prompt initiation of treatments; 3) discouraging the traditional healers from engaging in any practices that could be potentially harmful to the patients. Such practices include incisions and scarifications; 4) encouraging the traditional healers to adhere to the treatment regimens recommended by the medical doctors and putting in place a policy regulating the activities of the traditional and faith-based healers.

As part of the integration process, traditional and faith-based healthcare providers could be trained to have a better understanding of the causes of breast cancer. This training could help them better understand and explain the condition to their clients, thereby, helping to remove the traditional myths and misconceptions surrounding breast cancer.

9.16 Strengths and Limitations of the Study

9.16.1 strengths. This study contributes to the understanding of the health-seeking behaviors of women with advanced breast cancer in Southwestern Nigeria and the factors the women believe influence these behaviors. One strength is its purposeful sampling, which helped to obtain rich data from people who were experiencing the subject under study. A second strength is my calling as a religious nun. Religion and religiosity are deeply ingrained in the lives of Nigerians, who value and revere the religious. They trust them, and they usually seek their opinions and counsel during times health and illness. They are open in discussing with them. I believe that the study participants were open in discussing and sharing their experiences. My being a religious nun I can confidently say helped me to obtain rich data. Another strength is my understanding of both the local language and English, enabling participants to choose the language of their preference for the interview. A fourth strength is the location of the study: by carrying out the study where the participants live, I was privileged to have direct interactions with the study participants. I understood what the participants were sharing, and how the context was impacting their experiences. Conducting the study in the place where the research participants live also allowed me to gain a direct information, as indicated by Creswell (2007). A fifth strength is the study's emphasis on the importance of the social and cultural contexts in understanding the health-seeking behavior of the study participants. A sixth strength is its identification of the relevance of religion and spirituality among women who have breast cancer,

a topic on which little has been documented. A seventh strength of this study is that it reflects some themes identified in some other settings and socio-cultural contexts, and their consistency with studies from some other countries. A final strength is the study's potential to inform further research: this preliminary study could serve as foundation and resource for more extensive studies on issues relating to breast cancer management and care and the extent to which women presenting with breast cancer are affected by the quality of the care they receive.

This research did not pose any great risk to the participants. However, there was a chance that the participants might become distressed if the discussions led them to conclude that their condition was due to their neglect or their fault. To account for this, I provided each participant with the contact information of a psycho-oncologist working at the hospital. Counselling services were to be at no costs to the participants. Therefore, the cost of such services was not a barrier to seeking counseling support.

9.16.2. limitations. Some limitations have been identified. First, since the study was conducted in Southwestern Nigeria, which is densely populated by the Yoruba ethnic group, the views of the participants may not necessarily reflect the perceptions of women from other ethnic groups and that of women from other geopolitical zones in Nigeria. Therefore, a caution might be needed in generalizing the study findings to other ethnic groups in Nigeria. Interpretive description acknowledges that phenomena are neither time nor context-free. Generalization is not the aim; the goal is knowledge development. The in-depth knowledge gained through this study can benefit healthcare delivery. Furthermore, as indicated by Creswell (2007), depending on the extent and degrees of similarities of settings and circumstances, transferability of knowledge from one situation to another might be possible. Second, the interviews were audio-recorded, which could have affected the quality of the data gathered because the participants' awareness of

the audio-recorder might have affected how they shared their experiences. Third, I was unaware of what the research assistant who collected the informed consent told the prospective participants about the researcher. This information might have influenced the participants' perception of the purpose of the interview and, therefore, affected the type of data that was provided. Fourth, the scope of the study could be viewed as narrow. An investigation into the perceptions of nurses and other healthcare providers about the health-seeking behaviors of breast cancer patients could have widened the scope of the study. Fifth, in-depth interviews were the primary source of data collection, and this method alone may have been limiting. I considered triangulating the method with focus groups, engaging participants who had already been interviewed. Such focus groups could have increased the validity of the data; however, the high level of agreement with other studies like Ezeome (2010), Akhigbe and Akhigbe (2012) attest to both the data and interpretation. Sixth, the health belief model, used as a conceptual framework for this study is a Western-oriented model, with its philosophical underpinnings based on the experience of the Western population. It therefore lacked a cultural component, which could greatly influence the identification, labelling, diagnosis, and the choice of health-seeking behaviors. Seventh, data were collected from women who came to the hospital. There were probably many other women with advanced breast cancer who were not able to present in the hospital. Finally, although my aim was not to control or interfere with the research process, I acknowledge that my identity, calling as a religious, my personality, the mode of my dress did impact the research study.

9.17 Returning to the Research

The aim of this dissertation research was to explore the health-seeking behaviors and factors influencing the health-seeking activities of women with advanced breast cancer in

Southwestern Nigeria, from the women's perspectives. Interpretive Description and the Health Belief Model were the methodological and conceptual approaches adopted to carry out the investigation. This awareness can aid nurses and other healthcare professionals to know and understand their patients' health-seeking perceptions. This consciousness is important if health care professionals and patients are to successfully work together to better address patients' needs.

This dissertation research is unique in that no previous study has explored the experiences, perceptions, and interpretations of women with advanced breast cancer in Southwestern Nigeria from the women's perspectives. Additionally, it disclosed the health-seeking behaviors and the factors motivating the study participants to engage in specific health-seeking activities. The research study is unique because it interconnects the health-seeking behaviors and the factors influencing the health-seeking activities with the illness (Advanced breast cancer). The findings from this study indicate that individual perceptions, cultural perceptions, interpretation of symptoms, spirituality, and the supportive role of family members, friends, and other social networks all influence the participants' health-seeking behaviors. The decision to engage in any health-seeking behavior was, in most cases, made at the family level. The desire to live outweighed the participants' challenges and difficulties, which they considered to be: stigma, financial difficulties, fear, and the side effects of breast cancer treatments.

A model depicting the participants' health-seeking behaviors and another depicting the factors influencing the health-seeking activities of the study participants were developed. These models provide unique frames for nurses to assess their patients' health-seeking behaviors as well as the factors influencing their health-seeking activities. By using the models as assessment tools, nurses and other healthcare professionals can have an in-depth understanding of their patients' health-seeking behaviors and the rationale behind their health-seeking activities. This

revelation can empower nurses to provide culturally sensitive, contextually relevant individualized evidence-based nursing care required by their patients. The models can also serve as essential tools in planning and implementing evidence-based breast health counseling and health promotion activities that address the peculiar needs of their patients.

9.18 Conclusion

Interpretive description offered an invaluable methodological approach to examine and understand the experiences, perceptions, and interpretations of the health-seeking behaviors and factors women with advanced breast cancer in Southwestern Nigeria believe influence their health-seeking activities. Breast changes were identified as the trigger for engaging in health-seeking behaviors. However, many participants did not associate their breast changes with breast cancer. If women do not interpret their breast changes as signs of breast cancer, they are not likely to seek specialist and professional breast cancer care. The knowledge that emerged valued the participants' voices. This research supports the notion that nurses in the clinical setting listen to patients, hear their experiences, and factors they believe motivated the decisions made along their breast cancer illness trajectories.

The findings from this dissertation research contribute to a better understanding of the health-seeking behavior of Southwestern Nigerian women with advanced breast cancer, by offering new insight into how breast cancer, an illness perceived to be life-threatening can be optimally and comprehensively managed by nurses. This dissertation findings increase the awareness of the necessity for a comprehensive education about breast health and issues relating to breast cancer in Southwestern Nigeria. Nurses should provide education, counselling, and information to women and the general public, as well as plan and implement strategies to overcome barriers to seeking medical attention for breast abnormalities. The implications of the

study for nursing and healthcare practice, education, future research, and policy, as well as recommendations, were all presented.

9.19 Recommendations

Based on the findings and outcomes of this study, it could be said that in Southwestern Nigeria, breast cancer is associated with myths and misconceptions, which can perpetuate stigma. People need education and guidance in understanding issues relating to breast cancer and its management. These findings suggest the need to raise breast health and breast cancer awareness, through public health campaigns, public education, and behavioral change interventions at the general community level. Public and community health practitioners could intensify health promotion campaigns in all categories of healthcare institutions and hospitals, to provide relevant information that could enable people to make informed choices.

Increased knowledge and understanding of breast health, breast ill-health, and breast cancer-related issues could lead to a decrease in the incidence of breast cancer. Mass media coverage and effective media campaigns could assist in providing information on topics such as breast health and breast cancer. Therefore, training journalists on breast cancer and health reporting might be one way of addressing breast cancer-related myths and misconceptions. It could also, lead to earlier breast cancer identification, diagnosis, initiation of treatment, and a reduction in the mortality rates related to the illness.

Traditional healthcare provision has been part of the people's way of life since time immemorial. There is, therefore, the need to give the practice the official recognition it deserves, so that the traditional healing providers could better play their roles in assisting those that need them. This official recognition could help to build a complementary healthcare delivery system where holistic healthcare services are provided for the people.

The replication of this study in other geopolitical zones of Nigeria might be essential for comparison to identify similarities and variations in the people's health-seeking behaviors. The use of the interpretive description is recommended for future research because it could be adapted to the unique nature and the purpose of the research at hand.

9.20 Dissemination of Findings

As a researcher, I believe it is part of my role to disseminate and use the findings and outcomes of this study. I will, therefore, discuss the findings from this study and their implications for practice with the nurse managers and clinical nurses at the oncology unit of the hospital where the data were collected. The aims of the discussions will be to empower and encourage them to plan and implement evidence-based contextually relevant strategies to enhance the holistic management of women presenting with breast cancer at the unit. I will also discuss the findings with various women's groups and individuals who could initiate and implement positive changes in the local settings.

The findings will also be shared with the study participants, who indicated the willingness to be carried along with the project. Copies will be sent to my student advisory committee members and to the university library and e-commons, at the University of Saskatchewan, where it will be easily accessible to other researchers and users. Another copy will be sent to the University College Hospital Ibadan, Nigeria where the data were collected.

Findings from this study and its implications for nursing practice, education, and research will also be discussed with the leaders of the Nursing and Midwifery Council of Nigeria. The discussions will revolve around including this topic as a module in the Mandatory Continuous Professional Development Program (MCPDP) for Nigerian nurses.

The finding from this study will also be shared with nurse educators, nurse researchers,

and policy makers through conference presentations, seminars, published papers, and advocacy activities first at the local level and maybe at the national and international levels. The study outcomes will also be discussed with individuals and different stakeholders such as women's groups, religious institutions, other professional associations, and change agents, all of whom could implement strategies and make changes.

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Appendix A: Letter of Support From UCH, IBADAN, NIGERIA



UNIVERSITY COLLEGE HOSPITAL, IBADAN
The pioneer Teaching Hospital in Nigeria.
P.M.B. 5116, Ibadan Tel: +234 813 173 3398, +234 813 173 3446, 0700 824 4357 Email: cmd@uch-ibadan.org.ng Website: www.uch-ibadan.org.ng

January 9, 2018

Ms. Ogunkorode Agatha,
College of Nursing,
Health Sciences Building, E Wing 4207,
104 Clinic Place. Sackatoon SK.
S7N5E5
Canada.

Dear Ms. Ogunkorode,

Re: Request for Letter of Supports

Please refer to your letter dated December 29, 2017 on the above subject. I write to inform you that the Hospital is ready to permit and support you in data collection for your project titled **“The Health Seeking Behaviour of Women Presenting with Advanced Stages of Breast Cancer in Southwestern Nigeria”**, using this hospital. Please submit your application for data collection together with a copy of your ethics approval and short proposal of your project to facilitate further processes.


Yours sincerely,

Dr. V. I. Akinmoladun
Director of Clinical Services, Research & Training
Chairman, Medical Advisory Committee
For: Chief Medical Director

Prof. Temitope O. Alonge
- MBBS (Ibadan), FRCS Edinburgh, FWACS, MD Leicester, FPA
- Chief Medical Director

Dr. V. I. Akinmoladun
- BCh.D, MSc, FDSRCS (Eng.), FFDRCS (Ire), FWACS
- Chairman, Medical Advisory Committee; Director of Clinical Services, Research & Training

Mr. A. K. Shiyabola
- B.Sc, M.Sc, MPA, GO LSCM, FHAN, MNIM, ACIPM, CIPSMN, MNPA
- Director of Administration & Secretary to the Board



60th ANNIVERSARY CELEBRATION
UNIVERSITY COLLEGE HOSPITAL
IBADAN
1957 - 2017

Appendix B: University of Saskatchewan Ethical Approval



Behavioural Research Ethics
Certificate of Approval

PRINCIPAL INVESTIGATOR
Lorraine Holtlander

DEPARTMENT
Nursing

BEH#
18-03

INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED
Nigeria

STUDENT RESEARCHER(S)
Agatha Ogunkorode

FUNDER(S)
UNFUNDED

TITLE
Health-seeking Behaviors of Women Presenting with Advanced Stages of Breast Cancer in Southwestern Nigeria

ORIGINAL REVIEW DATE
08-Jan-2018

APPROVAL ON
10-Jan-2018

APPROVAL OF:
Application for Behavioural Research Ethics Review
Information Form Gate-Keepers
Consent Form Participants
Demographics
Interview Guide

EXPIRY DATE
09-Jan-2019

Full Board Meeting

Delegated Review

CERTIFICATION: The University of Saskatchewan Behavioural Research Ethics Board (Beh-REB) is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2 2014). The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS: In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: <http://research.usask.ca/for-researchers/ethics/index.php>

Vivian Ramsdent, PhD
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to:

Research Services and Ethics Office
University of Saskatchewan
Room 223 Thorvaldson Building
110 Science Place
Saskatoon, SK Canada S7N 5C9

Appendix C: UCH/UI Ethical Approval Certificate



INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)
College of Medicine, University of Ibadan, Ibadan, Nigeria.



Director: **Prof. Catherine O. Falade**, MBBS (Ib), M.Sc., FMCP, FWACP
Tel: 0803 326 4593, 0802 360 9151
e-mail: cfalade@comui.edu.ng lillyfunke@yahoo.com

UI/UCH EC Registration Number: **NHREC/05/01/2008a**

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Health-Seeking Behaviour of women presenting with Advanced Stages of Breast Cancer in South-Western Nigeria

UI/UCH Ethics Committee assigned number: UI/EC/18/0076

Name of Principal Investigator: **Agatha Ogunkorode**
Address of Principal Investigator: College of Nursing
University of Saskatchewan
Saskatoon, SK Canada

Date of receipt of valid application: 09/02/2018

Date of meeting when final determination on ethical approval was made: N/A

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and *given full approval by the UI/UCH Ethics Committee.*

This approval dates from **01/03/2018 to 28/02/2019**. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the UI/UCH EC assigned number and duration of UI/UCH EC approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC at least four weeks before the expiration of this approval in order to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. No changes are permitted in the research without prior approval by the UI/UCH EC except in circumstances outlined in the Code. The UI/UCH EC reserves the right to conduct compliance visit to your research site without previous notification.



Professor Catherine O. Falade
Director, IAMRAT
Chairperson, UI/UCH Ethics Committee
E-mail: uiuchec@gmail.com

Research Units • Genetics & Bioethics • Malaria • Environmental Sciences • Epidemiology Research & Service
• Behavioural & Social Sciences • Pharmaceutical Sciences • Cancer Research & Services • HIV/AIDS

Appendix D: Operational Approval from UCH Ibadan, Nigeria



UNIVERSITY COLLEGE HOSPITAL, IBADAN

The pioneer Teaching Hospital in Nigeria.

P.M.B. 5116, Ibadan Tel: +234 813 173 3398, +234 813 173 3446, 0700 824 4357 Email: cmd@uch-ibadan.org.ng Website: www.uch-ibadan.org.ng

March 5, 2018

Ogunkorode Agatha,
College of Nursing,
University of Saskatchewan,
104, Clinic Place, E Wing Health
Sciences Building,
Saskatoon, SK S7N2Z4,
Canada.

Dear Ogunkorode,

Re: Application for Operational Approval and Data Collection

Please refer to your letter dated March 1, 2018 on the above subject. I hereby inform you that approval has been given for you to collect data from women presenting with advanced stages of breast cancer for your study titled "Health-seeking Behavior of Women Presenting with the Advanced Stages of Breast Cancer in Southwestern Nigeria".

Please liaise with the Head, Department of Radiation Oncology, who by a copy of this letter, is being informed of the need to give you the necessary assistance and cooperation in this regard. Please endeavor to acknowledge the University College Hospital, Ibadan in the final report of your research. Also, note that submission of a copy of the report to the office of the Chairman, Medical Advisory Committee of this Hospital is highly important.

Yours sincerely,

Dr. V. I. Akinmoladun
Director of Clinical Services, Research & Training
Chairman, Medical Advisory Committee
For: Chief Medical Director

Prof. Temitope O. Alonge
- MBBS (Ibadan), FRCS Edinburgh, FWACS, MD Leicester, FPA
- Chief Medical Director

Dr. V. I. Akinmoladun
- BCh.D, MSc, FDSRCS (Eng.), FFDRCS (Ire), FWACS
- Chairman, Medical Advisory Committee; Director of Clinical Services, Research & Training

Mr. A. K. Shiyabola
- B.Sc, M.Sc, MPA, GD LSCM, FHAN, MNIM, ACIPM, CIPSMN, MNPA
- Director of Administration & Secretary to the Board



Appendix E: Participant Information and Informed Consent Form

IRB Research approval number: BEH # UI/EC/18/0076

This approval will elapse on: 28/02/2019

Title of the research:

Health-seeking Behavior of Women Presenting with Advanced Stages of Breast Cancer in Southwestern Nigeria

Name(s) and affiliation(s) of researcher(s) of applicant(s):

This study is being conducted by Ogunkorode Agatha, Graduate Student, College of nursing, University of Saskatchewan.

Sponsor(s) of research:

This study is self-sponsored.

Purpose(s) of research:

The purpose of this study is to explore and understand the health-seeking behavior and the factors that influence the health-seeking behavior of women presenting with advanced stages of breast cancer in southwestern Nigeria. This study is part of the requirements for obtaining a PhD in nursing from the University of Saskatchewan. It is hoped that this study will generate information that will contribute to the holistic management of women presenting with advanced stages of breast cancer in Southwestern Nigeria.

Procedure of the research, what shall be required of each Participant and approximate total number of Participant that would be involved in the research:

It is anticipated that a total of 50 Participant will be recruited for the study since it is a qualitative research. However, this number will be guided by data saturation and redundancy. The data collection exercise will involve two parts. The first part will consist of filling out a personal information form. In this information form, you will be asked questions about your background, such as age, marital status, education, and economic status. The second part of the study will involve an audio-recorded interview with the researcher. The interview will explore your health-seeking behavior and the factors that influence your engaging in any health-seeking behavior. The interview will be scheduled at a time that works well for you. The location will be in a private place, adequately prepared for them here in the hospital. This part will take about 90 minutes of your time. There may be a second interview to confirm or change the information you have provided. The interviews will be audio-recorded and notes will be taken during the interviews.

All information collected from this study will be kept confidential. Your participation will not affect your care.

Expected duration of research and of Participant(s)' involvement:

(For example: In total, we expect you to be involved in this research for three months. You should not spend more than 1 hour during each interview)

Risk(s):

You may experience emotional discomfort because you may be discussing some challenges and frustrations around your illness.

Benefit(s):

Some of the benefits of your participation in this study include an opportunity to talk about your experiences and the possibility of influencing nursing practice and research. On the emotional level, you will have the opportunity to discuss your challenges and frustrations with breast cancer. You will not get any monetary remuneration for taking part in this study.

Confidentiality:

Any personal information you provide during this study will be kept strictly confidential. Any information that may identify you or any third parties associated with the information you will provide will be deleted. The information from this study be used to publish articles in journals and for presentation at conferences; however, your identity will be kept confidential. Direct quotations from the interview may be used to buttress my report, you will, however, be given a false name.

Voluntariness:

You may feel tired from the interview. You have the right to refuse to answer any questions you do not wish to answer. You are free to take breaks or stop the interview at any time. You can also request that the audio-recorder be turned off at any time. A counselor from the clinic (Name of counselor and phone number) can be contacted to discuss any issues that you may encounter as a result of your participation in this study.

Alternatives to participation:

If you choose not to participate, this will not affect your treatment in this hospital in any way.

Due inducement(s):

You will be compensated for your transportation fees to and from the research site but you will not be not be paid for participating in this research.

Storage of Data

All information collected for this study such as audio-recordings, transcripts of interview and contact information will only be available to the researcher and the supervisors working on the study. The data will be locked up in a filing cabinet. Recordings will be stored with pseudonyms on the researcher's personal computer secured with a password. All stored information will be kept for a minimum of five years after the study is completed. After five years, the data will be destroyed beyond recovery. All study documents and information will be saved in a password protected USB device and be stored in Dr. Holtslader's office at the University of Saskatchewan for five years. To ensure confidentiality, the consent form will be stored separately from the data collected.

Consequences of Participant' decision to withdraw from research and procedure for orderly termination of participation:

You can also choose to withdraw from the research at any time. Please note that some of the information that has been obtained about you before you chose to withdraw may have been modified or used in reports and publications. These cannot be removed anymore. However, the researchers promise to make effort in good faith to comply with your wishes as much as is practicable.)

Modality of providing treatments and action(s) to be taken in case of injury or adverse event(s):

If you suffer any injury as a result of your participation in this research, you will be treated at the University College Hospital, Ibadan and the researcher will bear the cost of this treatment.

What happens to research Participant and communities when the research is over:

The researchers will inform you of the outcome of the research. During the course of this research, you will be informed about any information that may affect your continued participation or your health.)

Statement of person obtaining informed consent:

I have fully explained this research to _____ and have given sufficient information, including about risks and benefits, to make an informed decision.

DATE: _____ SIGNATURE: _____

NAME: _____

Statement of person giving consent:

I have read the description of the research and have had it translated into language I understand. I have also discussed with the researcher to my satisfaction. I understand that my participation is voluntary. I know enough about the purpose, methods, risks and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form and additional information sheet to keep for myself.

DATE: _____ SIGNATURE: _____

NAME: _____

Detailed contact information including contact address, telephone, fax, e-mail and any other contact information of researcher(s), institutional HREC and head of the institution:

This research has been approved by the Ethics Committee of the University of Ibadan and the Chairman of this Committee can be contacted at Biode Building, Room 210, 2nd Floor, Institute for Advanced Medical Research and Training, College of Medicine, University of Ibadan, E-mail: uiuchirc@yahoo.com and uiuchec@gmail.com

In addition, if you have any question about your participation in this research, you can contact the principal investigator, Ogunkorode Agatha at +1369-998-0727; +234-806-582-1012, or the research supervisors at Dr. Holtslander at 306-966-8402, or Dr. Ferguson at 306-996-6264 or Dr. Ntekim Atara at +2348203059292. This study has been approved by the University of Saskatchewan Behavioral Research Ethics Board on 10/01/2018. And UI/UCH Ethics Committee on ----(date)-----. If you have any questions regarding your rights as a Participant, you can call the University of Saskatchewan Research Ethics Office collect at 306-966-2084.

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT.

Appendix F: Consent Form in the Yoruba Language

ÌWÉ ÀKÍYÈSÍ FÚN ÈKỌ YÌÍ



UNIVERSITY OF SASKATCHEWAN
College of Nursing
NURSING.USASK.CA

ÌWÉ ÀKÍYÈSÍ FÚN ÈKỌ YÌÍ

Ìwé Ìtélòrùn Láti Jẹ Alábàṣe Nínú ÈKọ Yìí.

Àkọlé Èkọ Náà

Ìṣesí Àwọ̀n Obínrin tí Àrùn Ọ̀mu ti wọ̀ lára Ní Ìhà Gúsù-Ìwọ̀oòrùn Nìgreria.

Orúko Olùwádíí

Ogunkorode Agatha,

Akẹkọ̀ọ̀ Àgbà Ní Univetsity,

Èká Olùtọ̀jú Aláìsàn (Nursing),

University of Saskatchewan.

Canada.

Phone +1369-998-0727; 234-806-582-1012.

Àwọ̀n Olùdarí

Lorraine Holtslander, RN, PhD, CHPCN(c)

Graduate Programs Chair Professor?

College of Nursing, University of Saskatchewan,

4216 E Wing Health Science Building,

104 Clinic Place, Saskatoon, S7N 2Z4.

Phone: [306-966-8402](tel:306-966-8402)

Email: lorraine.holtslander@usak.ca

Linda Ferguson RN. PhD

Pro. Dir C Professor,

Past President, Canadian Association of Schools of Nursing,

Academic Health Sciences Building E Wing

College of Nursing, University of Saskatchewan,

104 Clinic Place,

Saskatoon, S7N2Z4.

Phone: [306-996-6264](tel:306-996-6264)

Dr. Atara Ntekim,

Department of Radiation Oncology,

University College Hospital, Ibadan, Nigeria.
Phone: +2348023059292
Email: kimata2000@hotmail.com

Ìdí Èkọ Nàà

Ohun tí èkọ yíi n lépa ni láti se iwádií isesi àwọn obinrin alárùn omú tí n wá iwòsàn àti láti mọ idí tó mú wọn n gba ònà bèè lápá Gúsù-iwòòdrùn Nigeria. Iwádií èkọ yíi jé apá kan pàtàkì nínú isẹ PhD fún itójú aláìsàn (Nursing) tí mo n se lówọ ní University of Saskatchewan. A sì ní irètí pé iwádií èkọ ti a n se yíi yóò fún wa ní imò itójú tó pèye fún àrùn omú tó ti wọra lápá Gúsù-iwòòdrùn Nigeria.

Ìkópa Nínú Èkọ Nàà

Èyí pín sí apá mēta. Fún apá kiní, a ó fún wa ní iwé fún idáhùn ibéèrè nípa ara wa fúnrawa. Wọn jé ibéèrè tí a lè fí mọ wá, gégé bí orúkọ, ojọ orí, ipò igbéyàwó, ibi tí a bá èkọ ilé-iwè dé, isẹ òwò. Apá kéjì èkọ nàà wá fún gbígba òrò wa sílẹ pèlú oluwádií èkọ yíi pèlú èrọ agbòròsilẹ. A ó sẹwádií àwọn ònà tí ẹ n gbà wá iwòsàn àti idí tí ẹ fí n se bèè. Apá kẹta èkọ nàà wá fún igbòròsilẹ láti ẹnu àwọn tí òrò kàn gbòngbòn nínú òrò àjọsọ nàà. AAwọn yíi yóò jé iba diẹ lára àwọn tó kópa nínú èkọ yíi. Wọn yóò dijọ sòrò pò nípa irírí wọn lórí àrùn omú obinrin pèlú isòro tí wọn n bá padé ní adúgbò wọn. Iwádií òrò tí a ó se àti ti àwọn tí yóò jókòó sòròpò ni a ó fí sí àsikò tó tẹrùn fún yín. Ibi tí a ó lò yóò wá ní ipamó, níbi tí a ti pèsè tó jojú fún wọn ní ilé iwòsàn yíi. Apá kan yíi yóò gba àádòrùn-ún isẹjú (90) àsikò yín. A tún lè se iwádií lẹkẹkẹ láti mọ bóyá èsì wa isáájú bọsí i tàbí bèè kọ. GBogbo òrò àjọsọ wa níhin-in wá ní àşiríbò. Wíwá síhin-in láti bá wa sòrò kò bá isẹ itójú yín wí.

Àwọn Ewu Tó Lè Yojú

Ó lè se yín bí àárè pèlú iwádií ti a n se àti àwọn òrò àjọsọ wa. Idàāmú lè mú yín lókàn nítorí òrò wa lè jemò isòro tí ẹ n rí nínú àìsàn yín. Ẹ ní ètò láti má se dáhùn ibéèrè tí ẹ kò fẹ fèsì sí. Àyè sì wá láti dádódúró jáde kúrò nínú ipadé nígbà kúùgbà. Ẹ sì lè ní kí a da èrọ agbohunsilẹ dúró nígbà kúùgbà. A lè lo rí Alábàró kan (dárúko rẹ) ní ilé iwòsàn yíi nípa isòro tí ẹ bá ni nínú èkọ òrò àjọsọ wa yíi.

Àwọn Èrè Tó Lè Yojú

Àwọn èrè kan tí ẹ lè rí nípa ikópa yín nínú èkọ yíi ni ànfààní tí ẹ ní làti sòrò lórí irírí yín àti pé yóò fikún mímòşese isẹ Nòrsì. Ẹ sì lè fí ibalẹ okàn sòrò nípa àgbélébùú àti isòro yín lórí àìsàn omú. Fífetísí àwọn ẹlòmíiràn onírú idààmú kan nàà lè fún yín ní ifokànbalẹ pé àwọn kan bíi tiyín tún wá nínú irin-àjo kan nàà pèlú yín. Ànfààní tún wá láti kọ bí àwọn kan tí n borí isòro àìlera wọn. Ẹ gbò, kò sí èrè owó ní kíkopa nínú èkọ yíi o.

Ètò Láti Fàsáyìn

Àtòkàn-wá gidì ni kíkopa nínú èkọ yíi. Ibéèrè tó bá rọrùn fún yín nìkan ni kí ẹ dáhùn. Àyè wá láti lo kúrò nídií èkọ yíi nígbà kúùgbà tó bá wù yín láìsí ipadànù kankan. Jíjádé lo bèè kò bá itójú àìsàn yín wí. Bí ẹ bá yàn láti jáde lo, gbogbo òrò yín tí a gbà sílẹ ni a ó parẹ pátapáta bí ẹ bá fẹ kí a se é bèè.

Àşiríbò Àti Àifinihàn

GBigbo ọ̀rọ̀ ara yín tikalára yín tí ẹ̀ bá bá wa sọ̀ ní a fi àṣírí bò. Àwọn ọ̀rọ̀ tó lè fi yín hàn, tàbí èyí tó lè fi àwọn tí ẹ̀ mò hàn ní a ó parẹ̀. Mo lè lo ohun tí a bá sọ̀ ní dídí ẹ̀kọ̀ yíí sínú iwé iròyìn tàbí kí n fi ẹ̀ iwé, tàbí kí n fi bá agbo àwọn ènìyàn sọ̀rọ̀; síbèsíbẹ̀ a kò ní lè mò yín. Èmi lè gbé ọ̀rọ̀ ẹ̀ni kan jáde bí ẹ̀ni náà ti sọ̀rọ̀ náà gan-an láti gbè ti ọ̀rọ̀ tí mo n sọ̀, sùgbọ̀n èmi yóò dá orúkọ kan lásán tí kíí ẹ̀ tirẹ̀.

Ìpamọ̀ Iṣẹ̀ yíí

GBogbo àwọn ọ̀rọ̀ tí a gbà sílẹ̀ nínú ẹ̀kọ̀ yíí, ní ti ẹ̀rọ̀ agbòròsílẹ̀, àwọn iwé iwádíí, àwọn ọ̀rọ̀ àwọn tí a yàn fún ifòrọ̀ jomitooro àti àwọn yójú tí a bá sọ̀rọ̀, gbogbo rẹ̀ wà fún ilò oluwádíí ẹ̀kọ̀ yíí nikan pèlú àwọn olùdarí rẹ̀ tí wọn n ṣiṣẹ̀ lórí ẹ̀kọ̀ náà. Àwọn àkọ̀sílẹ̀ iṣẹ̀ yíí ní a ó ti mó inú àpótí iwé. Àwọn ọ̀rọ̀ tí a kọ̀ sínú kòmputà oluwádíí ẹ̀kọ̀ yíí ní a ó fi sáábẹ̀ orúkọ lágbájá, tó sì jẹ̀ kòmputà ti a fi àmì àṣírí padé. GBogbo ọ̀rọ̀ tí a gbà sílẹ̀ yóò wà ní ipamọ̀ fún odindí ọ̀dún márùn-ún lẹ́yìn iparí ẹ̀kọ̀ lórí wọn. Lẹ́yìn ọ̀dún márùn-ún ní a ó pa àwọn akọ̀sílẹ̀ náà rẹ̀ láìṣeé rí mó. GBogbo iwé akọ̀sílẹ̀ ẹ̀kọ̀ yíí pèlú èyí tí a fetí gbọ̀ ní a ó gbé pamọ̀ lábẹ̀ USB tí yóò wà ní yàrá ilé iṣẹ̀ Dr. Holtslader ní University of Saskatchewan fún ọ̀dún márùn-ún. Láti rí i pé àṣíríbò, itẹ̀milòrùn yóò wà ní ipamọ̀ lóto yàto síbí ti àwọn ọ̀rọ̀ tí a gbà sílẹ̀ nínú ẹ̀kọ̀ yíí wà.

Àwọn Ìbèèrè

Bí ẹ̀ bá ní ìbèèrè lórí ohun kóhun lóòrè-kóòrè nípa ẹ̀kọ̀ yíí, ẹ̀ má ẹ̀ lóra láti bèèrè ọ̀rọ̀ lówọ̀ oluwádíí ẹ̀kọ̀ yíí Ogunkorode Agatha ní + 1369-998-0727; [+ 234-806-582-1012](tel:+234-806-582-1012), tàbí olùdarí fún oluwádíí Dr. Holtslader ní [306-966-8402](tel:306-966-8402), tàbí Dr. Ferguson ní [306-996-6264](tel:306-996-6264), tabi Dr. Ntekim Atara, ní +2348203059292. University of Saskatchewan Behavioral Research Ethics Board ti fowósí ẹ̀kọ̀ yíí ní ojọ̀ 09/01/2018.. Àti UI/UCH Ethics Committee ní ojọ̀ ... Bí ẹ̀ bá fẹ̀ bèèrè bó ti kàn yín láti kópa nínú ẹ̀kọ̀ yíí, ẹ̀ lè pe University of Saskatchewan Research Ethics Office ní [306-966-2084](tel:306-966-2084).

Appendix G: Participant's Consent Form in Yoruba



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Ìwé Mo GBó Mo GBà

Èmi ti ka (a ti kà á sí etí igbó mi) ọ̀rọ̀ nípa isẹ̀ yìí, àlàyé tí a ẹ̀ lórí isẹ̀ náà sì yé mi.
A sì fún mi láyè láti bèèrè ọ̀rọ̀, àlàyé tí a ẹ̀ lórí gbogbo ibèèrè mi sì tẹ̀ mi lórùn. Ó yé mi pé àyè
wà fún mi láti tún bèèrè ọ̀rọ̀ sí i nígbà kúùgbà láti ibùgbé oníṣẹ̀ ti a fi sílẹ̀ yìí.

Ó tún yé mi pé:

I. Ìkópa nínú èkó yìí jẹ̀ ohun ifẹ̀ inú mi (tifẹ̀tifẹ̀)

II. Àyè wā fún mi láti kúrò nínú èkó yìí láìsí ipádánù kankan.

III. Ohun tí isẹ̀ yìí dá lé lórí àti àbájáde ọ̀rọ̀ ajọsọ̀ yìí tí a kò tìì lò ni yóò wà ní ipamó fún ọ̀dún
márún-ún tí a ó sì pa a rẹ̀ lẹ̀yìn náà.

IV. Ohun kóhun tí mo bá sọ̀ yóò jẹ̀ ọ̀rọ̀ àṣírí láàárin mi pèlú olùwádíí èkó yìí àti àwọn olúdarí rẹ̀, a
kò sì gbódò lo ohun kóhun tí yóò fi mí hàn nínú iwádíí yìí.

V. Èmi náà gbódò fi àṣírí bo àwọn ọ̀rọ̀ àwọn ará mi míràn tí a jọ kópa nínú èkó yìí.

VI. Pé kò sí ipalára tàbí ewu ní fífaramó egbé olùwádíí ọ̀rọ̀ ajọsọ̀ yìí.

VII. Kò sí eni kẹ̀ni tó rọ̀ mí lályẹ̀ tàbí tó gba ọ̀nà àtọ̀ mú mi láti kópa nínú èkó yìí.

VIII. A fi yé mi pé a ti gba àṣẹ̀ Ethical fún èkó yìí lówó University of Saskatchewan Behavioral
Ethics Board àti UI/UCH Ethical Review Committee.

IX. A lè fi abájáde èkó yìí ẹ̀ iwé kí ó sì wà ní ilé ikàwé University.

X. A fi yé mi pé a ó fún mi ní àdàkọ̀ iwé itélórùn yìí lẹ̀yìn igbà tí mo bá ti fowó sí i.

Èmi mo gbà láti kópa nínú èkó tí Ogunkorode Agatha n ẹ̀ iwádíí rẹ̀ lábé idarí Dr. Holtlander
àti Dr. Ferguson, University of Saskatchewan, Canada, àti Dr. Dr. Ntekim Atara, Department of
Radiation Oncology, University College Hospital, Ibadan, Nigeria.

.....
Participant's ID

.....
Date

.....
Participant's Signature

.....
Student Researcher's Name

.....
Date

.....
Student Researcher's Signature

Appendix H: Study Gate-keeper Information Document

Title of the Study

Health-seeking Behavior of Women Presenting with Advanced Stages of Breast Cancer in Southwestern Nigeria.

Name of Researcher

Ogunkorode Agatha,
Graduate Student,
College of Nursing,
University of Saskatchewan.
Phone: +1369-998-0727; +234-806-582-1012

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Linda Ferguson RN. PhD
Pro. Dir © Professor,
Past-President, Canadian Association of Schools of Nursing,
Academic Health Sciences Building, E- wing
College of Nursing, University of Saskatchewan,
104 Clinic Place,
Saskatoon, S7N2Z4.
Phone: 306-996-6264.

Purpose

The purpose of this study is to explore and understand the health-seeking behavior and the factors that influence the health-seeking behavior of women presenting with advanced stages of breast cancer in Southwestern Nigeria. This study is part of the requirements for obtaining a PhD in Nursing from the University of Saskatchewan. It is hoped that this study will generate information that will contribute to the holistic management of women presenting with advanced stages of breast cancer in Southwestern Nigeria.

Inclusion and Exclusion Criteria

The inclusion and exclusion criteria that will guide Participant selection for this study include:
a) female gender, b) diagnosis with stage III or stage IV breast cancer, c) ability to communicate in either the English or the Yoruba language or both, d) ability to take part in an interview, e) approval by the oncologist and contact or gate-keeper nurse, f) inpatient at the hospital. The exclusion criteria will include women with stage III or stage IV breast cancer whose functional

status will not allow them to participate in an interview. Women with the advanced stage breast cancer who find it difficult to communicate; b) women who cannot speak either the English or the Yoruba language, c) women who did not consent to participate in the study.

Participation

This involves two parts. The first part will consist of filling out a personal information form. In this information form, Participant will be asked questions about their background, such as age, marital status, education, and economic status. The second part of the study will involve an audio-recorded interview with the researcher. The interview will explore the health-seeking behavior and the factors that influence Participant to engage in any health-seeking activities. The interview will be scheduled at a time that works well for the Participant. The location will be in a private place, adequately prepared for the purpose here in the hospital. Each interview will take about 30-45 minutes of Participant's time. There may be a second and a third interview to confirm or change the information that Participant had provided. During the second or subsequent interviews, Participant will be provided with the summary of the salient points and the initial interpretation of the data collected during previous interviews. Transcribed copies of Participant's interview will be provided to those Participant who request for them. All information collected from this study will be kept confidential. During the interviews, notes will be taken by the researcher and the interviews will be audio-recorded. The note-taking and audio-recordings are to ensure the accuracy of the information to be obtained. Participant's participation will not affect their care.

Potential Risks

Participant may feel tired from the interview. They may experience emotional discomfort because they will be discussing some challenges and frustrations around their illness. They have the right to refuse to answer any questions they do not wish to answer. They are free to take breaks or stop the interview at any time. They can also request that the audio-recorder be turned off at any time. A counselor from the clinic (Name of counselor and phone number) can be contacted to discuss any emotional discomfort and issues that they may encounter as a result of their participation in this study.

Potential Benefits

Some of the benefits of Participant's participation in this study include opportunity to talk about their experiences and the possibility of influencing nursing practice and research. On the emotional level, they will have the opportunity to discuss their challenges and frustrations with breast cancer. There is no monetary remuneration for taking part this study.

Right to Withdraw

Participation in this study is totally voluntary. Participant are free to answer only the questions that they are comfortable with. They may withdraw from this study for any reason, at any time, without any disadvantage of any sort. Their withdrawal from this study will have nothing to do with their medical treatments. If they choose to withdraw from the study, any information they have already provided will be destroyed beyond recovery at their request. If the data from all sources have been de-identified and integrated, it may be impossible to identify and withdraw data from specific individuals.

Confidentiality and Anonymity

Any personal information Participant provide during this study will be kept strictly confidential. Any information that may identify them or any third parties associated with the information they will provide will be deleted. I may use the information from this study to publish articles in journals and for presentation at conferences; however, every Participant's identity will be kept confidential. I may use direct quotations from the interview to buttress my report, Participant will, however, be given a false name.

Storage of Data

All information collected for this study such as audio-recordings, transcripts of interview and contact information will only be available to the researcher and the supervisors working on the study. The data will be locked up in a filing cabinet. Recordings will be stored with pseudonyms on the researcher's personal computer secured with a password and the researcher's secure cabinet on PAWS with a specific new folder. All stored information will be kept for a minimum of five years after the study is completed. After five years, the data will be destroyed beyond recovery. All study documents and information will be saved in a password protected USB devise and be stored in Dr. Holtslander's office at the University of Saskatchewan for five years. To ensure confidentiality, the consent form will be stored separately from the data collected.

Questions

If Participant have any questions about this study at any time, they should please feel free to contact the researcher Ogunkorode Agatha at +1369-998-0727; +234-806-582-1012, or the research supervisors at Dr. Holtslander at 306-966-8402, or Dr. Ferguson at 306-996-6264. This study has been approved by the University of Saskatchewan Behavioral Research Ethics Board on the 10th of January 2018. And operational approval has been granted by UI/UCH authorities on ----(date)-----. If Participant have any questions regarding their rights as Participant, they can call the University of Saskatchewan Research Ethics Office collect at 1-306-966-2975.

Appendix I: Participant Demographic Information Questionnaire

Please answer the following questions by checking a response or writing the answer in the space provided.

Date.....

Code no.....

1. What is your ethnic origin?

2. What is your primary language?

1. Yoruba

2. Ibo

3. Hausa

Some other language

(Specify): _____

3. How old were you on your last birthday?

_____ Years old

4. What is your highest level of education?

1. Less than primary six

2. Secondary School

3. Some college/Associate's
degree/technical certificate

4. Bachelor's degree

5. Graduate degree (e.g.
Master's, PhD, JD)

5. What is your current employment status?

1. Working for pay at a job or
Business

2. Not currently employed and looking for work

3. Not currently working and not looking for work

6. In 2017, what was your total family income from all sources? Was it:

1. Less than N50, 000. 00

2. N100, 000. 00

3. N200, 000. 00 or more

4. N500.000. 00?

7. Does anyone in your family or household have breast cancer or any other kind of cancer?

1. Yes

2. No

8. What was the time frame between when you first noticed breast changes and when you reported in the hospital?

Less than five months

Five to less than ten months

Ten to less than 15 months

More than two years

9. What is your religious affiliation? -----

Appendix J: Participant Interview Guide

Good morning/ afternoon. How are you today? How is your health condition? Let me start by thanking you again for agreeing to take part in this study.

My name is Agatha Ogunkorode. I am a graduate student from the University of Saskatchewan.

As I explained to you earlier on, I am carrying out a study on the health-seeking behavior of women presenting with advanced stages of breast cancer in Southwestern Nigeria, and the factors that influence women in engaging in any health-seeking activity for the treatment of advanced stages of breast cancer in Southwestern Nigeria. This study is part of my PhD.

Requirement. The aim of this study is to explore your health-seeking behavioral patterns, and any other factors that may be influencing health-seeking behavior for breast cancer among women. The goal of the study is to render an effective and comprehensive management of the disease to women. You have been purposely selected for this study.

I ask you to take this task seriously by sharing your opinions and ideas candidly and openly on the subject as this will facilitate the development of relevant interventions related to breast cancer in women.

The information collected will be confidential and it will be used for only the intended purpose of providing an integrated, comprehensive, and total management of breast cancer to women in Southwestern Nigeria.

To keep a more accurate record of our discussions and to ensure that it is accurately transcribed for my study as I explained to you before, I am proposing that we use a digital recorder. Do you mind if I use a digital recorder? (Observe for any objection and if there in none, proceed). I can see that there is no objection to our using a digital recorder for this interview. I will also be jotting down some points in my notebook for the same reasons I discussed with you

before. I thank you again for your cooperation.

If you want, and you request it, I will provide you with a copy of the transcript of the interview. If you want me to turn off the digital recorder at any point during the interview process, please let me know, I will do so. You do not have to answer any questions that you are not comfortable with. You are also free to stop the conversation at any time and withdraw from the interview without any consequences. Do you have any questions about the whole process before we proceed? (Participant will now be given the demographic form to fill out).

This interview should take about 30-45 minutes.

- 4) Describe for me in as much detail as possible how you learned about your illness?
 - i. Probe for the full story.
 - ii. What were the signs that you saw? Probe for an explanation.
 - iii. How did you respond to the observation?
 - iv. What was your explanation of the signs and symptoms?
 - v. Did you consult other people about your signs and symptoms?
 - vi. If yes, who are these people that you consulted?
 - vii. What advice did they give you?
- 5) Before you were diagnosed with breast cancer, did you know that you might be suffering from the disease?
 - i. If no
 - ii. What then motivated or pushed you to seek for care in the hospital?
- 6) When people are diagnosed with breast cancer, they respond in different ways.
 - i. Tell me how you responded
 - ii. What steps did you take?

- iii. Tell me in detail what you did?
- iv. What activities did you engage in to manage the illness?

4) What does breast cancer mean to you?

- v. In your opinion, is breast cancer treatable?
 - 1. If yes, how? If no, why not?
 - 2. Is breast cancer curable?
 - 3. If yes, how? If no, why not?

23) How long did it take between the time you noted the signs and symptoms of the illness and the time you decided to seek health care in the hospital?

- i. Did you seek health care elsewhere before you decided to go for treatment in the hospital?
- ii. If yes, where did you go to seek for health care?
- iii. What reasons made you to go there?
- iv. Tell me about the kind of treatment you were given there?
- v. Was the treatment helpful?

24) What would you say was a major factor that influenced your decision to seek for health care in the hospital?

- i. After initiating treatment at the hospital, did you seek for health care elsewhere?
- ii. If yes, where
- iii. What was your main reason for doing so?

25) What are the complications one is likely to get if one is not treated for breast cancer on time?

- 26) What in your understanding should a person do for the successful treatment of breast cancer?
- 27) Who has the final say on when and where you should take treatment when you are ill?
- 28) Do you have a particular person or place where you go to take treatment when you are ill?
- i. What motivates you to go there for treatment?
 - ii. What other factors make you go there for treatment?
 - iii. Tell me in detail the nature of the care you obtain there?
 - iv. How pleased were you with the care and attention given to you?
 - v. What was helpful?
 - vi. What was not useful?
- 29) What factors determine where you go for treatment?
- 30) How far is your home from the hospital?
- i. Does the distance from your home to the hospital affect your going there for treatment?
- 31) For how long on the average, do you usually have to wait at the hospital before seeing a doctor?
- 32) What can you say about the answers and explanations you get from nurses and other healthcare workers to all the questions and issues related to your illness?
- i. How would you describe your relationship with the nurses?
- 33) What support do you get from your family and friends in taking care of your illness?
- i. Who would you say provides most of your care/ support?
 - ii. What do they do?
 - iii. What should be done to assist you?

34) What would you say are the major challenges you have been facing in taking care of your illness?

i. How have you been addressing the challenges?

35) What have you learned from this illness?

36) What advice do you have for women having this kind of illness?

37) What can health care providers particularly nurses do to care more adequately for people with this kind of illness?

38) Do you think I should know anything else to understand the health-seeking behaviors you practice?

39) Towards the end of the interview, I will explain to the Participant that I will transcribe the recorded interview, think, and reflect about it. I will ask if I can contact her again should I think I have any other questions. By the time the interview has been analyzed, several questions may have occurred to me. I will write down the questions. The second interview may help in the clarification of issues and points raised during the first interview.

40) Is there anything you would like to ask me or tell me?

Thank you very much for your participation.

Appendix K: Interview Guide Questions in Yoruba

Health-seeking Behavior of Women Presenting with Advanced Stages of Breast Cancer in Southwestern Nigeria

ATÓKA IBÉÈRẸ ỌRỌ FÚN ÌPÀDÉ ÌWÁDÌÍ ỌRỌ LÓRÍ ÀWỌN OBÌNRIN TÍ N WÁ ÌWÒSÀN ÀRÙN ỌMÚ TÓ TI WỌRA NÍ GÚSÙ-ÌWỌOÒRÙN NIGERIA.

Atóka Ìwádíí Ọrọ Náà

Ẹ kú ikàlẹ̀ o. Ọní áá san wá o. Ẹ́ ara le? Ara áá yá o. Ẹ́wájú jẹ́ kí n dúpẹ̀ lówọ̀ yín tí ẹ̀ gbà láti kópa nínú ẹ̀kọ̀ yíí.

Orúkọ mi ni Agatha Ogunkorode. Èmi jẹ́ akẹ̀kẹ̀kọ̀ ẹ̀gbà láti University of Saskatchewan. Gẹ̀gẹ́ bí mo tí Ẹ̀làyé Ẹ́wájú, èmi n Ẹ́ iwádíí ẹ̀kọ̀ lóri àtíẸ́ àwọ̀n obinrin alárun ọ̀mú tó ti wọra ní Gúsù-ìwọ̀oòrùn Nigeria, pèlú àwọ̀n ohun tí àwọ̀n obinrin bẹ̀ẹ̀ n Ẹ́ láti wá imúláradá. Ìwádíí ẹ̀kọ̀ yíí jẹ́ apá kan pàtàkì nínú iṣẹ́ PHD tí mo n Ẹ́ lówọ̀. Ohun tí ẹ̀kọ̀ yíí n lépa ni láti wo àwọ̀n ọ̀nà tí ẹ̀ n gbà fún itọ́jú, àti àwọ̀n ọ̀nà míràn tí àwọ̀n èniyàn n gbà wá iwòsàn àrùn ọ̀mú láàárín àwọ̀n obinrin. Ohun tí ẹ̀kọ̀ yíí n lépa ni láti fun àwọ̀n obinrin ní itọ́jú tó kúnjú fún àisàn náà. A sì mòmò yàn yín fún ẹ̀kọ̀ yíí ni.

Mo n rò yín kí ẹ̀ gba iṣẹ́ yíí ní ọ̀kúnkúndún, kí ẹ̀ sọ tinú yín àti irísí yín ní kedere lóri ọ̀rọ̀ yíí, nítorí Ẹ́sẹ̀ bẹ̀ẹ̀ la Ẹ́ lè Ẹ́sẹ̀ borí àrùn ọ̀mú obinrin.

Ọ̀rọ̀ ajosọ wa yíí wà ní àṣírìbò, ilépa àṣekápá àrùn ọ̀mú obinrin ní apá Gúsù-ìwọ̀oòrùn Nigeria nìkan ni a ó lò ó fún.

Kí ọ̀rọ̀ ajosọ wa yíí lè wà ní pípé mo dábā́a kí a lo ẹ̀rọ̀ agbòròsílẹ̀ (digital recorder). Ẹ́ kò sẹ̀ni tó lòdì sí lílò ó? (Ẹ́kíyèsí ẹ̀ni tí kò bá fẹ́ Bí kò bá sí, máa bá ọ̀rọ̀ lo). Mo rí i pé kò sẹ̀ni tí kò fẹ́ bẹ̀ẹ̀. Èmi náà yóò máa kọ̀ kókò ọ̀rọ̀ wa sínú iwé ọ̀wọ̀ mi fún idí kan náà tí mo tí bá yín sọ tẹ̀lẹ̀. Mo dúpẹ̀ fún isowópò yín.

Bí ẹ̀ ba n fẹ́, tí ẹ̀ bá bèèrè fún un, èmi yóò fún ẹ̀ni bẹ̀ẹ̀ ní àdàkọ̀ àbájáde iwádíí tí a n Ẹ́ yíí. Bí ẹ̀ bá n fẹ́ kí n pa ẹ̀rọ̀ agbòròsílẹ̀ bí a ti n bá iwádíí ọ̀rọ̀ wa lo, kí ẹ̀ jẹ́ kí n mò. Èmi yóò sì Ẹ́ bẹ̀ẹ̀. Ẹ̀ kò ní láti dáhùn ibèèrè tí kò rọ̀rùn fún yín. Àyé sì wà láti dánú ọ̀rọ̀ dúró nígbà kúùgbà, àní láti jáde nídìí ọ̀rọ̀ láisí ohun tí yóò tẹ̀yin rẹ̀ wá. (Wàyíí ni a ó fún àwọ̀n tó wà ní ipídé ní iwé iye èniyàn láti kọ ohun tí a bèèrè níbẹ̀).

ìwádíí ọ̀rọ̀ yíí yóò gba àsikò àádòrùn-ún (90) iṣẹ́jú (wákàtí kan àti iṣẹ́jú mẹ̀ẹ̀dógún).

1. Ẹ̀làyé ní kíkún fún mi ohun tí ẹ̀ ti mò nípa àisàn yín.

- i. Ẹ́ iwádíí gbogbo itàn náà.
- ii. Àwọ̀n àmì wo lẹ̀ rí? Wádíí fún àlàyé.
- iii. Kí ni ẹ̀ Ẹ́ nígbà tí ẹ̀ rí àwọ̀n àmì náà?
- iv. Kí ni ẹ̀ ka àwọ̀n àmì náà kún?
- v. Njẹ́ ẹ̀ fi irírí àwọ̀n àmì náà lo ẹ̀ni kẹ̀ni?

- vi. Bí ó bá jé bèè ni, àwọn ta ni ẹ fi lọ?
- vii. Kí ni imòrán tí wọn fún yín?
2. Kí a tó ẹ ibèwò yín wò fún àrùn ọmú, njé ẹ mò pé ó ẹ́ẹ́ẹ́ kí ó jé pé àrùn ọmú ló wà lára yín?
- i. Bí bèè kò
- ii. Kí ló mú yín wá sí ilé iwòsàn fún imúláradá?
3. Léyìn ẹ́ẹ́ iwàdíí tí a sì mò pé àrùn ọmú ló n ẹ́ àwọn ènìyàn kan, oríşiríşì ọ̀nà ni ọkàn wọn fi n gbà á.
- i. Sọ fún mi bí ọkàn yín ti gbà á.
- ii. Àwọn ọ̀nà wo ni ẹ gbà?
- iii. Sọ fún mi lẹ́şẹ́şẹ́ ohun tí ẹ ẹ́.
- iv. Ẹ́şẹ́ wo ni ẹ ẹ́ fún itọ́jú àìlera náà.
4. Kí ni àisàn ọmú jásí fún yín?
- i. Njé ẹ rò pé àrùn ọmú ẹ́é wòsàn?
- ii. Bí bèè ni: Báwo? Bí bèè kò: Nítórí kí ni?
5. Báwo ló ti pé tó kí ẹ tó wá fún itọ́jú ní ilé iwòsàn léyìn igbà tí ẹ ti rí àwọn àmi àisàn náà?
- i. Njé ẹ lọ ibòmíráń fún itọ́jú kí ẹ tó pinnu láti wá gba itọ́jú ní ilé iwòsàn?
- ii. Bí bèè ni: Níbo ni ẹ ti lọ gba itọ́jú náà?
- iii. Kíló mú yín lọ ibè?
- iv. Sọ fun mi, irú itọ́jú wo ni ẹ rí gbà lẹ́hùn-ún?
- v. Njé itọ́jú náà ẹ́ yín lánfààní?
6. Kí ni idí pàtàkì tí ẹ lè sọ pé ó mú yín wá fún itọ́jú ní ilé iwòsàn?
- i. Léyìn ibèrè itọ́jú ní ilé iwòsàn njé ẹ tún lọ ibòníràn fún itọ́jú?
- ii. Bí bèè ni: Níbo?
- iii. Kí ni idí pàtàkì tí ẹ fi ẹ́ bẹ́?
7. Àwọn ilọ́júlẹ́ra wo ló lè şẹ́lẹ́ bí a bá pé láti gba itọ́jú fún àrùn ọmú.
8. Kí ni ẹ mò tó yẹ kí a ẹ́ fún itọ́jú tò péye fún àrùn ọmú?
9. Ta ni aláşẹ́ ibi tó yẹ kí ẹ ti lọ gba itọ́jú nígbà tí ara yín kò bá dá?
10. Njé ẹni kan tàbí ibi kan wà pátó tí ẹ ti n gba itọ́jú nígbà tí ara yín kò bá yá?
- i. Kí ló fà á tí ẹ fi n lọ ibè fún itọ́jú?
- ii. Kí ni àwọn ohun míràn tó n mú yín lọ síbè fún itọ́jú?
- iii. Sọ fún mi lẹ́şẹ́şẹ́ irú itọ́jú tí ẹ n rí gbà lẹ́hùn-ún?
- iv. Báwo ni itọ́jú ọ̀hùn-ún ti tẹ́ yín lórùn tó?
- v. Njé ó şèrànłowó?
- vi. Kí ni kò wúlò níbè?
11. Àwọn ohun wo ló lè mú yín mọ́ ibi tí ẹ ti lè lọ gba itọ́jú?

12. Báwo ni ibùgbé yín ti jìn sí ilé iwòsàn tó?

i. Njé ọ̀nà jínjìn ibúgbé yín sí ilé iwòsàn jẹ́ ohun idínà fún yín ní lílọ́ gba itọ́jú níbẹ́?

13. Báwo ni ẹ́ sáàbà tí n dúró pé tó kí ẹ́ tó lè rí Dòkítà ní ilé iwòsàn?

14. Kí ni irisí yín nípa idàhùn àti àlàyé àwọn Nọ̀rsì pẹ̀lú ẹ̀yí tí àwọn oníṣẹ́ itọ́jú n fún yín lórí àwọn ọ̀rọ́ tó jẹmọ́ àìlera yín?

i. Kí ni ẹ́ lè sọ nípa ịṣesí àwọn Nọ̀rsì pẹ̀lú yín?

15. Ìrànlowó wo ni ẹ́ n rí gbà láti ọ̀wọ́ idílẹ́ yín pẹ̀lú àwọn ọ̀rẹ́ yín fún iwòsàn yín?

i. Ta ni ẹ́ lè pè ní agbáterù ináwó fún itọ́jú yín?

ii. Kí ni wọn n ẹ́?

iii. Kí ni a lè ẹ́ láti ràn yín lowó?

16. Kí ni ẹ́ lè sọ pé ó jẹ́ àwọn ịṣòro pàtàkì tó dojúko yín nínú itọ́jú àìsàn yín yíí?

i. Bawo ni ẹ́ ti ẹ́ n dojúko àwọn ịṣòro yín náà?

17. Èkọ́ wo ni ẹ́ rí kọ́ nínú àìsàn yíí?

18. Ìmòrán wo ni ẹ́ ní fún àwọn obinrin tí àìsàn yíí n ẹ́?

19. Kí ni àwọn oníṣẹ́ iwòsàn, ní pàtàkì àwọn Nọ̀rsì, kí ni wọn lè ẹ́ láti ẹ̀tọ́jú tó gbésẹ́ tunbò sí i fún àwọn onírú àìsàn yíí?

20. Njé ohun miiran wà tí ẹ́ rọ́ pé ó yẹ́ kí n mò kí ịṣesí yín nínú irú àìsàn yíí lè yé mi dáràdàrà?

21. Njé ó ní ohun kóhun tí ẹ́ bá fẹ́ bèrè lowó mi?

Mo dúpẹ́ púpọ́ lowó yín fún ikópa yín nínú ọ̀rọ́ yíí.

Appendix L: Back-Translator's Oath of Confidentiality



**NURSING RESEARCH: Health-seeking Behavior of Women presenting with The
Advanced stages of Breast cancer in Southwestern Nigeria.**

BACK TRANSLATOR'S CONFIDENTIALITY CONTRACT

I have agreed to back translate the recorded interview by a doctoral student Agatha Ogunkorode

I understand that **CONFIDENTIALITY** will be maintained as I will **NOT** talk about the content of this interview. Participants' surnames and names will remain **ANONYMOUS**

This study has been reviewed by the University of Saskatchewan's Behavioural Ethics Board and has been approved as being ethically sound.

If I have any questions or desire further information, I may contact the research supervisors. Dr. Holtslander at 306-966-8402 or Dr. Ferguson at 306-966-6264.

I will **NOT** disclose the content of this interview to other people than the student

Back translator Name, Signature, and Date _____

Student's Signature and Date _____

Appendix M: Reflexive Journaling

“If not for my brother, I would have died.”

The family is a vital aspect of the Nigerian livelihood. During times of health and ill-health, the family is always there. The family always has a unifying force. Family members are always there for each other. They have always supported each other, and they have been there to help each other. “If not for my brother, I would have died”. Family members are always there to help and assist each other. Within the family, there is strong dedication to each other. The family is characterized by unity. All members are interested in the welfare of other members of the family. “My family visited the traditional healer and they brought different preparations for me to drink and to be rubbing on the breast.” Family support. Family dedication to each other. All family members look for remedy to ensure that a sick member gets well.

Faith, poverty, and healing

“I did not have money. So, I wanted to use faith to obtain healing.” This statement raises more questions. Is faith an antidote to poverty? What kind of solution does faith provide? Faith offers antidote to poverty not by way of technical solutions, but by way of moral solution. How does the researcher react to this conception between faith and poverty? How does the researcher react to the intellectual, moral, and spiritual connections evident in some study Participant?

I suppose, with faith in God comes the responsibility for the individual’s good. It seems to me that behaving responsibly towards oneself such as taking the appropriate measures to restore health when one is sick will be more pleasing to God than neglecting to do

so. What then is the appropriate measure? Appropriate measure depends on individual's perceptions and believes. Does individual perception mean irresponsibility?

Expecting miracles

Nigerians love miracles. "Doctor Jesus, who raised Lazarus from the dead will heal me", "I am hoping in God for my own miracles." God has done it before, He will do my own as well. What do our people need? Attitudinal changes? Can faith without action bring effective healing?

Poverty and anguish on people's faces

In the stories the participants shared, and the overall story uncovered by the interpretive analyses, the participants disclosed financial challenges. The need for financial assistance in managing breast cancer treatment is evident. They are longing for a kind of financial assistance in managing the illness. Poverty and anguish are written on people's faces.