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Treatment Choices of Breast Cancer: Do Socio-Demographic Characteristics of Patients Influence the Type of Treatment Sought? The Chronicles of Some Ghanaian Patients at the Cape Coast Teaching Hospital

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Abstract

Cancer of the breast is undoubtedly one of the leading public health concerns of women. A woman's survival odds are extensively dependent on regular screening, early diagnosis, and prompt treatment. Empirical studies have suggested that the urgency to screen for possible malignant growth, early diagnosis, and the type of treatment sought, are based on a plethora of reasons, with the socio-demographic dynamics of patients being a crucial factor. If socio-demographic dynamics have the propensity to drive women to seek treatment or otherwise, then there is the need to interrogate further how these dynamics influence their treatment choices. As such, the aim of the study was to explore the influence socio-demographic dynamics have on the treatment choices of patients. The qualitative research approach informed the methodological orientation of the study. In-depth interviews were conducted to elicit information from twenty patients at the Cape Coast Teaching Hospital. Three treatment types were identified as the preferred options of patients. To a very large extent, the age and marital status of patients influenced the type of treatment sought. The paper recommends that due to the high cost of treatment and management of breast cancer, the National Health Insurance Scheme should cover some aspects of management to reduce the treatment burden on patients.

Subject Areas

Oncology

Keywords

Breast Cancer, Socio-Demographic, Treatment Choices, Orthodox Medicine, Alternative Treatment

1. Introduction

A woman's intention to undertake cancer screening or report timely for diagnosis is hinged on several reasons such as susceptibility to cancer, and family history among others. Socio-demographic characteristics like age, marital status, education, occupation, and income, have been advanced as determinants for a woman's willingness to seek swift medical aid [1] [2]. The discussions below expatiate the tenets of socio-demographic dynamics in the health-seeking behaviour of cancer patients.

Some researchers have argued that higher formal education status surges screening participation and early diagnosis because women with advanced formal education statuses often participate in cancer screening programmes and they have the tendency to report the signs and symptoms of breast cancer early for diagnosis. Elsie *et al*. [3] for instance reiterated that, women who have a primary level of education or higher, patronized breast screening more than those without any formal education. This is because educated women have the advantage to access information on the risk factors and symptoms of the illness and can comprehend the recommended health guidelines. Augmenting the above, Opoku and colleagues' study in Ghana found that, highly educated women were more likely to have clinical screening than their uneducated counterparts [4]. In addition, they observed that compliance with treatment was more profound among the educated women than it was in the less and non-educated women. Ohene-Yeboah & Agyei [5] also revealed that the majority of the highly educated women had better knowledge of cancer risk factors and symptoms and screening techniques than those who were uneducated. Other socio-demographic determinants measured closely with education, are occupation and income. To Remennick [6], the level of education is a viable indicator of better jobs and higher incomes. Thus, presumptively, the higher the level of education the better the job and income level which give the individual the capacity to subscribe to health-enhancing goods and services, such as hospital services and healthier foods. Ndikom & Ofi [7] similarly describe that in Nigeria the uptake of cancer screening especially mammography was not encouraging among low-income women, whereas, highly paid professionals showed more interest in screening and complied with the health recommendations. In Ghana, women in low-income jobs were found less likely to undergo mammography screening than women with higher income statuses [5] [8].

For age, several studies have conveyed that screening intention has consistently been associated with older ages [9] [10] [11]. The rate of screening inten-

tion is often predominant in older women because breast cancer risk increases concurrently with age.

For Gender, Uskul [12] argues that the gender roles of women largely inform their health-seeking behaviour. To Uskul, if their priority is about satisfying the needs of their families (that is performing the roles as mothers and wives) than their health, they are less likely to seek medical attention.

Christou & Thompson [13] intimated that for marital status, few studies have found a relationship between it and screening intentions of women. According to them, findings on the influence of marital status on screening intentions are mixed. For example, Ohene-Yeboah *et al*. [14] in their study revealed single women are more likely to patronize screening; while the findings of Dei [15] and Clegg-Lamptey *et al*. [8] proved otherwise, as married women are more likely to patronize breast cancer screening. Another dimension of marital status is patriarchal undercurrents. Some scholars have discussed patriarchal nuances as a hindering element to married women accessing health services. As an illustration, Kawar [16] described that in Jordan, many husbands are reluctant to permit their wives to visit or access physicians for screening and diagnosis, since they would have to expose parts of their bodies for physician examination. This usually curtails women's freedom to make decisions regarding their health. Similarly, Asobayire & Barley [17] explicated that in Kasina Nankana, the marriage and family setting are highly patriarchal thus married women are obliged to inform and seek approval from their husbands whenever they need to visit a health facility. Visiting a hospital to disrobe and be examined by a medical practitioner is an uncomfortable situation for women hence reluctant to go for medical screening.

The habitat of an individual is a contributing factor to screening intentions. People living in urban areas have a higher tendency of having intentions for screening as compared to those in peri-urban and rural areas. This is often due to the availability of modern health facilities [14] [18].

The forgoing presentations have demonstrated the bearing of socio-demographic characteristics on breast screening participation by women. Cancer of the breast is an invasive cancer, with the disease occurring more commonly among Ghanaian women. To Dei [15], it is the major cause of mortality among women in Ghana. Opoku *et al*. [4] set the incidence rate at 26.4 per 100,000 every year making it the most commonly occurring cancerous growth in women. In as much as a woman's survival chances depend on early cancer screening and medical care, the kind of treatment sought is equally vital as it determines her survival chances. In every medically diverse society, there are varied treatment options to explore, with each promising an efficacious treatment for diseases. In the advent of the disease, the pertinent questions enquired are, what treatment preference do women living with the disease prefer? Do their socio-demographic characteristics influence their treatment decision (*i.e.*, orthodox or alternative or both)? Are the dynamics aligned to a particular treatment type? These interroga-

tions shaped the basis of the research. The tenet of this study is not to present statistical values/association between socio-demographic characteristics and treatment options, but the relevance of it is to provide an in-depth description of the extent to which patients view their socio-demography as an instrumental factor in their choices of treatment. Also, it is to contribute to empirical data on breast cancer discourse.

2. Methodology

The study employed the qualitative research approach. This method of inquiry is grounded in reporting the expressions of people on how they make sense of their experiences [19]. This approach was adopted to explore and generate much information as possible from the study participants on how their demographic elements influence their treatment choices. The study setting was the Cape Coast Teaching Hospital. The hospital is a referral facility with 400-bed capacity. The hospital provides specialist services such as surgery, endoscopy, orthopaedics, obstetrics and gynaecology, pathology, and neurosurgery, among other medical services. Cape Coast Teaching Hospital was selected because it has a Breast Clinic which receives patients from all over the country. The Breast Clinic is resourced with state-of-the-art equipment and is staffed with a team of surgeons, radiation oncologists, and nurses.

In recruiting participants for the study, purposive, convenient, and referral sampling techniques were adopted. Twenty patients participated in the research. For the exclusion criterion, patients who were yet to receive confirmation of having breast cancer were exempted, because the experiences of women who have been diagnosed and living with the disease were of interest to the study. The patients/participants were categorized into two groups. The first group consisted of women who were diagnosed with breast cancer and were undergoing treatment at the hospital. The second cohort was the friends and family members of the first group, who had been diagnosed with the disease but had not visited the hospital for treatment.

In-depth interviews were used as the data collection tool. It provided participants the opportunity to describe in their own words, their experiences as patients living with breast cancer. As an ethical requirement, clearance was given by the Hospital Ethical Board. Also, participants were informed of the purpose of the study and their right to withdraw from it at any given time. They were assured of confidentiality of disclosure, thus all names as seen in the data are pseudonyms used by the participants.

The data was collected in 2017 within a period of four weeks. Each interview session lasted for an average of thirty-five minutes. Responses were audiotaped and transcribed. The transcripts were given back to the participants to confirm if the information reflected their narrations. After the validation process, themes were generated out of the data. They were developed manually using Thematic Analysis Approach [20]. The data were subjected to the six rigorous phases of

the Thematic Analysis Approach namely, familiarizing with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and lastly producing the write-up from the data.

3. Results

3.1. Treatment Types Available to Patients

Although the focus of the study was to explore how socio-demographic characteristics influenced patients' treatment choices, it was however important to find out the kinds of treatment patients were keen on patronizing. Three treatment types were identified as the preferred options. These were **orthodox treatment**, **herbal treatment**, and **spirit-herbal** treatment. They described the orthodox treatment as the treatment offered in a health facility. The herbal treatment is delivered by herbalists and finally, spirit-herbal treatment is provided by a spiritual figure who combines rituals and herbs for the treatment of breast cancer. For most of the patients, these treatment variants were often not singly solicited. The needs of the individual defined the kind(s) of treatment sought. The populous combinations were; orthodox &herbal, and orthodox & spirit herbal. Their preferences had a blend of socio-demographic forces and what they deemed as an effective treatment.

3.2. Socio-Demographic Characteristics and Treatment Choices

Table 1. Demographic characteristics of participants.

Demographic Variables		Number of Participants
Age	<30 years	3
	30 - 40 years	10
	50 years and above	7
Marital Status	Single	6
	Married	9
	Divorced	3
	Widowed	2
Formal Educational level	No formal education	3
	Junior High School (JHS)	5
	National Vocational Training Institute (NVTI)	2
	Senior High School (SHS)	7
	Diploma	3
Occupation	Teachers	6
	Traders	9
	Caterers	3
	Farmers	2

Continued

Religion	Christianity	11
	Islam	4
	Traditional	3
	Others	2
Location of Participants	Rural	3
	Peri-urban	5
	Urban	12

The results reflected the expressions of patients who subscribed to orthodox treatment, those who had defaulted, and patients who patronized a blend of the two. To this end, six socio-demographic categories namely age, marital status, formal education, occupation & income, religion, and location of patients were explored. (**Table 1**) It was gathered from the data that, socio-demographic characteristics influenced patients to either default or continue orthodox treatment. The level of influence varied, as some characteristics were much more prominent than others. The outcomes are therefore presented below.

3.2.1. Age of Participants

The younger patients were more "daring" in their search for well-being. The data showed that eight participants had not been to the hospital after diagnosis and were receiving alternative treatment. Three women who were undergoing treatment at the hospital indicated their desire to explore other options for holistic well-being. These were patients below 50 years and they reckoned that trying other alternatives to identify the most effective, is important. Conversely, the older patients were not prepared to "gamble" with their lives. They were skeptical about seeking alternative health because to them the orthodox treatment is more effective than the other options.

3.2.2. Marital Status

As the divorced and the widows continued with the treatment, the single and the married often evaded orthodox treatment and patronized alternative treatment. The singles and married cited the fear of losing their breasts and the resultant adverse effects on their intimate relationships as the primary motive for occasionally absconding from medical treatment. There was a misconception among patients that loss of a breast is associated with orthodox treatment, thus, there is no need to take chances but look for other treatments which often promise absolute treatment without any loss of breasts.

Below are some accounts of patients showing different concerns:

"*I am single, I am due for surgery meaning they will remove my breast. How would I get a husband*" *This means I will not give birth, because I do not think any man would be interested in a girl with no breast like me. If I am unable to marry or give birth then I have failed as a woman and I can't*

be compared to other women. [*she cries uncontrollably*]. (Grace, 21 years)

"*My concern is; my breast will be removed. It has been part of me for ages now. I am going to lose it. Also, how would I feel as a woman without breast? The breast is very important. It shows that you are a woman*". (Renee, 40 years)

"*This illness affects your self-esteem as a woman. The thought of losing your breast is scary. You know that something valuable is gone. When I get intimate with my husband, it is never the same as before I had the illness. Although he says it is okay, I know it is never okay. It is a very disturbing moment for me*". (Ama, 35 years)

"*I am not worried about my breast. I am old and what do I need this* [*pointing to the infected breast*] *for*" *I am blessed with five children; my husband is late. At this age am I now going to marry*? [*laughs loudly*] *as for me, if removing the breast will save me why not. I am concern about getting healed and not thinking about losing my breast*". (Esi, 60 years)

"*Young ladies are the ones who get more worried and cry. In my view, their health is much more vital than the breast they cry over their breast. If the doctors do not remove the breast and you die, what will be your gain*? *As for me when I was told they have to remove the breast, I just asked them to proceed. Now I have done the surgery and am living*". (Sabina, 68 years)

3.2.3. Formal Education Level

Though the formal education level of patients was generally low, the few ones with relatively high formal education (Junior High School (JHS), Senior High School (SHS), National Vocational Training Institute (NVTI), and Diploma) did not only resort to orthodox treatment but patronized alternative treatments like herbal medicine and spiritual assistance. A detailed analysis of the data sets showed that the level of education was overshadowed by age and marital elements. The single and the married formed majority of the educated participants and as deliberated earlier, for these cohorts, it was about getting healed and saving their breasts. Essentially, any remedy, which promises total healing, was sought after.

3.2.4. Occupation and Income

Generally, the women acknowledged that treatment of breast cancer in any form is expensive. Even women who had appreciable earnings admitted it was a heavy drain on their pockets due to the regular visits to the hospital. Participants specified further that the payment schedule for alternative treatment was flexible as payment could be made in installments. This was not the case for orthodox treatment where patients had to make an upfront payment before treatment commenced. This made the alternative treatment an attractive option to consider.

A twist, which aligned exclusively with occupation, was some patients' expressions of spiritual occurrences linked with their occupation. This was commonly asserted by retailers and farmers. Patients in this category were more likely to

abscond from orthodox treatment. The traders reasoned that their line of work has a host of envious business partners and shop neighbours as well as malicious spirits in the offing to cause mayhem to prospering individuals. In their view, cancer of the breast is not natural and its cure goes beyond orthodox treatment so they resolved that they cannot get cured in the hospital. Concerning the farmers, they explained that owing to the nature of their work, they come into contact with a lot of spiritual occurrences which could be responsible for them being stricken with the ailment. They expressed the following views:

> "*The job I do is full of bad people who are envious of my success. Before I was diagnosed with the illness, I went to my shop and saw some particles in front of my shop and I swept them off. I started sweating profusely few hours after sweeping the particles away. Two weeks after this incident, I had severe pains in my left breast. I have been diagnosed with the illness but when I reflect back, I think someone sprinkled the particles at my shop. I have been visiting the hospital for a year now and I am not getting any better. Some of my friends* [*referring to other breast cancer patients*] *are healing faster than me, meanwhile, I came to the hospital before they did. I have decided that if I don't see any big improvement in my health this year, I will look elsewhere because it a spiritual attack and I don't think they* [*referring to the health workers*] *can help.*" (Yankee, 45 years)
>
> "*My occupation* [*farming*] *is risky because people do all manner of things to own one. Even when the land is yours, people would want to take it from you. They even go to the extent of casting spells and incantations so that something evil will happen to you, and they will take over the land. I inherited my farmland from my maternal grandmother, and since then there have been clashes from my extended family. Some have threatened me physically, others have invoked curses. I think breast cancer was a curse invoked on me by some of my family members*". (Rose, 45 years)

3.2.5. Religion

The treatment action a patient took was informed by the doctrines of the religious assembly the patient belonged to. Those whose beliefs resided in the fact that adversities do not ensue in the vacuum but then are triggered by unforeseen forces, settled for alternative treatment after being diagnosed with the illness. They were hooked on faith-based healing. They depended on their spiritual heads for prayers, fortification, and herbal treatments. Contrariwise, those whose religious ideologies were not in contradiction with seeking orthodox treatment, were more likely to carry on with treatment. Below are some sentiments shared:

> "*In my religion we are advised to seek medical treatment when we are sick. When I was diagnosed with the illness, I informed one senior nurse about it, she told me to get medical help quickly. So, in my religion, although we pray for healing, we believe in visiting to the hospital for medical attention*". (Yaa, 68 years)

"*Things just not happen for no reason. Any occurrence which happened in the physical had already happened in the spiritual. Anything I do I seek spiritual guidance. It is alright to go to the hospital but one still needs spiritual guidance.*" (Benedicta, 48 years)

"*I am a believer of herbs and other spiritual fortifications. As humans, it is important to fortify yourself against unforeseen attacks. After I was diagnosed, I realized I needed to fortify myself very well. Therefore, I have been using herbs on the infected breast and I bathe with the herbs. That's why I don't go to the hospital*". (Vim Mama, 55 years)

3.2.6. Location of Participants

The patronage of a particular treatment over another was contingent on factors like the accessibility of diverse treatment options and nearness to a health facility. Having different treatment options in a locality presented patients with the opportunity to either maintain or escape orthodox treatment. For nearness to the health facility, participants narrated that proximity to a health facility motivates an individual to carry on with orthodox treatment. They observed that breast cancer treatment together with transportation charges is exorbitant, therefore when the treatment center is far-off, it could be demotivating for them.

4. Discussion

As typical of every study, participants had varying socio-demographic characteristics. In as much as each dynamic played a significant role in treatment choices, the extent of influence was different. For example, the age and marital status of patients intimately influenced their treatment preferences as against education. For age, though in most literature, breast cancer is described as an illness that affects women at their post-menopausal age, in this study, patients' age distribution however showed that women in their premenopausal and menopausal periods were more affected by the illness. This could mean that breast cancer is no longer "an illness for the old" as in Ohene-Yeboah & Agyei [5] study it was reported that most of the study participants were below 50 years.

Many of the patients who were below the 50-age cohort often patronized alternative treatment. This is quite interesting because all other factors being equal, young people are most likely than their older counterparts to fancy modern treatment, as in the case of orthodox medicine. It is assumed that they would appreciate orthodox medicine better than the older ones who are likely to recoil from modern medical treatment because of their exposure to traditional outlook. However, this was not the case in this research. Younger participants were more "audacious" in the pursuit of their health. A probable justification is that young patients are much more concerned about their appearance so they were prepared to explore all avenues to recuperate and more importantly, save their breasts.

Sentiments by the young, single, and married are expected taking into consideration their age and marital status. A critical analysis of their narratives showed

that body image was a major concern. Changes in their looks made them feel that they had lost a vital part of their body. They no longer felt feminine enough. The breast is appreciated as a medium that connects women to their gendered roles. Deformation of it alters the social roles of women as wives and mothers. This creates a sense of failure and disengages them from looking normal like other healthy women. As Karbani *et al.* [21] and Vieira, *et al.* [22] pointed out, women are constantly competing with one another for the attention of the opposite gender. For this reason, one must be physically attractive since there would be strong competition in the affective-sexual market. If their claim is anything to go by, then it stands to reason why the young, single, and married women were concerned over the loss of their breasts and rigorously sought other treatment because a defective breast signifies that she is no longer able to fulfill her reproductive and erotic functions.

Education has the propensity to challenge the philosophy/beliefs of people and question the status quo. Formal education presumably creates the avenue for people to become objective as they require more scientific evidence for any explanation of events. Contrary to the popular argument elucidated by Elsie *et al.* [3], Opoku *et al.* [4], and Dei [15] that educated women are more probable to patronize medical screening than none educated, it must be appreciated that in terms of treatment, the undercurrent is different. It is about which treatment option is capable of administering complete wellness to meet their health needs, regardless of the outlook of the treatment type.

Undoubtedly, treatment and management of breast cancer are expensive. Numerous health and social needs are competing for the same resource/income of the women. When there are no subsidies or insurance coverage, and one has to make an upfront payment each time visitation to the hospital is made, obviously the cost would be a pain in the neck of patients. It is not surprising some of the women sought care at alternative places due to their relatively flexible mode of payment.

The expressions of malevolent spirits as responsible for their predicament and the reliance on religious doctrine as a basis in selecting a treatment type demonstrate that religious ideologies and the fear of the unknown are formidable concepts that infiltrate and cement perceptions of people. This is comparable to Twumasi [23] and Suh's [24] study where it was revealed that in the African context and more especially in Ghana, spirituality and the fear of the unknown is an opium which permeates facets of an individual's social being. Thus, it was not surprising the opinions of some participants reflected so.

The result on patients' habitation showed two angles which were the closeness to a hospital facility and the concentration of diverse treatment in a locality. For those close to health facility, it was easy accessing the facility and vice versa. Participants who had an assorted treatment options applied "variety is the spice of life" to their treatment choices, where they explored other options. This finding concurs with similar studies of Pei & Rodriguez, and Ohene-Yeboah *et al.* [14]

[18] who stated that habitation contributes to the screening intentions of women.

5. Conclusions

To sum up, the purpose of the study was to examine if patients' socio-demographic dynamics had the capacity to determine the kind(s) of treatment sought. Consequently, twenty patients living with the illness were interviewed to present their accounts. The conclusion drawn from their narratives suggests that socio-demographic characteristics shaped their treatment patterns. It was evident that the treatment of breast cancer did not only lie in the bosom of orthodox treatment but three treatment types (**orthodox**, **herbal**, and **spirit-herbal treatments**) were identified as the desired options.

The level of influence of socio-demographic dynamics was not homogenous. Age and marital status to a very large extent influenced patients' continuity of orthodox treatment or otherwise. Patients who were fifty years and above were more stable in their search for treatment as they were not particularly concerned by the changes in their appearance, unlike the younger women. To the younger women, any remedy, which guaranteed complete healing, was pursued. The influence of education was not striking because it was eclipsed by age and marital factors. Flexible payments characterized by alternative treatment enticed some patients, also, the seeming spirituality linked to the causes of breast cancer, gave some patients the inkling that treatment extends beyond the borders of orthodox treatment.

6. Recommendations

Based on the findings, the following are recommended:

- We recommend that due to the high cost of treatment and management of breast cancer, the National Health Insurance Scheme should cover the cost to reduce the treatment burden on the patients. Also, in the absence of insurance cover, hospitals can create breast cancer funds to support the women and also have a flexible payment schedule so to attract more patients.
- Clinicians must be aware of the influence socio-demographic characteristics have on treatment choices. Such understanding will aid them, especially the public health and the community health nurses, to identify groups that tend to abscond from treatment or combine treatment. Being privy to reasons why some patients are more likely to seek other treatments, will help the health workers to adopt an approach or interventions which will encourage and educate women on the possible negative effects of having more than one treatment option.
- Authorities such as the Food and Drugs Authority, the Center for Research into Plant Medicine and Standards Authority should identify alternative health practitioners and scrutinize their activities/treatment to ensure that treatments are safe for anyone who would want to patronize their services.

Conflicts of Interest

The authors declare no conflicts of interest.

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