Women's cultural perceptions and attitudes towards breast cancer : Northern Ghana

ASOBAYIRE, Alice and BARLEY, Ruth <http://orcid.org/0000-0003-0958-9619>

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Abstract

This study investigates problems confronting breast cancer awareness in Ghana by ascertaining how societal perceptions and attitudes influence women's awareness of breast cancer in the Kassena-Nankana district. Data was gathered through focus group interviews and documentary analysis of current practices within the region. Data was thematically analysed following an inductive analytical framework. The study concludes that women's perceptions of and attitudes towards breast cancer and its treatment are influenced by a myriad of economic and socio-cultural factors, which practitioners need to take into account when planning public health initiatives. There are a number of economic challenges facing breast cancer education and awareness programmes due to a lack of adequate numbers of specialised health personnel and breast cancer screening facilities in the district. Additionally, socio-cultural factors such as the absence of biomedical terminology in the local language, gender inequality and the prevailing influence of traditional health practitioners further compound the situation. Knowledge, awareness and attitudes of women towards breast cancer can also be improved if husbands of married women and respective community compound heads are targeted by public health educationists to get actively involved in education and awareness campaigns. The need to incorporate indigenous languages in public health educational materials for breast cancer in remote communities of deprived districts of Ghana is also recommended.

Background

Breast cancer is a critical public health concern that must be addressed by all community stakeholders. Evidence indicates a rising global incidence of breast cancer in developing countries, which hitherto recorded a low incidence of the disease (Opoku *et al*., 2012). Clinical studies from Sub-Saharan Africa show that breast cancer in native black African populations is often severe with adverse prognostic features (Gukas *et al*., 2005; Ohene-Yeboah and Adjei, 2012).

Possible explanations include young age at presentation, advanced stage at diagnosis, large tumour size, high grade histologic sub-types and low rates of hormone receptor positivity (Gukas *et al*., 2005; Clegg-Lamptey and Hodasi, 2007) explaining why African women are more likely to die from the disease than women from middle and high income countries (Ohene-Yeboah and Adjei, 2012). Recent evidence supports the divergent view that this reflects the late stage at diagnosis, lack of awareness, non-availability of screening methods and other epidemiologic risk factors (Ohene-Yeboah and Adjei, 2012).

There are many challenges to breast cancer control in low-and middle-income countries (Wadler *et al*., 2010). Health literacy, which can be defined as the ability to seek, understand and utilise health information, is important for good health. Nonetheless, knowledge of the aetiology and complications of breast cancer, in Africa as a whole, seem to have eluded many individuals across the continent (Briggs *et al*., 2010). Studies report that low levels of education and lower socioeconomic status are associated with advanced breast cancer at presentation (Elgaili *et al*., 2010; Ohene-Yeboah and Adjei, 2012).

Lack of access to orthodox health care is a critical issue in many developing countries (UN, 2007) with traditional medicine comprising the first source of health care for about 80% of the population (Leonard, 2001; WHO, 2011). Due to the prevalence of traditional healers' (THs) services there is an urgent need to integrate THs into modern medicine. The World Health Organisation (WHO, 2011) recently reported that despite progress many countries still face challenges, including unfavourable policy, economic and regulatory environments for the local production of traditional medicine. Researchers have urged policy makers for a number of years to learn from THs and include traditional methods in policy and practice (Hoff, 1997). Others have advocated for the regulation of THs and traditional medicine as well as the application of strategies and ways of aligning traditional healing with human rights frameworks (Richter, 2003).

Shrikant and others (2010), advocate that establishing a strong health workforce including community health workers (CHWs), in low and middle-income countries is necessary to address a community's basic health. Further, current innovative measures in health sector staffing suggest CHWs should be introduced to augment the work of orthodox health professionals. This is a new strategy of breast cancer care in sub-Saharan Africa (Wadler *et al*., 2010). Whilst data on breast cancer prevalence in Ghana, is limited, it is reported that 60% of 158 breast cancer patients reported to the Korle-Bu Teaching Hospital in Accra, only when their condition had deteriorated to stage III–IV of the disease: with an average duration of symptoms of 10 months. Even so, about 35% was lost to follow up (Clegg-Lamptey and Hodasi, 2007).

Additionally, there is a lack of a systematic national screening programme in Ghana, involving mammography to screen and identify women who may be at risk from breast cancer or have breast cancer and need further examination (Clegg-Lamptey *et al*., 2009). As a result, cancers are emerging as a significant public health problem (Wiredu and Armah, 2006). Breast cancer is a common cause of hospital admissions and mortality among Ghanaian women. In Ghana, women who are at risk and often diagnosed with breast cancer are very young between 40 and 49 years, thus breast cancer initiatives should target young women (Biritwum and Amaning, 2000; Wiredu and Armah, 2006; Ohene-Yeboah and Adjei, 2012).

Ghana's problem is compounded by a lack of modern health facilities with only three teaching hospitals in the whole of the country (Dzakah, 2010). The lack of a national breast cancer screening programme reflects the weak health care system and poor access to health facilities (Ohene-Yeboah and Adjei, 2012). The situation is worsened by resource constraints in the health sector as there were only 2,306 doctors in the country in 2010. The doctor-patient ratio was: 1: 9,455; the nurse-patient ratio was: 1:1,800; and the midwife-patient ratio was: 1: 7,600 in 2010. These present a serious challenge for safe motherhood services as the number of service providers, especially midwives are woefully inadequate (GSS, 2009; NPC, 2011).

The cost of breast cancer care is a critical issue in Ghana where breast cancer patients are required to make out-of-pocket payments to pay for their screening, diagnosis and treatment (Opoku *et al*., 2012). Ghana's overall poverty rate has reduced significantly over the past twenty years from 51.7% in 1991/92 to 28.5% in 2005/6. This indicates that the millennium development goal (MDG1) target of reducing extreme poverty could be achieved well ahead

of the 2015 target of 26%. Equally, the proportion of the population living below the extreme poverty line dropped from 36.5% to 18.2% over the same period against the 2015 target of 19%. Nevertheless, economic constraints are often reported as the over-riding factor that inhibits patients accessing treatment (De-Graft Aikins, 2007).

Gender inequality in a number of social, economic and administrative areas further compounds this problem (Clegg-Lamptey and Hodasi, 2007; Sossou, 2011). The status of women's health is reflected in indicators such as maternal mortality, contraception and abortion. High maternal mortality and low educational levels put women in a low social and economic status, which further limits their access to quality health care services (NPC, 2011). Despite efforts to increase girls' education, 54.3% of females aged 15 years and above had never been to school by the year 2000 (GSS, 2002; Sossou, 2011). In 2010, literacy rate for women in Ghana was 52% compared to 63% for men. Invariably, illiteracy among females is associated with high fertility and maternal mortality and low level of empowerment (NPC, 2011).

Ohene-Yeboah and Adjei (2012), linked low levels of formal education with a lack of awareness of early warning signs of breast cancer among their participants. Other factors that contribute to the long delay in seeking medical help for breast complaints in Ghana, include the prevalence THs who are accessible even in urban and semi–urban communities (Ohene-Yeboah and Adjei, 2012). Negative social connotations associated with breast cancer prevail (Wiredu and Armah, 2006). Research has shown that there is a relationship between traditional beliefs, values, and religion and health knowledge and perceptions (Avong, 2000; Tomlinson, 2003). Consequently, current policies incorporate the services of THs into the Ghanaian health care system (Mensah, 2000).

Cultural factors that impede the successful introduction of public health education programmes and directly influence women's health in the northern part of Ghana have been previously documented. The Kassena-Nankana people are polytheistic animists who worship ancestors and spirits and attribute most chronic diseases to supernatural forces (Adongo *et al*., 1997).

Additionally, there are further cultural challenges faced by women in accessing mainstream healthcare services in rural communities in the district. For instance, Ngom and others (2003) reported that women's autonomy (agency) is very low. When women or their children are sick, authorisation is required from compound members before attending a modern health facility.

These factors have a substantial impact on public health in these communities. Health initiatives, such as breast cancer awareness programmes, need to take these structural factors into account to ensure that initiatives are accessible to those they are trying to reach, empowering individuals to possess the agency they need to effect change[1].

The population settlement in the Kassena-Nankana District (KND)[2] is typified by the extended family system where people live in scattered compounds. These are usually headed by a male, known locally as a *Baga*, who is responsible for the social, economic, political and religious advancement of the members of the compound. As a result of this rigid socio-cultural community structure, the *Baga* is seen as a custodian of healing powers. Members belonging to these clustered families have a moral obligation to conform to acceptable behaviour and rules as defined by their respective compound heads (Ngom *et al*., 2003).

In view of the above constraints, Sossou (2011), advocates for the full political participation of women in the socio-political procedures in Ghana as a social justice and human rights issue that can transform social attitudes and wider cultural structures. Additionally, Opoku *et al*., (2012), suggest the need to develop an appropriate socio-economic and cultural specific model to improve breast cancer in Ghana. These should include the need to increase awareness and encourage women to undertake breast self-examination (BSE) [(Opoku *et al*., 2012)].

Theoretical Framework

Structuration theory was coined by Giddens (1984) to marry two principal elements of social thinking: structure and agency. Structuration theory endeavours to reconceptualise structure and agency as a mutually dependent duality with structure thought of as both the catalyst for and product of social action (agency). Thus agency is able to both reproduce and transform social structures (Giddens, 1984). Building on Giddens' work Stones (2005) has developed his theory of 'strong structuration' which retains Giddens' notion of the duality of structure whilst also arguing for the need of ontology-*in-situ.*

[1] Employing a structuration model structure and agency are understood as being intertwined with structure thought of as being both the catalyst for and product of social action (i.e. agency). Thus agency is able to both reproduce and transform social structures.

[2] KND is used to refer to the original KND in this study despite the creation (separation into) of Kassena-Nankana West and East districts.

Adopting a strong structuration framework this study analyses the perceptions and attitudes of women towards breast cancer in Ghana exploring the cultural context in which these women are social actors. Specifically, it focuses on women in the KND, one of the most economically deprived districts of Ghana (GSS, 2005; Ghana Districts, 2010). This article argues that public health practitioners need to take into account structural factors that can both be a barrier and a resource to the development and delivery of culturally appropriate public health initiatives.

Methods

Data was gathered through focus group discussions (FGDs) with women from the local community and documentary analysis of current practice in the region. Field research was undertaken in November, 2010. The following questions were examined: (i) what do women in deprived communities of the KND know about breast cancer and associated services? (ii) what are the challenges facing breast cancer awareness programmes in the KND? and (iii) how can women's knowledge about breast cancer be improved in the KND?

The Study Area(s)

The population of the KND, estimated to be 156,090 (GSS, 2005; Ghana Districts, 2010) falls within one of the most deprived regions in Ghana. The KND is the first and the only district in Ghana with a well-established and functioning medical research centre affiliated to its district hospital, the War Memorial Hospital (WMH) in the capital Navrongo. These institutions have increased public health knowledge in the district (Adongo *et al*., 1997).

Research Participants

Ten women representing the ten largest settlements of the population in the KND were selected for focus group discussions (FGDs): six farmers, two traders and two teachers. Farmers and traders belong to the informal sector, while teachers belong to the formal sector of the economy (GSS, 2005). The youngest participant was twenty-five, the oldest was fifty-six. Participants perform different leadership roles in their respective communities and had diverse social, economic and educational backgrounds, facilitating a balanced opinion during discussions (Ngom *et al*., 2003). Apart from two, all were married. Since all the participants could speak both Kassim and Nankam dialects, the FGDs were conducted in these languages. This was to understand how local dialects influence the design and implementation of public and reproductive health programmes in rural Ghana.

Focus Group Interviews

FGDs were split into two and held on two separate days, Tuesday and Friday, in Navrongo, the district capital. These days are significant as they fell on market days, where people from scattered villages and communities converge to trade. FGD were held in the late morning after participants had finished trading, finishing to allow participants to travel home via normal routes. Discussions were very open and frank as all discussants were female including the researchers. The socio-cultural context means that most Ghanaian women are particularly mindful of how they express their views in the midst of their male counterparts, especially when discussing issues relating to female anatomy.

Data Analysis

A digital voice recorder was used to record FGDs. Handwritten notes were also taken to capture non-verbal data. Recordings were played back to participants immediately after the FGDs to allow them to confirm what they had said. These were transcribed and subsequently translated from local dialects into English. Data was thematically analysed following an inductive analytical framework. Inductive analysis holds that patterns, themes, and categories of analysis emerge out of the data rather than being imposed prior to data collection and analysis (Srivastava and Hopwood, 2009). Analysis therefore involved reading the transcripts to identify frequently-occurring issues to allow patterns and themes to surface.

Ethical Issues

The research was conducted in line with principles of ethical practice. The research proposal was reviewed by the Department of Psychology, Sociology and Politics, at Sheffield Hallam University. In communities, access to participants was gained through community leaders. Participants signed a consent form after it had been translated and read to them allowing them to ask questions about the study. For those who could not read or write, their implicit approval was sought. Participant anonymity and confidentiality has been ensured throughout the project.

Results

This study found that structural factors can be understood as being both a barrier and a resource to public health promotion. In this section we will discuss our results in relation to both of these aspects.

CULTURAL BARRIERS TO BREAST CANCER AWARENESS

Education and language (in both formal and informal forms) are important components of any viable public health programme. The two teachers in the FGDs had obtained Diplomas in Education, the two traders had obtained Middle School Leaving Certificate (MSLC) and the remaining six had not had any form of education (were not able to read or write either in a local or foreign dialect). While the two teachers could speak other languages, all eight other women could only speak Kassim and Nankam. This influenced their level and appreciation of the topic under discussion with regards to appreciation of the concept from both linguistic and cultural perspectives.

Participants' understanding and knowledge of breast cancer was limited depending on whether they had ever experienced any breast conditions themselves or knew someone who had:

> *…sometimes, a woman's breast can be sore such that it is difficult to treat…this could lead to death…but we call it yil'le ngwoom dwongo (sore breast which will not heal)…(FGDP-9)*

As there appears to be no translation for the term breast cancer in either local language, a lack of knowledge of breast cancer can be seen as both confounding and being confounded by a lack of linguistic capital. Although the women who participated in the FGDs had some idea about breast diseases, and mentioned a range of breast conditions, which they argue are curable, they rarely associated these with breast cancer. While using the term *yil'le ngwoom dwongo*, which may be the nearest translation for breast cancer participants did not fully understand what breast cancer is as it pertains to developed countries. The term, *yil'le ngwoom dwongo* is accepted as a working translation for breast cancer in this research.

The most common breast disease that participants referred to is *yil'le fusem* (swollen breast), which usually occurs after a woman has given birth. Participants commonly thought that when a woman is unable to breastfeed after giving birth that this can lead to a swollen breast or *ngwoom pongwa* (a boil in the breast). This is understood to be a result of an accumulation of excess breast-milk. Herbal products are the most common method of treatment. These are thought of as being very potent for the cure of swollen breasts in women. Due to historical and cultural factors participants believe in the efficacy of these treatments.

Participants also held misconceptions as to what constitutes breast cancer explaining that sometimes women with large breast sizes have the propensity to be at risk of developing long

term breast cancer. However, a distinction was made between slim women with large breasts and women who are considered to be morbidly obese with bigger breasts. Women who experience excruciating pain in the breast or have *yil'le chichiu* (breast lumps) are also thought of as at risk as are those who have constant discharges from the nipple irrespective of whether they are breastfeeding or not. Some respondents also identified breast abscesses (*yil'le ngunim*), which will not heal as symptomic of breast cancer.

As participants have little knowledge about breast cancer, early detection is limited. Respondents, who had consulted a health professional with a breast-related problem, mentioned that they had been encouraged to examine their breasts on a regular basis. However, few reportedly, did so after leaving the health facility due to cultural taboos surrounding touching parts of your own body. With few Public Health Nurses working in the district, it is becoming increasingly difficult to further educate women on the importance of BSE while sensitively responding to cultural values and taboos. Additionally, few healthcare professionals working in the KND speak local dialects making communication between participants and professionals difficult. Participants were not only interested to know about the causes and effects of breast cancer, but were also eager to learn about how to identify predisposing factors. However, due to a lack of adequate health personnel this enthusiasm is not likely to be sustained.

Respondents especially, those without formal education perceived that breast cancer is a mere lump or boil. People who suffer from similar health conditions habitually consult THs within their communities as their first point of contact with a health provider. THs ply their trade by the use of selected herbs, leaves and barks and treat their clients through incantation and consultation with their deities. The belief that these providers possess supernatural powers, which they have inherited from their forefathers, cements their authority within the community:

> *…his ability to cure unknown diseases is like a form of inheritance in their family…his father and grandparents were very powerful when it comes to treating conditions that the hospitals cannot provide answers to… (FGDP-10)*

In many instances, their prescriptions for health conditions have proved very efficacious. They are consulted on almost every strange disease. It is only when they have not been able to provide a remedy that patients seek an alternative cure in orthodox medicine. This issue of patient delay, resulting from traditional beliefs is particularly important in relation to breast

cancer where early detection is imperative. Additionally, participants perceived that modern medicines/drugs are manufactured from herbs, concluding that there is no difference between modern and traditional remedies. Differences between these two forms of medicines are often highlighted as only relating to packaging and the personnel who prescribe them. Some participants had only ever used traditional remedies.

Economic factors were additionally cited by women as it is costly for people in the KND to seek orthodox medical attention. Respondents suggested that breast cancer screening should be free for women who are at risk. Another barrier is the lack of screening services in the KND as well as the cost involved in accessing these services at health facilities elsewhere in the country. Healthcare professionals are reluctant to tell women that the lump in their breast might need mammogram since there is a lack of access to mammography in the district. In the whole country, breast cancer screening facilities are only located in two teaching hospitals: Komfo Anokye Teaching Hospital in Kumasi and Korle Bu Teaching Hospital in Accra. The distance between Navrongo, the KND capital, and Kumasi is about 293 miles (471 km), while the distance between Navrongo and Accra is about 374 miles (602 km) [(Tripmondo, 2011)].

Low literacy (lack of numeracy and literacy skills in both local and foreign languages) among women in the KND additionally makes it difficult for women to access further information about breast cancer. The few available public health educational materials on breast cancer are only printed in English which is not commonly spoken in the district. Respondents suggested the need to develop breast cancer educational materials in local dialects. While this may be difficult and a perfect translation may be hard to find, participants agreed that the benefits of doing this would far outweigh the challenges since people literate in their local language would be able to explain the condition and its implications to their illiterate relatives.

A major problem identified as hindering community members' understanding of breast cancer is social stigma as 'breast cancer' is often viewed as a kind of punishment:

> *…we heard that a lady who travelled to the city came home to die with a strange disease that affected her breast…She was said to have done something wrong to someone who pronounced curses upon her… (FGDP-8)*

Within this discourse, whenever a woman suffers from an advanced form of swollen breast, the first process towards her treatment is to locate the cause of her perceived misdemeanour. Where THs are unable to provide a remedy, it is concluded that the woman might have been cursed. People begin to avoid sufferers, even though there may be no medical evidence or spiritual justification. Hence, women who experience a lump in their breast tend to initially hide it.

CULTURAL RESOURCES TO BREAST CANCER AWARENESS

Participants voiced suggestions for improving education about breast cancer in their own communities arguing that when women's knowledge and awareness about breast cancer is improved, it will reduce the delay in reporting breast cancer to orthodox health professionals. There is, therefore, a need for public health educationists and breast cancer advocates to intensify awareness campaigns in the district. Raising awareness is, however, only one factor within this process as cultural barriers also need to be addressed.

Any in-roads towards improving women's knowledge and attitudes about breast cancer should involve a strategy that aims to reduce social stigma:

> *…women who suffer from breast cancer could be perceived as witches…for instance, people can suspect that the woman has used her breast for ritual purposes or something like that… (FGDP-10)*

There is a need to challenge these perceptions so that women can openly discuss their breast problems without fear of stigmatisation. Community role models can be encouraged to get involved in breast cancer awareness and educational campaigns helping to reduce social stigma. Participants also suggested that there is a need to use both breast cancer survivors and sufferers in these campaigns. Community events such as durbars, festivals and other gatherings were identified as an appropriate place for promoting health education as the majority of community members attend. Additionally, it was suggested that health personnel organise special programmes for women.

Since strange diseases (such as breast cancer) are perceived as a punishment from the gods, this makes it imperative for women to consult the *Baga* in their position as spiritualists whenever they fall sick. Within communities, there may be some negative influences on

women's health as the male *Baga* might have limited knowledge about women's reproductive health issues. There is a perceived tension between the authority of *Bagas*, THs and orthodox health professionals:

> *…any attempt to reduce the social stigma associated with women who suffer from breast cancer should necessarily, have to involve the traditional hierarchy and other people who have a presence in the communities…the Bagas… (FGDP-2)*

Traditional religion has a mass following in the district. The role of THs was considered as very important in improving awareness of breast cancer. Hence, respondents suggested that if THs are well educated on issues of breast cancer and associated preventive services, they will be able to influence their communities in accessing orthodox medical facilities by giving them their blessing. This will also help reduce cases where THs promptly, prescribe herbs and other concoctions for conditions beyond their competences.

The establishment of Christian groups in the district is serving as the pivot around which people, and women in particular, engage with members of communities outside their immediate compound and kinship circles. Leaders of religious groups broadcast creeds in contrast to the traditional beliefs of the people in the KND. Participants unanimously agreed that the leadership of churches located in larger communities should be used as another medium for the spread of breast cancer awareness and education:

> *…this new phenomenon can be utilised effectively, in health promotion…this will be a low cost method towards addressing the problem… (FGDP-1)*

Due to the patriarchal hierarchies of communities, this however, cannot be the only form of education as ultimately *Bagas* and male family members can grant or deny women access to a medical facility.

Respondents also perceived that women's knowledge and attitudes toward breast cancer could improve if their husbands, in the case of married women, were also given some education. The customary marriage system bestows upon the man the responsibility for the economic, social and general welfare of his wife and her children. Since morality and chastity in marriage are held in high esteem by families, married women are required to inform and seek

authorisation from their husbands whenever they need to visit a health facility. A complication in the KND is that all the medical officers at the WMH (WMH, 2009) are male. This has both social and health ramifications:

> *…I cannot allow another man to touch my breast…I would be accused of being adulterous if found in such a compromising position…I do not want to be divorced, which will bring disgrace upon my family… (FDGP-8)*

The above quote shows how power and health issues are negotiated between married couples. Men continue to exercise enormous authority over their wives. Women also feel obliged to respect their husbands' views as divorce is seen as a sign of failure and disgrace not only to the woman involved but her entire extended family. When husbands have a better appreciation and understanding of the dire consequences of breast cancer, it is hoped that they will willingly permit as well as provide the needed funds for transportation to enable their wives to report to modern health facilities when women identify a lump in their breasts.

Participants suggested that women's groups in the district can also be utilised as a cancer awareness campaign tool. The formation of social groups is a key feature in the district. Separate (gendered) meetings are held when major decisions are being taken pertaining to social, economic and political issues in the community. This structure could be used to the advantage of breast cancer advocacy groups:

> *…the cultural practices of the people in the communities will encourage women to freely discuss issues of breast cancer at their separate group meetings… (FGDP-4)*

Participants agreed that using traditional groups and communication methods is an important tool to improve the knowledge and attitudes of women of all ages about breast cancer.

Discussion

This study found that respondents' knowledge and awareness of breast cancer was largely influenced by their level of education and their linguistic capital. In Ghana, it appears that women with low levels of educational attainment are much more predisposed to the disease due to their lack of awareness. Ohene-Yeboah and Adjei (2012) suggest that improvements in levels of education and general socioeconomic conditions is likely to lead to a reduction in the number of women who present to the hospital with advanced breast cancer.

Formal sector workers in the FGDs showed a sense of awareness of some major public health conditions, including breast cancer, even if they could not identify their causes and treatment options. A major cause of the problem, which equally affects the perception of respondents with regards to their knowledge of breast cancer, is the language used to describe it. This finding is similar to the observation made by Adongo *et al*. (2005) that health workers often translate what the community describes as *pua* as 'malaria'. The local word of a health condition can be a determining factor in people's knowledge of a condition and subsequently its impact in the community. This study raises the issue of translation, which as we have seen in the KND, affects the impact that health education can have on a population in regards to delivering breast cancer awareness programmes.

Respondents' view that women with large breasts have the tendency to be at risk of developing long term breast cancer. Invariably, respondents who have not had any formal education perceive that breast cancer is a disease that affects formally educated women, the affluent and people who have travelled to big towns or cities. A similar finding is reported by some researchers that malaria is seen as an illness of the formally educated as it is a concept that is rarely discussed in local communities (Adongo *et al*., 2005). Research in Iran and Saudi Arabia has discovered similar findings both in relation to breast cancer and public health in general (Jain and Agrawal, 2003; Tomlinson, 2003; Parsa and Kandiah, 2005).

This study finds that there are numerous structural challenges facing breast cancer awareness programmes in the KND. Public health educators need to devise culturally appropriate strategies to enable them to improve breast cancer awareness campaigns. For this to become a reality, it is important for health personnel to learn and understand local languages (Ohene-Yeboah and Adjei, 2012). As Briggs *et al*. (2010) note, improving health literacy amongst community members is key to raising awareness. This study also contends that staffing shortages can be reduced if CHWs are trained to implement awareness programmes. Research has shown that CHWs who understand the socio-cultural context, and share a life experience with community members, are important in the delivery of public health services (Wadler *et al*., 2010).

To fully utilise this resource, this study suggests that professional health workers should be posted to communities to train and support CHWs giving them information and resources to

effectively implement awareness programmes. Revolving around the tenets of primary health care ideology, this will create a synergistic health care delivery system by utilising both modern and THs (WHO, 1978). The above strategy could be particularly effective in rural communities, like the KND, where many professionally-trained health personnel refuse postings due to a lack of social amenities, health facilities and equipment (MOH, 2005).

This study also found that respondents believe certain myths about breast cancer. These myths are entrenched in traditional belief systems. A similar observation has been made in the KND (Ngom *et al*., 2003; Adongo *et al*., 2005) and elsewhere in Ghana (Tabi *et al*., 2006) where THs claim that they possess divine sources of healing. This study observes that individuals seek traditional remedies irrespective of their level of education: formal or informal. In Nigeria, Avong (2000) additionally argues, that policy makers need to take account of traditional beliefs to ensure that policies are effective.

This study also shows that different opinions exist regarding the contributory factors impeding women's access to breast cancer diagnostic mechanisms. Parsa and Kandiah (2005) suggest that effective public screening needs to be initiated in PHC settings in order to make it easily available to all women. Supporting this context-defined approach in the communities of sub-Saharan Africa, Wadler *et al*. (2010) contend that breast cancer screening can be woven into existing infrastructures already prominent in many middle-income countries. In doing so, women's attitudes will change as they become familiar with, and see the benefits of, these techniques.

Due to the cost implication involved for women in KND in accessing breast cancer screening facilities in Ghana's two teaching hospitals this study reveals that women should be educated on how to practice cost-effective procedures such as BSE. A similar observation is made by other researchers in Latin America (Anderson and Cazap, 2009). To alleviate unnecessary fear, BSE techniques need to be taught as part of a wider breast cancer education programme (Parsa and Kandiah, 2005). Aylin *et al*. (2005) suggest that women's own knowledge and involvement will be crucial in the early detection of, and considerable reduction of social stigma about, breast cancer. This study supports this assertion.

Literature shows that the problem of stigmatisation and discrimination against sufferers of chronic health diseases such as breast cancer emanates from a lack of knowledge about the

causes of specific health conditions (van Helden, 2003) leading to some people perceiving it as a punishment from god (DFID, 2006). This study reveals that the over-riding perception in the KND is that any 'strange' disease, has a spiritual origin. Consequently, social stigma, as Baiden *et al*. (2007) previously indicated, appears to be a major problem in the region. Communities in the KND perceive that women who die from incurable diseases are a disgrace to themselves and their respective families. Indeed, the spiritual and supernatural attributes of breast cancer is prevalent in Ghanaian society (Opoku *et al*., 2012). Erroneous ideas about breast cancer could be changed by rigorous education to improve the knowledge of women at risk.

A key resource in ongoing research and implementation towards breast cancer awareness programmes in Ghana is the Breast Health Global Initiative (BHGI), which has opened the BHGI Learning Laboratory in Kumasi, with the aim of training a new set of breast cancer health practitioners (Wadler *et al*., 2010). However, this study advocates that public health education on breast cancer in the KND needs female personnel with specific skills, cultural capital, including local dialects and an awareness of cultural barriers to health care provision in the area.

This study also observes that some traditional remedies can mask breast cancer recovery by temporarily reducing swelling and other symptoms. Communities, therefore, need to be educated about the 'false cures 'of certain remedies, which in the long run can cause more problems as patients do not seek advice from conventional health workers before it is too late. Additionally, education about the causes of breast cancer is needed. Health workers should not dismiss traditional remedies as long as they are not doing any harm, but try to get THs to work alongside health workers by promoting both traditional and conventional cures. This approach values THs authority while also ensuring that patients will access conventional treatment. By gaining the THs approval, health workers may be able to convince more patients of the benefits of conventional medicine. A collaborative health care delivery strategy would help bridge the knowledge gap between orthodox and traditional medicine, an approach advocated by the World Bank (2010).

Cultural factors that impede the successful introduction of public health education programmes and promotion of women's health in the northern part of Ghana have been previously documented (Adongo *et al*., 1997). This study also observes that socio-cultural norms have

implications for the ways that breast cancer education is disseminated in the KND. Ngom *et al*. (2003) explain that *Bagas* have the authority to allow or forbid a community member to access a health facility. Therefore breast cancer awareness programmes within the current health financing arrangements in the KND require the active involvement of husbands and *Bagas* to ensure their effectiveness. A similar view has been expressed recently by Opoku *et al*. (2012).

This is due to two main reasons. Firstly, there are the customary implications of a male health personnel conducting critical breast examination of a married woman. Secondly, there are socio-economic implications as married women in the communities are predominately financially dependent on their husbands. These factors, often unknowingly, perpetuate women's inequality as women's health is viewed purely as reproductive health perpetuating their role as mothers and wives. By promoting the reality of breast cancer, as a disease that affects all women not just mothers this perception of women can be broken down as women and women's health, begins to be viewed as more than just reproductive. A similar situation has been reported in Uganda (Kiguli-Malwadde *et al*., 2010).

Leadership of women's groups are an effective channel that can be used to change the perception and attitudes of women about breast cancer. The effectiveness of these groups has been identified in the area of health financing in the KND where Akazili *et al*. (2005) found the existence of risk sharing groups like *ananoore* (women's groups) and church groups whose members contribute money that is used for funerals and other general needs. The same mechanisms could be applied in breast cancer education and awareness programmes.

Conclusion

This study explored the perceptions of a small group of women from KND uncovering their understanding of breast cancer and suggestions for improving awareness and treatment in their communities. Building on this exploratory study, future research should seek to increase the sampling framework using quantitative approaches; to include respondents from all communities in the district. Future studies should also seek to combine the views of women, married men and *Bagas* in order to understand how men understand breast cancer and their views towards treatment.

The main themes developed through this study could serve as the basis for the development of future research. Research into any public health problem requires understanding of the cultural

context (structure) and the agency of community members. Lack of literature alongside a paucity of regional and district level data on breast cancer in Ghana reveals a specific gap in policy and practice. This research begins to fill this gap though more research in this area is still needed.

Our research findings show that women at risk are not aware of a number of issues relating to breast cancer. The lack of health personnel and breast cancer advocates needs to be addressed taking into account the social and cultural context. Consequently, sustainable breast cancer education programmes should not only involve local women, but community heads/*Bagas*, husbands and practitioners of traditional medicine. Professionals also need to be trained as to the most appropriate forms of dissemination allowing for the economic and cultural context in which they will be working to ensure that delivery is feasible and supportive of women's holistic wellbeing.

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