

A Qualitative Study on Black African Female Postgraduate Students' Beliefs and Understanding of Breast Cancer

By

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DECLARATION

I declare that this research thesis titled: **A Qualitative Study on Black African Female Postgraduate Students' Beliefs and Understanding of Breast Cancer** is my original work, except where otherwise stated. I declare that this thesis has not previously been submitted for any qualification at any other university. **I have acknowledged all sources in the reference list.**

Londiwe N. Nyandeni

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DEDICATION

To my parents, Mr and Mrs D. Nyandeni, and my sister Mrs Gugulethu Nyandeni-Dube. Niyohlezi nisenhliziyweni yami angisoze nganikhohlwa ngenangenzela khona!!!!

May you all rest in peace.

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ABSTRACT

The aim of this study is to provide a qualitative understanding and beliefs regarding breast cancer of Black African female postgraduate students. The study was conducted at a tertiary institution in KwaZulu-Natal. The subjects for this study, ten in total, were purposively and suitably selected. The data was collected through one-on-one semi-structured interviews, which were recorded on an audiotape. They were then transcribed and translated, and further analysed through thematic analysis, in order to identify similarities among the responses of the participants.

The results suggest that there is adequate knowledge of breast cancer among Black African female postgraduate students. Due to their education and exposure to knowledge about breast cancer, their beliefs can be argued to be more westernised. Further education on breast cancer is, however, recommended.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Breast cancer is the leading cause of cancer related deaths in women (American Cancer Society, 2012; Thomas, Saleem & Abraham, 2005; World Health Organisation [WHO], 2011). While breast cancer mortality rates are high in developing countries, the illness is observed more frequently in developed countries, according to Ozmen (2011). Breast cancer is rarely observed in women under 30 years of age; however it shows a wide increase after this age and also in postmenopausal years (American Cancer Society, 2012; Ozmen, 2011). Despite being associated with high mortality rates, especially in developing countries, breast cancer is an illness that can be diagnosed and treated early, according to the American Cancer Society (2012). The most commonly known and used breast cancer screening programmes in the world include breast self-examination, clinical breast examination and mammography (American Cancer Society, 2012; Cancer Association of South Africa [CANSA], 2014; Thompson et al., 2005).

1.2 The research problem

In Africa, there are several misconceptions regarding breast cancer that may contribute to the high mortality rates. Coughlin and Ekwueme (2009) reported that some Africans believe that breast cancer only affects White women. Others believe that breast cancer is the result of ancestors turning their backs on individuals, witchcraft, God's will and punishment for social misbehaviour. These authors added that as a result of these misconceptions and beliefs, women do not share their experiences and knowledge with others following their diagnosis of breast cancer. Research has shown that breast cancer among Black South African women

seems to be more advanced at presentation to hospitals than in other racial groups (Sheppard, Adams, Lamdan & Taylor, 2010). Walker, Adam and Walker (2004) further argued that the incidence rate in Black women in South Africa is likely to rise even further, when considering the various aspects of their lifestyle. The key focus of this research is therefore centred on determining the beliefs and understanding that young Black African female postgraduate students have about breast cancer.

1.3 Purpose of the study

The purpose of the study is to explore the beliefs and understanding of breast cancer amongst Black African female postgraduate students. International studies such as that conducted by Kruger and Appflestaedt (2009) found that Black women with breast cancer report late to hospitals, when treatment is no longer possible. Very limited studies have been conducted on breast cancer in the South African context, but of the few that have been done, Vorobiof, Sitas and Vorobiof (2001) reported that 79 per cent of Black African women of all ages diagnosed with the illness usually present to hospital in the late stages of the illness.

This study aimed at investigating how breast cancer is understood from a young female's perspective. The sample included ten Black African female postgraduate students that were selected through the purposive sampling method. The data was collected through one-on-one, semi-structured interviews. Analysis was done through thematic analysis and themes were identified and discussed. The Health Belief Model was used as a theoretical framework for the study, as it is commonly used in breast cancer studies. The study was guided by the following objectives:

- To explore the understanding of breast cancer.
- To explore how culture may play a role in breast cancer screening and early detection.

- To understand the influence of the understanding on the decision making process for the treatment and management of breast cancer.

The main research questions included the following:

- What is the understanding of breast cancer?
- How can culture play a role in breast cancer screening and early detection?
- How does this understanding influence the decision-making process for the treatment and management of breast cancer?

1.4 The outline of the dissertation

Chapter Two presents the review of literature carried out for the current study, and will also indicate the scarcity of the available research conducted within the Black African population to date. This scarcity compliments the need for the present study. While Chapter Three provides details and justifies the methodology used in this study, Chapter Four offers the analysis of the data and the discussion of the findings from a theoretical perspective. Finally, Chapter Five provides conclusions and recommendations, together with an appraisal of the limitations of the study.

1.5 Conclusion

This chapter has introduced and provided the background to the study. The research problem has been stated, as well as the purpose of the study, namely to explore the beliefs and understanding of breast cancer amongst Black African female postgraduate students. A brief outline of the dissertation has been provided and chapter Two will discuss the literature review conducted for this study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter discusses the review of the literature on breast cancer; it will begin by defining breast cancer and its stages, and by discussing the early detection methods for breast cancer. It will further discuss the global statistics of breast cancer, and thereafter the incidence of breast cancer in Africa, focusing specifically on the South African context. The chapter will include cultural factors surrounding breast cancer, examine the role of traditional healers in the illness and discuss the management of breast cancer. Finally, a discussion of the Health Belief Model will be presented, as it will be used as a theoretical framework to understand the results.

2.2 Defining breast cancer

Breast cancer is a multifaceted illness, with interactions between biological and environmental factors, according to Moorely, Corcoran and Sanya (2013). It has been defined as a group of cancer cells that grow into surrounding tissues or spread to distant areas of the body, such as the breast (Cancer Association of South Africa [CANSA], 2014). Breast cancer is a specific type of cancer that occurs in both women and men; however it is extremely rare in men, CANSA (2014) reports that only about 1 per cent of males develop breast cancer. The illness has different stages from stage 0 to stage IV, with the staging differentiating the severity of the illness.

2.2.1 Stages of Breast cancer

The stages of breast cancer usually describe the severity of the cancerous cells in the body, with stage 0 describing the cancers that remain within their original location and that are non-invasive, while stage IV have spread to other parts of the body, including the breast, and are invasive cancers as well (CANSA, 2014). The screening methods when diagnosing cancer provide some information about the stage, and the stage is important because it helps the Oncologists to decide on the best treatment. The stages will be briefly discussed below, in order to create a better understanding of the illness.

Stage 0

Non-invasive breast cancers are regarded as stage 0. At this stage, there are no cancer cells breaking out of their original location. (CANSA, 2014)

Stage I

Stage I describes invasive breast cancer and it is further separated into subcategories known as IA and IB. The subcategories of this stage differentiate the severity of breast cancer within this stage. Stage IA describes the cancer that has not spread outside the breast and stage IB describes either small groups of cancer cells in the breast or a tumour in the breast (CANSA, 2014).

Stage II

Stage II is separated into subcategories known as IIA and IIB. Stage IIA encompasses invasive breast cancer in which no tumour can be found in the breast, however cancer is found in the lymph nodes under the arm or near the breast bone. Stage IIB, describes invasive breast cancer in which the tumour above is larger and may or may not have spread to the axillary nodes (CANSA, 2014).

Stage III

Stage III includes subcategories known as IIIA, IIIB, and IIIC. Stage IIIA describes the invasive breast cancer where no tumour of any size can be found in the breast, and the cancer has spread to the axillary lymph nodes or the lymph nodes near the breastbone. Stage IIIB describes invasive breast cancer in which the tumour has spread to the chest wall and caused swelling. Stage IIIC describes invasive breast cancer in which, if there is the presence of a tumour, it may have spread to the chest wall and the cancer has spread to the axillary lymph nodes (CANSA, 2014).

Stage IV

Stage IV describes invasive breast cancer that has spread beyond the breast to other organs of the body, such as the lungs, distant lymph nodes, skin, bones, liver, or brain. ‘Advanced’ and ‘metastatic’ are words used to describe stage IV breast cancer, according to CANSA (2014).

2.3 Breast cancer risk factors

There are a range of risk factors that have been associated with an increased risk of women developing breast cancer. Many of those risk factors cannot be changed, but some can be modified, states Remennick (2006). According to Chen (2015), the presence of breast cancer risk factors does not mean that cancer is predictable as some women with risk factors never develop breast cancer, however it is still important for women to be aware of such factors for early interventions, if need be. The risk factors include: Gender (breast cancer is the most common cancer in women and occurs more commonly in women than men), aging (breast cancer occurs mostly in older women, the incidence rises with age until the age of 45 to 50), and family history (family history is an important risk factor for breast cancer, even

though a history of breast cancer involving relatives is reported by a significantly low percentage of women with breast cancer. Modifiable risk factors of breast cancer include a woman's dietary and lifestyle factors (Chen, 2015; Remennick, 2006).

It is important to note and identify risk factors for breast cancer in all women, irrespective of their ethnicity, as women may benefit from the screening and preventive measures for breast cancer. Depending on when the diagnosis is made, treatment is advised and has been proven to be effective during the early stages of breast cancer (Yilmaz, Bebis & Ortabag, 2013). Literature has shown that early detection of breast cancer through inter alia breast self-examination and mammogram is important for the treatment and prognosis of breast cancer (Bennet, Blanks, Patnick & Moss, 2007).

2.4 Breast cancer screening, diagnosis and monitoring

2.4.1 Breast self-examination

Breast self-examination is described as the physical examination of the breast tissue and is something that individuals can do by themselves. It is believed that if individuals know how their breasts look and feel they will be able to recognise the change in their breasts (American Cancer Society, 2007; CANSA, 2006). Breast self-examination is considered an important early detection method as it allows women to become familiar with their breasts and to know what is normal and abnormal (American Cancer Society, 2007). According to Crossing and Manaszewicz (2003), for young women, breast self-examination is by far the only screening method available to them to detect abnormal changes at an early stage, because the screening is self-administered and young women do not need to pay for the service. Yankaskas et al. (2010) expand on this, stating that breast self-examination is in fact the only screening method for young women because mammograms are only advocated for

women aged 40 and over, despite the fact that there are women diagnosed before age 40. Regular breast self-examination is thus a cost effective, convenient, private and simple method of screening for breast cancer for women of all ages.

2.4.2 Mammogram

An x-ray picture of the breast that is used to check for breast cancer is referred to as a mammogram (American Cancer Society, 2007; CANSA, 2006). The images produced via mammography make it possible for the detection of tumours which cannot be felt by individuals through other means, such as breast self-examination. Just as for breast self-examination, Thompson et al. (as cited in Yilmaz, Bebis & Ortabag, 2013) state that early detection of breast cancer with mammography makes it possible for the treatment to be commenced early in the course of the illness, before it spreads.

2.5 Beliefs

Throughout the world there are certain beliefs that women hold regarding the screening and diagnosis of breast cancer, and these beliefs aid in the treatment modalities of the illness. A study by Bottorff et al. (1998) found that South Asian women living in Canada were not well informed about breast cancer yet had beliefs related to breast health practices. Beliefs such as (1) women need to fulfil their duties and responsibilities to their family, (2) seek advice from health professionals or screen for breast cancer, (3) barriers to accessing medical services and (4) belief that cancer was associated with death.

In another study on the Canadian Punjabi-speaking South Asian women, these women perceived their cancer diagnosis as the will of God and used spirituality to cope, even though they were stressed by the diagnosis and believed that it equalled death (Gurma, Stephen,

Mackenzie, Doll & Borrotavena, 2006). Similarly, Goldblatt, Cohen, Azaiza and Manassa (2012) found that Arabian women also believed that breast cancer was God's will, or punishment from God, and perceived cancer to be a death sentence. Because of these beliefs, faith in God served as a source of strength, comfort and meaning finding among these women. Likewise in a study by Donnelly et al. (2013) women believed that cancer was a punishment from God but also believed that some people were diagnosed with cancer because they did not breast feed their babies.

2.6 Breast cancer knowledge

In developing African countries like Zambia, a study on breast cancer knowledge and breast self-examination practice among rural and urban women found that both rural and urban women's knowledge of breast cancer was very low, which could be attributed to a lack of knowledge and perhaps also a lack of educational programmes on breast cancer. (Mukupu & Muita-Ngoma, 2007). Similarly, findings by Moorely, Corcoran and Sanya (2013) reported low levels of knowledge about the illness and a fear of the diagnosis of breast cancer among inner city Nigerian women, particularly those with low education levels and from older age groups. Further research by Mbuka-Ongona and Tumbo (2013) also suggested poor knowledge of breast cancer prior to diagnosis, but also reported a marked increase in knowledge after attendance at an oncology clinic. Findings from a study in Turkey echoed these researchers' arguments that women's levels of education, knowledge of the illness and their ability to protect their health, together with education on breast cancer, predicted the performance of breast cancer screening and reduced the mortality rates (Yilmaz et al., 2013). In agreement with the above mentioned studies, a study by Azubuike and Okwuokei (2013) on the knowledge, attitudes and practices of women towards breast cancer in Benin City, Nigeria found that the majority of the women in the study were enlightened and had

knowledge about breast cancer because they had tertiary education. This therefore suggests that people with higher education tend to have better knowledge of breast cancer.

2.7 Breast cancer global statistics

2.7.1 Global incidence and prevalence statistics

Globally, breast cancer is the most commonly diagnosed cancer and the leading cause of cancer death in women, with an estimated 1.7 million new cases recorded in the year 2012 (World Health Organisation [WHO], 2013). Every 60 seconds, somewhere in the world an individual dies from breast cancer and at the current rate an estimated number of 13 million breast cancer deaths will occur around the world in the next 25 years.

Breast cancer incidence has been increasing in most regions of the world, but with inequalities between rich and poor countries. The incidence rate is reported to be highest in developed countries but mortality rates are high in developing countries, which may be due to a lack of early detection and access to treatment facilities (WHO, 2013).

2.7.2 Incidence and prevalence statistics of breast cancer in Africa

According to the WHO (2013), the highest incidence of breast cancer is seen in developed countries, and the lowest in developing countries. Although this is the case, mortality rates are reported to be higher in the developing countries, reports Fregene and Newman (2005). Akaro-Anthony, Ongundiran and Adebamowo (2010) report that about two thirds of Nigerian women are diagnosed with breast cancer at advanced stages. Poor knowledge and lack of education are the main reasons for the late diagnosis, add Akinola et al. (2011). Similar findings were reported in other parts of African countries such as Zambia, Botswana and South Africa (Mbuko-Ongoma & Tumbo, 2013; Mukupo & Muita-Ngoma, 2007;

Walker et al., 2004). For the purpose of this study, the focus will only be placed on breast cancer in South Africa.

2.7.3 Breast cancer in South Africa

According to Walker et al. (2004), the incidence of breast cancer in South African Black women in rural areas 30 years ago was very low, as low as five to ten per 100, 000 women. Between the years 1986-1992, breast cancer was the second leading cancer in females, with cervical cancer as the leading cancer. As the environment has changed, however, breast cancer has overtaken cervical cancer and is now the most diagnosed cancer among women (Vorobiof et al., 2001). Because of lifestyle changes the rate of breast cancer is likely to increase among Black African women.

Seventy-nine per cent of African women of all age groups are diagnosed with breast cancer at stage III or IV; this shows a significant difference in the rates of breast cancer between Black African women and other ethnic groups in South Africa. The study by Vorobiof et al. (2001) reported that 77.7 per cent of stage III and IV breast cancer incidences were found in Black women, while 30.7 per cent were found in non-Black women. This incidence can be explained by the delay in seeking medical treatment, which can be caused by a variety of factors. A study of Black women diagnosed with cancer by Sheppard, Williams, Harrison, Jennings and Lucas (2010) found that cultural values such as spirituality and collectivism were important in their cancer therapy experience. This meant that for women with breast cancer, decision making regarding the different choices of therapy available were made as a collective. Treatment options were viewed as a process involving families, and sometimes the members of the community. This is because some communities are usually collectivists. Collectivist communities emphasise the importance of relationships within the social system and there are certain expectations that are transmitted through generations that indicate good

decision-making strategies and those that are bad (Guess, 2004). Individuals living in such a system regard themselves as people who live within a community in which they assist one another. This is referred to as 'ubuntu', a term that refers to a spirit of togetherness.

2.8 Cultural factors and breast cancer in the (South) African context

Kreuter, Lukwago and Bucholtz (2003, p.133) defines culture as a “set of shared and socially transmitted information that is evident in a group’s practices, values, norms and way of life and that is transferred down from generation to generation”. An individual’s cultural beliefs and understanding of the meaning of an illness can influence the individual’s attitude towards treatment, adds Remennick (2006).

A study by Mondolo, deVilliers and Ehlers (2003) on cultural factors associated with the management of breast lumps amongst Xhosa women found that the key informants used both the traditional and professional health care systems. A factor contributing to these Xhosa women delaying the process of seeking medical treatment was the fact that they were in denial about their illness. Lack of knowledge about breast cancer, embarrassment and the fear of the possibility of death were among the other factors that prevented the Xhosa women from seeking treatment.

Having to expose one’s breast for examination by male health professionals would also hinder the screening process, because of the cultural and religious beliefs held by some women. As suggested by Regmi, Williams and Regmi, (2009) and Moorley et al. (2013), Islam religion forbids nakedness and women are also not allowed to expose themselves in front of men other than their husband; for this reason some women would be hesitant to visit health clinics unless they had women staff.

A study conducted in Jordan by Kavar (2009) revealed another important cultural factor that impacted on women undergoing screening; women could not go for screening tests of their own free will. They had to obtain permission from their husbands and thus indicated that they would only go for breast cancer screening if their husbands agreed to it. Similar findings by Thomas et al. (2005) revealed that in many male-dominated societies, women's decisions and activities were mostly controlled by men; as a result, access to screening services was hindered by the men's disapproval of the practice. Additionally, in cultures where men practiced polygamy, they might abandon a sick wife. Therefore a woman with breast cancer might choose to deny symptoms of the illness and delay treatment because of a fear of rejection, or even out of concern that she might become a burden to her husband emotionally and financially (Amosu, Degun, Thomas & Babalola, 2011; Thomas et al., 2005).

Health beliefs differ from culture to culture, as some people believe that illness occurs because of God, or that it is meant to occur and cannot be avoided. Black African communities usually associate illness with evil spirits and witchcraft; as a result ethnic diversity and cultural values have an impact on health beliefs and may, in turn, influence treatment (Ramathuba, Ratshirumbi & Mashamba, 2015). If treatment of breast cancer is delayed, this then further increases the mortality rates among Black African women.

Vorobiof et al. (2001) stated that Black women who have traditional beliefs perceive their sickness through the framework of indigenous beliefs, and these beliefs usually revolve around the issue of good health, which is perceived as having a balanced spiritual, social and emotional life. Because most Black women have traditional beliefs, they interpret their illness as a sign of conflict in their social relationships and the majority of these patients with

breast cancer believe that their cancer is caused by the acts of witchcraft. Their first priority when receiving treatment, therefore, is to consult the traditional healers, before they even think of going to the hospital for Western medicine.

2.9 The management of breast cancer

2.9.1 Biomedical management of breast cancer

Breast cancer is managed in various biomedical ways, depending on the stage of the illness at the time of treatment. According to the National Cancer Foundation [NCR] (2013), treatment of breast cancer should take into account the individual needs of the patient, and involve good communication in order to allow the patient to make informed decisions about their care. The treatment modalities include surgery, hormonal therapy, chemotherapy and radiotherapy.

2.9.1.1 Breast cancer surgery

There are two established surgical procedures for the treatment of invasive breast cancer for the illness in the breast itself. (1) Conservation surgery, which involves the removal of the tumour together with a rim of surrounding normal breast tissue, with preservation of the breast. (2) Mastectomy, which involves the removal of the whole breast (NCR, 2013; Walsh & O'Higgins, 2000).

2.9.1.2 Hormonal therapy

The female hormones called oestrogen and progesterone can trigger the growth of some breast cancer cells. Therefore, some drugs or treatments are used to lower the levels of these hormones or block their effects. Hormonal therapy can be done before or after surgery and it

can also be used to treat breast cancer that has reoccurred (NCR, 2013; Walsh & O'Higgins, 2000)

2.9.1.3 Chemotherapy

Chemotherapy is a type of treatment that includes a drug or combination of drugs to treat cancer. The goal of chemotherapy is to stop or slow the growth of cancer cells. It is considered a systemic therapy, meaning that it may affect the entire body. The drugs target rapidly growing cancer cells, but they can also affect healthy cells that grow rapidly. Therefore the effect on both cancer and normal cells often causes chemotherapy side-effects which include hair loss, vomiting, diarrhoea and nausea (NCR, 2013; Walsh & O'Higgins, 2000).

2.9.1.4 Radiotherapy

According to Walsh and O'Higgins (2000), radiotherapy is a highly effective way to destroy cancer cells in the breast that may stick around after surgery. Despite what many people fear, radiotherapy is relatively easy to tolerate and its side effects are limited to the treated area.

2.9.2 Traditional healers and the management of breast cancer

Traditional medicine plays a very significant role in primary health care in developing countries, asserts Truter (2007). It is estimated that 70 per cent to 80 per cent of the population makes use of traditional medicine in Africa; and specifically in South Africa, between 60 per cent to 80 per cent of people are estimated to consult a traditional healer before going to a primary health care provider, according to findings by Setswe (as cited in Truter, 2007). Traditional healers use traditional African medicine and assist in illnesses caused by witchcraft or neglect of ancestors. They are highly respected in the community, and people visit traditional healers more than they visit Western doctors.

There are two types of traditional healers in South Africa, sangomas (diviners) and inyangas (herbalists). A diviner may or may not have knowledge of medicinal herbs, as they specialise in divination and operating within a traditional religious supernatural context, and act as a medium with the ancestral spirits (Truter, 2007). Becoming a diviner is not a personal choice, but rather a calling bestowed by ancestors to an individual. Training to become a diviner does not have a specific time frame because the qualification depends on whether the teaching diviner has received their fee, adds Truter (2007). An inyanga (herbalist) possesses knowledge of curative herbs and does not receive a calling, choosing rather to become a herbalist. Herbalists usually spend a few years as a trainee and do not have divine powers. People physically visit the herbalist and have their case history taken and herbalists generate their business through referrals. The herbalists usually have shops where their herbs and remedies are sold (Truter, 2007).

Breast cancer is predominately understood from a medical framework influenced by Western medicine. In South Africa, there are traditional healers who provide traditional methods of treatment and management for breast cancer. In a study by Vorobiof et al. (2001), participants believed witchcraft to be the cause of their illness; therefore, traditional healers were seen as appropriate to treat their illness. Traditional healers are perceived as having ‘expert’ knowledge regarding the treatment and origins of breast cancer. Patients regard this as a way of dealing with the origins of the illness and consulting a traditional healer does not imply that they are delaying the medical treatment. In some rural communities, the traditional healers are seen as the only legitimate option in the treatment of cancer (Vorobiof et al., 2001).

Likewise, a study by Wright (1997) reported that patients believed that their cancer was sent by an angry or jealous person through sorcery. Sorcery is understood as the use of a secret combination of substances such as herbs and animal parts by one person, to cause harm to another person. The participants in the study believed that cancer was put in their food (idliso), was taken in when they were sleeping, or that they got it because it was left on the floor and they walked over it (umeqo). The participants believed that this poison then moved towards their breast when it entered their bodies. Participants believed that if a person did not get indigenous African medicines (imbiza) as treatment, then the poison within the individual's body would eventually kill them.

Similar to the Vorobiof et al. (2001) findings, indigenous healers were perceived as the only legitimate and successful healers of breast cancer. In contrast to this perception, the participants viewed the biomedical approach to cancer treatment as having invalid knowledge about cancer, which resulted in doctors administering inappropriate and harmful treatments to cancer patients. Studies by Wright (1997) and Moorely et al. (2013) have shown that the range of different cultural beliefs might be an important factor when an individual seeks medical treatment for their illness. The reality is that traditional healers often fit with the cultural fears and beliefs about breast cancer and they are also less expensive. Ekortarl, Ndom and Sacks (as cited in Truter, 2007) suggest this as a reason why people move away from medical treatment and towards spiritual and herbal care. With the general belief therefore that cancer inevitably causes death, evidenced by the findings from the studies discussed above, people believe that there is no benefit in going to the hospital. This, together with the belief in witchcraft and sorcery, leads people to seek treatment from traditional healers. As a result, people spend time and money with non-medical practitioners and only seek proper medical attention late in the course of the illness.

2.10 The theoretical framework

The Health Belief Model (HBM) will be used as the theoretical framework for the current study, as it has been used in a variety of studies of breast cancer.

2.10.1 The Health Belief Model

This study will be informed by the Health Belief Model. The Health Belief Model (HBM) was developed in 1958 by social psychologists Hochbaum, Rosenstock and Kegels, working in the U.S. Public Health Services. According to Hochbaum et al. (as cited in Janz, Champion & Strecher 2002), it is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. The main constructs of the model include perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. The HBM has been used in a variety of studies as the theoretical framework to study breast cancer, namely:

- Health beliefs, perceived self-efficacy and breast self-examination among Thai migrants in Brisbane (Jirojwong & MacLennan, 2003),
- Breast cancer health beliefs and perceived barriers to self-examination amongst Hindu women in South Africa (Govender, Soma, Persad, Moodley & Rajah, 2013), and
- Determining the awareness of and compliance with breast cancer screening among Turkish residential women (Yilmaz et al., 2013).

The model has also been used by Cohen and Azaiza (2005) to explore culturally relevant differences associated with screening behaviours. Because of its use in several studies exploring health behaviours in general and cancer screening behaviours specifically, this model served as the ideal theoretical basis on which to base the present study.

There is very limited research in South Africa on breast cancer knowledge, and little research of young Black women's beliefs of breast cancer screening, understanding of breast cancer etc. With the limited research that has been conducted in this country, it has however been noted that there is a high incidence of late presentation of breast cancer in Black African women. This study therefore aims to understand the reasons for late presentation. Is it because of cultural beliefs or because of a lack of knowledge on the subject? Most of the research has been based on rural or specific African groups, rather than on young women who live in urban areas and are conducting postgraduate studies, and are thus more educated than their rural counterparts. Women at university have access to information and clinics, and this study intends to explore their knowledge, beliefs and opinions of breast cancer. It also intends to find out if their experience (family member or friend with cancer) has informed their knowledge on the subject.

Perceived susceptibility, perceived seriousness, perceived benefits and perceived barriers serve as the main constructs of the Health Belief Model. The main constructs of the Health Belief Model are modified by different factors such as education level, culture and an individual's past experiences. In addition to an individual's beliefs and modifying factors, the model also suggests that behaviour is influenced by cues for action and self-efficacy (Janz et al., 2002). Each construct of the Health Belief Model will be discussed in detail below.

Perceived susceptibility is defined as a personal perception of the risk of illness and it is believed to be the one of the more powerful perceptions in promoting people to adopt healthier behaviours (Janz et al., 2002). The greater the perceived risk, the greater the likelihood of engaging in behaviours to decrease the risk, asserts Mc Cormick-Brown (1999).

Perceived susceptibility in breast cancer may include the risk of a breast cancer diagnosis in the long term or immediate future.

The construct of perceived seriousness addresses an individual's belief about the seriousness of an illness. Medical information or knowledge, beliefs that a person might have about the difficulties that an illness would create and the effects that the illness will have on life in general is what forms the basis of the perception of the seriousness of the illness (McCormick-Brown, 1999).

Perceived benefits are regarded as an individual's opinion of the usefulness of a new behaviour in decreasing the risk of developing an illness (Janz et al., 2002). Perceived benefits play an important role in the adoption of secondary prevention behaviours such as screening for breast cancer (Edberg, 2007). It is believed that the earlier breast cancer is found, the greater the chances for the individual to survive. It is also known that when an individual regularly does a breast self-examination that this can be used as an effective means to detect breast cancer at an early stage. Not all women practice breast self-examination regularly; they have to believe that there will be a benefit in adopting this behaviour. This was found to be accurate among Black women, who believed that breast self-examinations were beneficial and thus did them more frequently (Graham, 2002). People usually adopt healthier behaviours when they believe that new behaviour will decrease their chances of developing an illness.

A perceived barrier is an individual's own evaluation of the obstacles in the way of him or her adopting a new behaviour. Perceived barriers are the most significant in determining behaviour change; for a new behaviour to be adopted a person needs to believe the benefits of

the new behaviour are more important than the consequences of continuing the old behaviour. This enables barriers to be overcome and the new behaviours to be adopted (Edberg, 2007). In Champion's study (1993), it was reported that even though women know that breast cancer is a serious illness and that they are at risk, the barriers preventing them from performing breast self-examination have greater influence over the behaviour than the threat of cancer itself.

Adding to the beliefs and the modifying variables, the Health Belief Model suggests that behaviour can be influenced by things that can make people change their behaviour and which are regarded as cues for action (Janz et al., 2002). Knowing a friend or a family member with breast cancer can be a significant cue for action for an individual to practice breast self-examination regularly.

Believing in one's own ability to do something, also known as self-efficacy, is also a significant factor in a new behaviour; when women believe that they can perform breast self-examination properly, abnormal lumps are more likely to be detected early and screened for breast cancer early on in the course of the illness. According to the Health Belief Model, people's beliefs and perceptions make an impact on their health behaviours; they will not change their behaviour unless they believe that they are at risk. Therefore having self-efficacy can also contribute to an individual adopting a new behaviour.

2.11 Conclusion

Breast cancer is a very serious illness and when detected early, the chances of survival for the individual are increased. If detected late however, the prognosis of the illness becomes

poor. This chapter reviewed the relevant literature on breast cancer; it firstly focused on defining breast cancer and its stages, and discussed breast screening, diagnosis and monitoring. It further briefly discussed the global breast cancer statistics, discussed the incidence of breast cancer in Africa, and narrowed the discussion to the South African context. The chapter also discussed the beliefs that women hold about breast cancer, cultural factors and the management of breast cancer. The Health Belief Model was introduced and discussed as a theoretical framework for this study. The following chapter will discuss the methodology of the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The purpose of the study was to explore the understanding and beliefs of breast cancer among Black African female postgraduate students from a tertiary institution in KwaZulu-Natal. The aim of this chapter is (1) to describe the study paradigm selected for the study; (2) to describe the research design; (3) to explain the data collection procedure; (4) to describe the data analysis procedure and outline the ethical considerations to best address the purpose of the study.

3.2 Study paradigm

Social constructionist is a theory of knowledge that was adapted for this study as it examines the development of constructed understandings of the world that form the basis for shared assumptions about reality. The theory centres on the notion that human beings rationalise their experience by creating models of the social world and share these models through language (Andrews, 2012). This was significant in this study because of the use of the Health Belief Model as a theoretical framework which is based on the beliefs and attitudes of the individuals, which will assist in understanding the participants' constructed understanding of breast cancer and the deeper meaning of the illness.

3.3 Research design

A descriptive research design with a qualitative approach was used in this study. According to Holloway (1997), even though qualitative research has a number of different approaches that exist within the wider framework of this type of research, these approaches all have the

same aim, which is to understand the social reality of individuals, groups and cultures. A qualitative approach in this study allowed the researcher to explore the meaning and understanding of young Black African female postgraduates' beliefs about breast cancer. It also allowed for the provision of rich data and in-depth information to answer the research questions.

3.4 Research setting

The study was conducted at a tertiary institution in KwaZulu-Natal, Durban, South Africa. The tertiary institution is believed to have a Black African student population of about 60 per cent, according to Dell (2011), and thus provided an adequate sample for this study, as discussed below. The participants recruited for the study were postgraduate students registered at the College of Humanities. Ethical clearance to conduct the study was granted by the institution's Ethics committee and permission was granted from the relevant gatekeepers to access the participants for the study.

3.5 Sampling method and study participants

The participants were selected through a non-probability purposive sampling technique. According to Neuman (2011), purposive sampling is used in exploratory research and participants are selected with a specific research purpose in mind. The recruitment of participants for this study was influenced by the purpose of this study, which was to explore the beliefs and understanding of breast cancer among Black African female postgraduate students. Research has shown that Black African women usually present at hospitals with late stage breast cancer, rather than seeking treatment earlier (Kruger & Appffelstaedt, 2007; Vorobiof et al., 2001). The fact that these women seek diagnosis and treatment when it is too late for treatment to be effective made it imperative to explore the beliefs of young, educated

Black African women in an urban environment, in relation to breast cancer, in order to effect change and promote education about Western treatment. Recruitment was done by the researcher in order to ensure that the sample fitted the criteria. The participants that were included in the study were five Black African female honours students and five Black African female masters students from the College of Humanities. A total of ten participants were recruited for the study as this was a qualitative study and thus only required a small sample. Saturation of information was reached with the ten participants. The participants were between the ages of 21 and 35 and thus possessed the capacity to provide informed consent and to acknowledge their participation in the study.

3.5.1 Table 1: Study participants' biographical information

Pseudonym	Sex	Age	Level of studies
Zodwa	Female	21	Honours
Lethu	Female	24	Masters
Dintle	Female	30	Honours
Zandi	Female	32	Masters
Zinzi	Female	22	Honours
Uyanda	Female	35	Masters
Lisa	Female	26	Honours
Linda	Female	29	Masters
Akhona	Female	29	Honours
Luyanda	Female	28	Masters

Participants were assigned pseudonyms in order to protect their identity.

3.6 Data collection instrument

A one-on-one, semi-structured interview was used as a data collection instrument for the study, and this was an appropriate method for the subject under study. Conducting one-on-one, semi-structured interviews gave the participants the freedom to communicate their own perspectives. Traversa (1998) suggested that semi-structured interviews give participants time to express their diverse views and also allow the researcher to react and follow up on ideas emerging from the interviews.

3.7 Data collection procedure

The data was collected after an approval letter was received from the Ethics committee of the tertiary institution in KwaZulu-Natal, and after permission to conduct the study was granted by the gatekeeper. The researcher visited four masters and honours classes to inform the students about the study. Before the classes commenced, the researcher provided the students with a brief description of the study and left contact details for interested participants to contact the researcher for more details. The interested participants subsequently contacted the researcher and a meeting was scheduled between the researcher and the interested participants. Details about the study were given to the participants, with emphasis placed on voluntary participation and maintaining the confidentiality of the participants' identities.

Participants were met at the university library and a written letter and informed consent form explaining the aim and the nature of the study were given to the participants. Informed consent was obtained from the participants, and confidentiality and the protection of their identity also assured. The informed consent was obtained after providing the participants with detailed information about the study and the assurance that their participation was

voluntary. For the purposes of the thesis they were to be given pseudonyms, and this would ensure their anonymity in the event that the thesis was to be published or presented.

After consent was received from the participants, semi-structured, one-on-one interviews were used as a means to collect the data for the study. The interviews were conducted in the privacy of a small lecture venue, which was selected based on its availability for an hour. This safeguarded against any disruptions during the interview process. Each participant was interviewed at a time that was convenient to them.

The time taken for each interview varied between participants and depended upon the information they were willing to provide. Five interviews lasted for 30 minutes, two lasted for 45 minutes and the last three interviews lasted for an hour each. All interviews were audio recorded with permission from the study participants. All ten interviews were conducted in English, but because the participants were allowed to express their opinions in their home language, one participant used isiZulu in the course of her interview.

3.8 Quality criteria (credibility, trustworthiness and dependability of the study)

Shenton (2004) suggests that in addressing credibility, researchers attempt to demonstrate that a true picture of the phenomenon under study is being presented. For this study credibility was assured, firstly by reviewing literature on previous studies about breast cancer and then by identifying gaps within the literature. The use of data collection methods and analysis that have been successfully utilised in previous studies also assisted in maintaining the credibility of the study. Participants were given a thorough explanation of the study before data collection, so that they could make informed decisions about participating in the

study. They were also advised that participation in the study was voluntary, with the aim of establishing a rapport with the participants.

Trustworthiness and dependability of the study was ensured by going back to the participants and conducting short interviews with them. The researcher shared and discussed the findings of the study in order to verify and clarify that the participant's views were captured in the way that they had intended (Shenton, 2004). Re-interviewing the participants and clarifying the participant's data also gave the researcher a chance to follow up on some of the questions that surfaced during data analysis.

3.9 Data analysis

The data from the audio recorder was transcribed. There was only one interview where the participant used isiZulu words or phrases that needed to be translated into English without the loss of meaning. Transcription involved carefully listening to the responses of the participants and writing them down verbatim. Research shows that there are challenges when translating, especially in qualitative research, with regards to the miscommunication of data. This has the potential to become more difficult when researchers move away from their native language and culture, as they are expected to ensure the accurate representation of the participant's words, beliefs and behaviours during the process of data collection, in an effort to comply with the requirements for qualitative research (Esposito, 2001). Esposito (2001) adds that these challenges in translation can be overcome to a large degree by re-interviewing the participants, as this provides an opportunity for the researcher to validate the findings through participant feedback. A potential drawback to the process is the fact that it may not always be feasible to repeat the interviews. The participant in this study who

provided answers in isiZulu was thus re-interviewed, in accordance with the report by Esposito (2001).

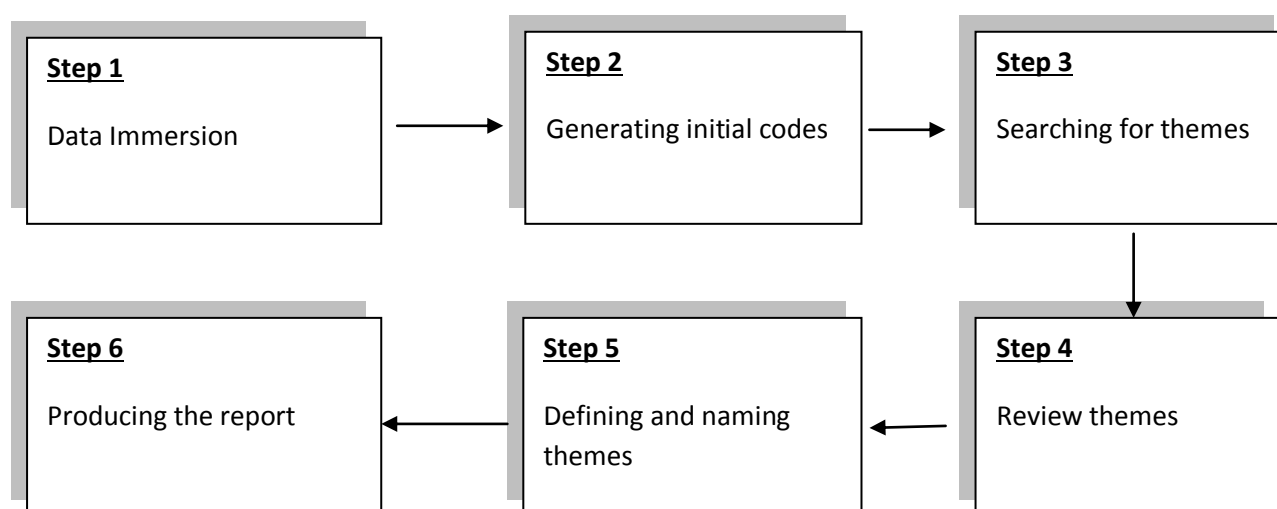
The data was then analysed thematically, as outlined by Braun and Clarke (2014). Thematic analysis is a method used for identifying, analysing and reporting patterns (themes) within data, and it also organises and describes the data in detail (Braun & Clarke, 2014). According to these researchers, thematic analysis is a process that starts at the beginning of the data collection by looking for patterns of meaning and issues of potential interest in the data. It also involves constantly moving back and forth between the data in order to identify patterns in the data.

Data analysis for this study followed the six phases utilised when using thematic analysis to analyse data. Phase one required the researcher to familiarise themselves with the data and to immerse themselves in the data until they were familiar with the depth and breadth of the content. This stage began immediately after data collection. Phase two allowed the researcher to start generating and producing initial codes from the data collected. Phase three began when the data was initially coded, and this phase required the researcher to sort out the different codes into possible themes (Braun & Clarke, 2014), while others were discarded as the process of coding continued.

The researcher then moved on to phase four once the possible themes had been identified, and this phase involved the reviewing and refinement of these potential themes. After the themes had been reviewed and refined, the researcher commenced with phase five. Phase five involved defining and naming themes. At this point of the analysis, the researcher defined and further refined the themes that were presented in the analysis, further organising

the data within these themes. The sixth and final phase began once the researcher had finalised the set of themes and involved the final analysis and write up of the report. While doing this, the researcher kept in mind the fact that data analysis was not a linear process, but rather one where moving back and forth between data was required until clarity was reached, in accordance with the guidelines by Braun and Clarke (2014). The coding system was thus constantly refined and altered, with flexibility as the key as the coding system continued to evolve. It is also important to note and emphasise that themes were allowed to emerge with numerous readings of the transcripts.

3.9.1 Figure 1: Graphical representation of steps to thematic analysis. (Braun & Clarke, 2014)



3.10 Ethical considerations

Ethical clearance was granted by the institution, which allowed for the study to be conducted. The Dean of the College of Humanities at the tertiary institution in KwaZulu-Natal was informed of the nature of the study and permission was asked and obtained to conduct the study at the aforementioned college (see Appendix 3).

Any research involving humans as subjects should always be guided by ethical codes. It is the responsibility of every researcher to protect the participants in their study; to this end the participants were provided with written information regarding the nature of the study. The participants were also informed of the aim of the study and their right to participate or not, as well as their right to withdraw from the study at any point if they felt uncomfortable. Anonymity and confidentiality was also ensured (see Appendix 2).

3.11 Conclusion

The purpose of this study was to explore the beliefs and understanding of breast cancer among Black African female postgraduate students. Data was collected from a purposive sample of ten Black African female postgraduate students, using one-on-one, semi-structured, audio taped interviews. Themes were identified using thematic analysis and the data was analysed. The next chapter will present the findings and the discussion of the study.

CHAPTER FOUR

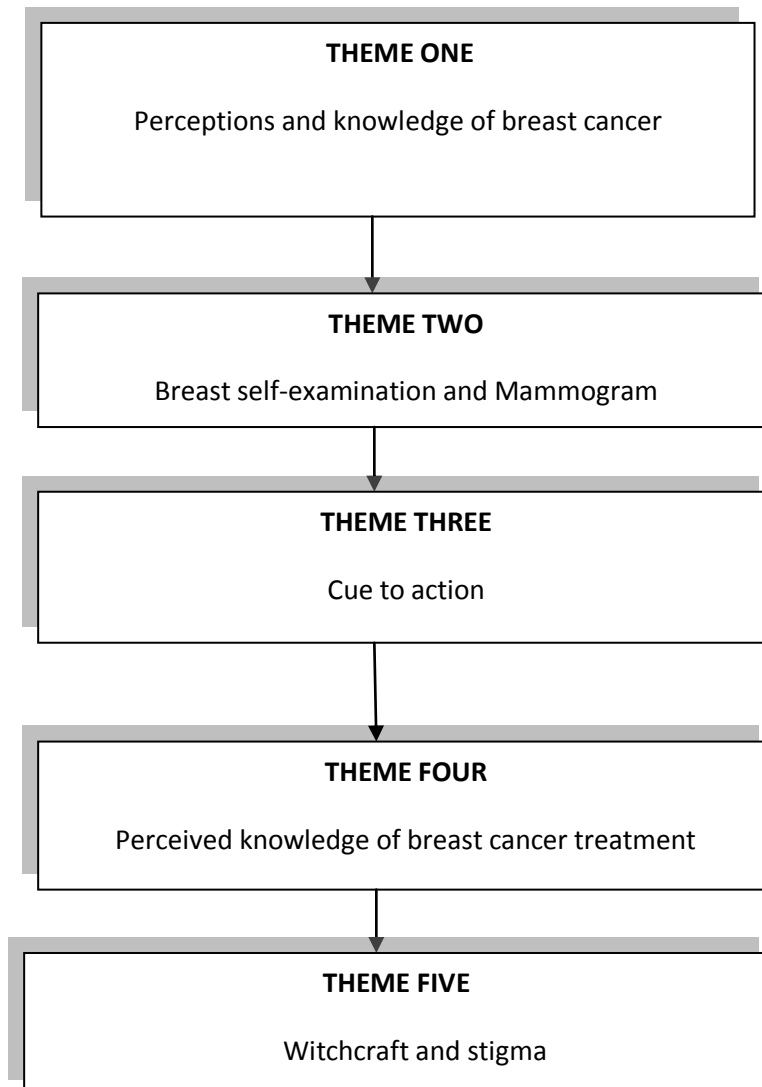
RESEARCH FINDINGS AND DISCUSSION

4.1 Introduction

This chapter presents the findings and discussion of the study. The data was analysed and themes identified using thematic analysis. The data was drawn from the interviews with the participants. The core focus of this research project was to explore the beliefs and understanding of breast cancer amongst Black African female postgraduate students. The researcher was particularly interested in their knowledge and understanding of the illness as Black African postgraduate students. The scant literature available regarding breast cancer within this population group suggests that Black African women seek hospital treatment only once their illness has reached an advanced stage, thus increasing the mortality rate among this group (Sheppard et al., 2010). A motivating factor for this study was the hope and belief of the researcher that if women were better equipped with information regarding breast cancer and its preventative measures, then the mortality rate among Black African women would decrease.

The first section of this chapter presents a diagram of the themes identified during the analysis of the data and will ultimately present the findings of the study, together with a discussion of the findings. The themes identified were: Perceptions and knowledge of breast cancer, breast self-examination and mammogram, cue to action, the perceived knowledge of breast cancer treatment and lastly, one of witchcraft and stigma.

4.1.1 Figure 2: Diagram of themes.



4.2 Theme 1: Perceptions and knowledge of breast cancer

The theme, 'Perceptions and knowledge of breast cancer' relates to a participant's understanding of breast cancer as an illness, and the screening measures used in the early detection of breast cancer.

Linda: *"It is cancer that develops an uncomfortable lump on the breast, which can sometimes result in your breast being removed due to the spread of the cancer. It mostly occurs on women who have a history of cancer in their family".*

Lisa: *"I think breast cancer starts as a disease which attacks the woman's organ (breast). If not caught early it develops into cancer. At this stage it becomes harder to treat and curable by removing part of the breast or removing it completely to prevent the cancer from spreading to other parts of the body".*

Of the ten study participants, Lethu was adamant about her understanding of cancer. She understood and accepted it as being a curse and had nothing more to say about it, other than the following quote:

Lethu: *"To my understanding, breast cancer is a women's curse, or even death penalty to other(s) who cannot survive it even after treatment".*

One participant, Uyanda, understood that breast cancer was diagnosed in men, as well as in women. She also understood the process of diagnosis, and went as far as describing the types of treatment that she was aware of.

Uyanda: *“My understanding is that, you get an infection which develops into a cancer over the period of time. It can be diagnosed (in) both men and women, but women are more prone. If a member of a family, a mother, grandmother has been diagnosed you are more likely to be diagnosed; it is genetic, but not always. Younger women are not as likely to be diagnosed as compared to older women. Early diagnosis means more chances of being cured and late diagnosis mean(s) one can die. Treatment comes through chemotherapy, which is dependent on the severity of the cancer, which is diagnosed in stages but I don’t know how many stages. Some women have had their breast removed to stop the cancer from spreading on the whole body”.*

Similarly, Dintle had an understanding of what breast cancer was, and even described some of the preventative measures that could be utilised in order to try and minimise the chances of developing a cancer diagnoses. It was clear from the interview that this participant understood the importance of early detection for the outcome of the illness.

Dintle: *“I know that breast cancer occurs as result of abnormal changes that developed from cells in the breast. Anyone can have breast cancer. You cannot blame yourself for having breast cancer; however, you can minimise the risk of getting cancer by following healthy habits like eating healthy and exercising, etc. Breast cancer responds well to treatment when it is detected early, but if not detected early it progresses and you will eventually die from it”.*

Even though the participants had different views and explanations of what breast cancer was and how it developed, all ten of them understood how an individual could identify an

abnormal lump in their breast and that if not identified or diagnosed early, the illness progressed and spread, becoming more difficult to treat and ultimately fatal.

One participant acknowledged that it was not only women who suffered from breast cancer, and that men could also be diagnosed with the illness. The Cancer Association of South Africa (2014) confirms this participant's understanding, reporting that although breast cancer is mainly associated with women, men can also develop it, with an estimated 1 per cent of men being diagnosed with breast cancer in South Africa annually. A positive family history of cancer is a further contributing factor to the diagnosis, which suggests that there are chances of it being genetic. As stated by CANSA (2014), and discussed in the previous chapter, there are many different factors that can affect an individual's risk of getting breast cancer. These risk factors include: Gender, aging, genetic risk factors such as a family history of breast cancer, and other factors related to personal behaviours such as smoking, drinking, and diet. The theme indicated that one participant believed that a family history of breast cancer was a risk factor for a possible future diagnosis of the illness. Thus, if a participant was aware of this, then they might use it as their cue for action in terms of them screening for the illness, either through breast self-examination or through the use of mammography. Screening would then, in turn, enable early treatment if needed.

Participants reported having some knowledge about breast cancer, and among the descriptions of the illness, nine participants expanded further by giving examples of how to screen themselves for lumps that might be cancerous. Participants that perceived themselves to be informed about breast cancer would be more likely to be adhering to the recommended breast cancer screening methods than those that had little or no knowledge, however, the researcher's observation cannot distinguish whether the sense of being well informed

definitively encouraged adherence to screening methods. Further research in this area is needed to determine whether helping women to be better informed about breast cancer will increase their chances of adhering to the recommended screening methods.

The theme is significant because knowing about breast cancer and its screening methods may decrease the rate of presentation to hospital for treatment in the late or final stages of the illness, and encourage Black African Women to seek treatment far earlier. Late presentation of breast cancer is not a new trend internationally, as it has previously been described in a study conducted in the Sub-Saharan region by Mbuka-Ongona and Tumbo (2013). The study by these researchers added to the body of knowledge that early detection of breast cancer was dependent on awareness and knowledge of screening techniques. This was particularly relevant in the case where rural women reportedly lacked the appropriate information about breast cancer and the early detection measures for this illness.

Black women in South Africa tend to be diagnosed with breast cancer at a much more advanced stage than women from other racial groups, according to Sheppard et al. (2010), and it is believed that this late presentation occurs when a cure is no longer possible, leading to higher mortality rates from the illness amongst this group. This late diagnosis lends itself to the assumption that Black women do not utilise regular screening methods for the detection of breast cancer, and this lack of screening may be because of the women's beliefs and attitudes towards breast cancer. Janz et al. (2002) attribute these attitudes to a variety of factors incorporated in the Health Belief Model.

The participants in this study had some knowledge about some of the early detection measures for breast cancer, but the majority only reported two of the screening methods available, namely breast self-examination and mammogram.

4.3 Theme 2: Breast self-examination and mammogram

Breast self-examination proved to be the only screening method that participants appeared to be confident about as a way to screen for breast cancer. From their descriptions, participants were knowledgeable about the process of performing breast self-examination. Unlike the findings by Mbuka-Ongona and Tumbo (2013), the participants in this current study had information and an understanding of breast self-examination as a screening tool. By performing the screening, the belief is that breast cancer can be detected at an early stage. As Luyanda and Uyanda stated:

***Luyanda:** “I think its called self-examination, where you have to touch your breasts, looking for lumps or any unusual feeling”.*

***Uyanda:** “I know how to screen myself, early mornings after a bath: Lay down with my back. Lift my arm above my head. With the opposite hand, I feel my boob using the tip of my fingers. I touch around the base of my boob, feeling for lumps and pain that... I try to do this at least once a month... I once thought I had a lump but it was an abscess... That’s the cheapest and most convenient because you know your body better and you easily feel any difference”.*

Six participants were able to describe the procedure for breast self-examination, even though they did not use the correct terminology. This was noteworthy as it showed that they

understood what was required of them when screening their breasts. One of the ten participants knew the correct terminology, as well as the description of the process, which was beneficial for that participant.

Dintle: *“Breast self-exam: You start by checking your breast using the mirror. You check the size, shape and colour of your breast. While you are at the mirror, you look for any signs of discharge coming out from the nipple(s). Then you examine your breast using your hand to check for abnormal lumps. You use your right hand to feel the left breast, and it’s vice versa. You can either do this while you are lying down or while you are standing”.*

Participants thus understood that breast self-examination was one of the ways that an individual could screen themselves for cancer, and this method proved to be one that participants were familiar with and seemed to practice. The process of breast self-examination is believed to only be successful if the person is familiar with the look and feel of their breasts, as this will enable them to recognise any changes in the breast when they encounter them (CANSa, 2014).

Mammography was the second breast screening method that participants described. Again, some participants knew how a mammogram was done but did not have the correct terminology for the procedure.

Linda: *“I can only talk from my experience, from the little that I remember of it. About three years back I had lump on my breast, of which I had suspected to be breast cancer. So the process was that the doctor felt the breast, to have a clue what kind of*

a lump it was. The doctor had to take some blood from the lump to test what kind of lump it was, then I also had to do an x-ray scan. From all that process they could tell that the lump was not cancer”.

Zodwa: *“I know mammogram is a sort of an x-ray used to detect abnormal cells in the breast”.*

Akhona: *“Mammogram: It’s an x-ray examination of the breast”.*

The awareness of breast screening tools for early detection of this cancer was of significance as research thus far has shown that Black African women are only diagnosed with breast cancer when the illness has progressed significantly (Vorobiof et al., 2001). The findings of this study suggest that the participants were aware of screening options and of the illness itself, factors which could empower them to make the appropriate health decisions to limit their risks.

The latest National Cancer Registry statistics indicate that breast cancer is the second leading cancer in South Africa (NCR, 2009), and because of a change of lifestyle in South Africans, in African women the incidence rate is believed to be increasing even further (Kruger & Appffelstaedt, 2007). The rise in the incidence rate could translate into an increase in the mortality rate: The mortality rate is attributed to the late presentation of breast cancer, which can also be attributed to the lack of knowledge regarding the screening programs or methods (Kawar, 2009; Mbuka-Ongona & Tumbo, 2013). Thus, possessing the knowledge of how to examine the breasts and what signs and symptoms to look for would help to minimise the risk of being diagnosed with breast cancer once it was too late for effective treatment,

ultimately resulting in contributing towards a decrease in the mortality rate among Black African women.

Mbuka-Ongona and Tumbo (2013) revealed that rural women lacked the appropriate information about breast cancer and about the early detection measures. The findings from this study conducted on urban postgraduate students with a higher education level, where the participants were seen to be much more knowledgeable about breast cancer, suggest that an urban environment and access to education allow for women to gain knowledge of the illness and to combat it effectively.

As previously stated, the Health Belief Model has been regularly applied to breast cancer screening. The model stipulates that health-related behaviour is influenced by a person's perception of the threat posed by a health problem, and by the value associated with his or her action to reduce that threat (Janz, et al., 2002). According to this model, a woman who perceived that she was susceptible to breast cancer and knew that it was a serious illness would be more likely to perform regular breast examinations. This theme shows how women in this study perceived their susceptibility to breast cancer and how having knowledge about it could motivate them and be their cue for action; to practice regular screening measures in order to detect lumps that might be cancerous at an early stage. If women regularly screened their breasts, then the rate of late diagnosis would likely decrease.

4.4 Theme 3: Cue to action

Five participants reported that knowing someone, either a close friend or relative, who had been diagnosed with cancer made them want to have a better understanding and to learn more about the illness.

Zandi: *“I know someone who had cancer. This made me want to learn more about the breast cancer and its causes”.*

Lethu: *“I know a couple of people who survived it but not anyone close to me, and this gave me hope that it can be curable if the disease is found earlier, and also can be a killer disease if detected late”.*

Uyanda: *“I know two ladies (relatives) who passed away due to breast cancer and I have heard of two people who are survivors. It made me understand that one needs to constantly screen themselves, that it can be a long painful process to have breast cancer, that even Black people are highly susceptible to breast cancer, that it can be traumatic for the people close to the victim”.*

Knowing an individual with breast cancer and witnessing them go through the process of diagnosis and treatment made these participants understand the seriousness of the illness. Knowing of someone who had been diagnosed and treated, and had survived, gave them hope and led to an understanding that the illness was survivable if treated early enough. This knowledge was gained whether the individuals diagnosed were family, friends or even just members in the community, indicating that some degree of public awareness exists of breast cancer as an illness. The participants here were prompted to learn more about the illness and

its treatment, in order to protect themselves against it, as they realised that the cancer did not discriminate in terms of age, race or culture. The belief by some Black women that cancer is a White person's illness (Jones et al., 2014) has been disputed by these participants' personal experiences, as well as by the illness incidence in other Black communities (Jones et al., 2014; Mbuka-Ongona & Tumbo, 2013; Wright, 1997).

Individuals who perceived themselves as susceptible to breast cancer; who perceived that the illness has potentially serious consequences; who believed that preventive actions such as breast self-examination and having mammograms done would cause a positive outcome for them in terms of their health; who perceived that barriers to taking preventative action were outweighed by the benefits thereof; and who believed that they were able to engage in certain preventative health behaviours, were more likely to engage in that health behaviour (Janz et al., 2002).

4.5 Theme 4: Perceived knowledge of breast cancer treatment

Although participants were relatively knowledgeable about the screening process, only seven participants voiced their awareness of the treatment and management process. The fact that these seven were aware of the treatment options indicates that there was information transferability. Through the experiences and knowledge of family and friends mentioned earlier, they had an adequate understanding of treatment. This finding was supported by the following quotes.

Zandi: *"Treatment includes surgery where abnormal cells are removed. There are other breast cancer treatments but I am not certain about them".*

Lethu: *“Chemotherapy, I’ve heard is very painful, but does help if it’s the first stage. The last stage of chemo is said to be a very painful experience and some do not survive it”.*

Instead of explaining or giving examples of the treatment options that are available for breast cancer, the other three participants shared the importance of breast cancer treatment. The participants reported the following imperative reasons for undergoing treatment after diagnosis:

Zinzi: *“The treatment is done to prolong the illness and numb the pain or the possible chances of pre-death whilst we really know that there hasn’t been a cure for this. But the treatment is set to start immediately once the patient has been diagnosed with breast cancer”.*

Zodwa: *“When breast cancer is detected early it responds well to treatment, provided that you are compliant to it. No traditional medicine can cure cancer, whether it’s detected early or late”.*

Luyanda: *“If cancer has progressed to certain stages (later stages), it can’t be treated and your breast cannot be amputated... then you’ll eventually die from it. If you aren’t compliant to medication prescribed for you as a result of your traditional or religious beliefs, you are actually giving cancer cells a chance to progress”.*

All ten participants had an idea of what breast cancer was and how it was screened for; most participants also took the diagnosis of breast cancer seriously, especially if they knew of someone who had been diagnosed or if they themselves had thought they had breast cancer.

The majority of the participants had a basic understanding of breast cancer; as well as sufficient knowledge about the treatment options that were available. Knowledge regarding the treatment options for breast cancer could be due to the research participants having a great deal of trust in medical personnel being the most knowledgeable about the illness and thus the most able to advise cancer sufferers regarding treatment. Oncologists are the experts in cancer treatment. From the findings, all participants described their perceived knowledge about the treatment of breast cancer at a basic level. The awareness of the types of treatment options could be seen as encouraging in that people were making informed decisions.

Even though three of the participants had no idea about the treatment of breast cancer, some knew that there was something called “chemotherapy” used to treat cancer, and that it was a long and painful process. For participants, the long and painful process meant attending the oncology clinic every day and not knowing if the body would respond negatively or positively to the treatment. When the patients underwent treatment, their family watched them going through a period of anticipation and dread, waiting and hoping that the treatment worked. This process therefore instilled fear in the individual, and became an emotional rollercoaster, leaving the individual in need of support from family and loved ones. Despite this, all of the participants reported believing that the medical route was the best way to treat cancer, as opposed to consulting traditional healers.

As previously discussed in the study, research by Vorobiof et al. (2001) has shown that the high mortality rate in female Black African cancer sufferers in South Africa is caused by their late presentation to hospitals for treatment. It could be argued that the reasons for the late presentation might be because the women first sought help from traditional healers when

looking for a cure or treatment. According to Sheppard et al. (2010), Black women who usually held traditional beliefs perceived their illness through a framework of indigenous beliefs. These women believed that their cancer was a result of witchcraft and that it was inflicted upon them by a jealous or an angry person, thus the need for help from a traditional healer (Wright, 1997). In terms of the Health Belief Model, these cultural beliefs would be the modifying variable towards behaviour change, meaning that women would follow their cultural beliefs in the hope that they would get treated for their illness.

The participants in this study, however, seemed to have a different view towards the treatment of breast cancer: They believed that once diagnosed and commenced on a specific Western treatment plan, a patient needed to be compliant with the medication and not mix this Western medication with any traditional medicine, as this would affect the prognosis. The researcher wondered why the participants held this view. Possible explanations could be the participants' past exposure to the illness in their close social circles or perhaps the fact that they had a higher education level than women in a rural setting, which in turn impacted on their perception of breast cancer.

This theme was significant because it showed how having access to education and being equipped with sufficient knowledge about an illness can play a major role in the treatment of breast cancer. Prognosis is likely to be good in cases where individuals such as these are diagnosed early and remain compliant with the treatment regime, thus reducing the mortality rate among Black African women.

4.6 Theme 5: Witchcraft and stigma

Lethu and Luyanda had the following to say about culture and the understanding of breast cancer:

Lethu: *“So many cultural people do not believe in such disease. They might think they are bewitched and do not get medical attention as soon as possible - taking the cultural route and end up dying; and some are not even educated enough about such diseases, which might cause one to have a bad stigma in their cultural community if they are found to be diagnosed with breast cancer”.*

Luyanda: *“Other people might be ignorant to the fact that it is a biomedical sickness, they might think its witchcraft”.*

Participants perceived the cultural understanding of breast cancer as having been influenced by the belief that cancer was due to bewitchment. This belief influenced people not to seek Western medical attention, as cancer was not understood as an illness. This perception is similar to the finding by Wright (1997), where women believed that breast cancer was the result of witchcraft.

Culture is defined as a set of shared and socially transmitted information about the world that is transferred down through generations (D’Andrade & Strauss, 1992). These researchers add that because culture is socially transmitted, it carries with it the idea that people who interact regularly know the same unwritten laws and criteria for that group. When it comes to illness, the values and beliefs from a cultural model of illness influence the perceptions about an illness, the types of treatment that are useful for the illness and the outcome of health

behaviours related to the prevention and control of the illness (Coreil, Wilke & Pintado, 2004). As stated earlier, it is also usual in such cultures for the treatment for any illness to be decided on as a collective.

Culture and its practices and expectations are something that is embedded in an individual. The responses given by Lethu and Luyanda imply that individuals understand breast cancer in terms of their cultural practices. Even though breast cancer is a medical illness and can only be treated medically, people may still resort to traditional medicine due to insufficient knowledge of the illness. Insufficient knowledge regarding breast cancer among communities may also make affected individuals hesitant to explore other treatment options because of stigma within the communities.

Wright (1997) and Vorobiof et al. (2001) reported that Black women who held traditional beliefs usually interpreted their illness as a sign of conflict with someone in their lives, and believed that their cancer was caused by acts of witchcraft. It was therefore logical for these individuals to seek and receive treatment from indigenous healers.

Participants reported that in the Black African culture, breast cancer was not considered as a serious illness when compared to other illnesses. The belief that witchcraft was the cause could be argued as one of the reasons for this. Another possible cause could be that the majority of the cases were not diagnosed and individuals did not seek help from medical doctors because they lacked information about the illness. Knowledge of the illness only came in the final stages of the illness when the patients went in to hospital, and once they

had died, no one talked about the circumstances that lead to their death, thus further contributing to the lack of knowledge about the illness.

4.7 Summary of the study findings

Half of the participants believed that a reason for breast cancer not being taken seriously was because there was not much education done within the Black African cultures about this illness. Women did not know how to screen themselves because they were not informed about it. If these women ever had abnormal pain in their breast, they consulted traditional healers who were also not informed about breast screening. This then left the breast cancer untreated and ultimately lead to the death of the individual concerned.

The view that Black African communities did not have much knowledge about the illness was dominant in this study's findings. The study participants themselves, however, demonstrated some knowledge about the illness, which they had acquired in different ways. If communities were educated about the illness and encouraged to talk about it, this could reduce the stigma, encourage the correct treatment and make a difference to the mortality rate.

When talking about culture and breast cancer, it was quite interesting to note that almost all of the participants tended to distance themselves from the 'culture'. The participants used the terms 'they' and 'other people', which was observed by the researcher: This indicated that the participants considered themselves as part of the 'culture', as their use of the words 'they' and 'other people' referred to collective beliefs rather than individual beliefs. This was in keeping with the majority of African cultures that believe in collectivism rather than individualism, and that the spirit of togetherness should be practised at all times. Although

part of a culture, the participants felt that they perceived things differently and that their ways of thinking were now also influenced by their level of education. They reported that they had learnt to be critical in the way that they viewed things, and no longer took things at face value or did certain things just because it was commonly done in their culture.

Breast cancer is reported to be the leading cancer among Black African women and is prevalent among women of all race groups. Research has shown that the high mortality rate among Black women occurs because these women do not have enough knowledge about breast cancer, its screening measures and treatment options. This chapter discussed the themes that emerged from the data gathered from the study participants. The themes included perceptions and knowledge of breast cancer, breast self-examination and mammogram, cues to action, perceived knowledge about treatment options and witchcraft and stigma. The findings of this study suggest that the participants are aware of breast cancer and believe that they are also susceptible to this cancer, regardless of their race. The argument here is that if women are well equipped with knowledge of breast cancer and the screening measures available to detect the illness, they will begin to do regular screening themselves. If they suspect that they may have it, then they will be able to get assistance early and be cured of the illness. If screening is done regularly the mortality rate is likely to decrease.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

This chapter presents the conclusions drawn from the study and reflects on the limitations of the study. Recommendations following the outcome of the study are also made.

The aim of this study was to explore the beliefs and understanding of breast cancer among Black African postgraduate female students. The data was collected through one-on-one, semi-structured interviews and analysed through thematic analysis. The themes that emerged from the data analysis included: The perceptions and knowledge of breast cancer, Breast self- examination and mammogram, cues to action, perceived knowledge of breast cancer treatment and witchcraft and stigma. The Health Belief Model was used as a theoretical framework in this study, in order to help understand the findings of the study better.

The findings from this study suggest that the participants in the study appeared to have sufficient knowledge about breast cancer, including that of breast cancer screening methods, and fair knowledge regarding the treatment options that are available for the illness. The lesser degree of knowledge regarding the treatment options may be because the participants have not been exposed to the information first hand, but they firmly believe that the doctors and oncologists are the people to be consulted when seeking treatment, as they possess the best knowledge regarding the treatment options for breast cancer. Exposure to or knowledge of someone in their social circle or community proved to be an added factor in gaining a more comprehensive understanding of breast cancer. Thus, knowing someone in their social

circles with breast cancer became a cue to action for the participants in gaining more knowledge of the illness.

The findings suggest that the participants also perceived that they were susceptible to breast cancer as Black African women. Those participants who had no personal, familial, or social exposure to breast cancer were also less likely to report having adequate information of the illness. This suggests the importance of education about the illness and of engaging Black African women about the significance of breast cancer. Even though the participants in the study appeared to have sufficient knowledge of breast cancer, they did not demonstrate detailed knowledge of the details of the illness. To illustrate this point, they knew what breast cancer was, two of the screening methods available were described but other methods such as clinical breast examination and ultrasound scanning were not mentioned, which further emphasised the lack of detailed knowledge of the illness. There was also a lack of knowledge regarding the treatment options available for breast cancer.

For these Black African female postgraduate women, culture was viewed from a traditional perspective, however their higher education level and exposure to knowledge about illness and cancer lends itself to the argument that their beliefs are more Westernised. It became clear from the findings and discussion that there is a lot of education that still needs to be done within the Black African culture, in terms of breast cancer. Black women need to be educated about breast cancer and it is possible that this might assist in decreasing the mortality rates among this population group.

5.2 Limitations of the research

- The study was conducted on a small sample of young women, which makes it difficult to generalise the results of this study. The findings have, however, revealed significant data which can aid in future research.
- The study was limited to Black African female postgraduate students only.

5.3 Recommendations

- Even though the results of this study cannot be generalised to the entire university population, handing out flyers with information about breast cancer during the National Breast Cancer Awareness Month (October) can increase awareness and be used as a preventative measure.
- It is recommended that a similar study be conducted among older women, in order to obtain a sense of their beliefs and understanding about breast cancer.
- The study could be extended to women of other ethnicities, rather than just Black women. The role of culture in knowledge and practices surrounding breast cancer could also be explored.
- A larger sample could be used for future studies.
- It would be relevant to explore whether the sense of being well informed about breast cancer encouraged adherence with screening methods.

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APPENDIX ONE: LETTER OF PARTICIPATION

Letter of participation and information

Dear Participant

My Name is Londiwe Nyandeni and I am currently a Clinical Psychology Masters student at the University of KwaZulu-Natal, at the school of Applied Human Sciences. As part of the requirements in completing my degree I am required to conduct a research study. The title of this research study is: *A qualitative study on Black African female postgraduate students' understanding of breast cancer.*

This research aims to explore the cultural understanding of breast cancer and breast screening of female Black African postgraduate students from a tertiary institution in KwaZulu-Natal. This research study also aims to achieve the following objectives:

- To explore the cultural understanding of breast cancer.
- To explore how culture may play a role in breast cancer screening and early detection.
- To understand the influence of this understanding on the decision making process for medical treatment and management.

The participants will be selected based on the following criteria: They have to be female College of Humanities honours or masters students from all of the six schools involved, and be Black Africans between 21 to 35 years of age. This age group has been selected because they are mature in terms of developmental stages.

Your participation in this project will provide the research field with valuable information. Please be aware that participation in this research is **completely voluntary** and you may withdraw from this study at any time, without the risk of any negative consequences.

Should you require any additional information, please feel free to contact either of the following:

Londiwe Nyandeni (Researcher)

Cell: 0732910228

Email: lnyandeni@gmail.com

Lucinda Johns (Supervisor)

Telephone: 0312607620

Email: johnsl@ukzn.ac.za

Should you wish to obtain information on your rights as a participant, please contact

Ms Phumelele Ximba

University of KwaZulu-Natal

Research office

Telephone: (031) 3603587

Your participation and assistance in the completion of this study will be greatly appreciated.

Thank You

Londiwe Nyandeni

Postgraduate Student- Masters Clinical Psychology

University of KwaZulu-Natal

APPENDIX TWO: INFORMED CONSENT FORM

University of KwaZulu-Natal (Howard College Campus)

Masters Research Project

A qualitative study on Black African female postgraduate students' understanding of breast cancer

Thank you for agreeing to participate in this study. This form will outline the purpose of the study and will also provide a description of your involvement as a participant.

This research project is for the purpose of accomplishing a Master's degree in Clinical Psychology at the University of KwaZulu-Natal, Howard College Campus. This research project will be a qualitative study using semi-structured, one-on-one interviews to gain your understanding of breast cancer.

Please be aware that you are not required to make any payments in order for you to participate in this study. Also note that there will be no payments made to you as a result of participating in this study.

The following conditions will be met:

- ❖ The research study involves semi-structured, one-on-one interviews that will last for one hour.
- ❖ Your responses will be kept confidential and your identity will not be revealed.
- ❖ Pseudonyms will be used and any information that may uniquely identify you will not be included.
- ❖ The audiotapes will not be used for anything else but the purpose of this study.
- ❖ You will not be at any disadvantage, should you choose not to participate in the study.
- ❖ You may refrain from answering any particular questions if you do not feel comfortable answering them.
- ❖ You may also withdraw from the study at any time if you feel uncomfortable, without any punishment.
- ❖ A copy of the research findings will be given to you at your request.

CONSENT FORM

I _____ (full names of participant) hereby confirm that I have read and understood the information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form.

I hereby provide consent to:

Audio-record my interview YES ☐ NO ☐

Participant name

Signature

Date

Researcher Name

Signature

Date

Should you wish to obtain information on your rights as a participant, please contact:

Ms Phumelele Ximba

University of KwaZulu-Natal

Research Office

Telephone: (031) 3603587

APPENDIX THREE: GATEKEEPER LETTER

20 February 2015

To whom it may concern,

PERMISSION TO CONDUCT RESEARCH IN THE COLLEGE OF HUMANITIES

Dear Ms Nyandeni

Please be informed that approval is granted for you to conduct research in the College of Humanities amongst the Black African female Postgraduate students under the supervision of Ms Lucinda Johns.

Regards



Mrs S Maharaj

Manager: School Operations

School of applied Human Sciences

Howard College Campus

APPENDIX FOUR: ETHICAL CLEARANCE LETTER



23 March 2015

Ms Londiwe Nothando Nyandeni 208500195
School of Applied Human Sciences
Howard College Campus

Protocol reference number: HSS/1640/014M

Project title: A qualitative study on Black African Female Postgraduate students understanding of breast cancer

Dear Ms Nyandeni

In response to your application dated 13 December 2014, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **Expedited Approval** **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully


.....
Dr Shenuka Singh (Chair)

/px

cc Supervisor: Lucinda Johns
cc Academic Leader Research: Professor D McCracken
cc School Administrator: Ms A Luthuli and Ms A Ntuli

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

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Website: www.ukzn.ac.za



Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

APPENDIX FIVE: TRANSCRIPTS

Interview

Demographics: Linda, 29 years old

Interviewer: From the briefing we had prior to your participation in this study, I just want to remind you that the title of my research project is a qualitative study on Black African female postgraduate students' beliefs and understanding of breast cancer. Okay, so I am basically interested in your views and your own personal understanding of the illness.

Interviewee (Linda): Okay, no problem we can begin.

Interviewer: What is your understanding of breast cancer?

Interviewee (Linda): It is cancer that develops an uncomfortable lump on the breast, which can sometimes result in your breast being removed due to the spread of the cancer. It mostly occurs in women who have a history of cancer in their family.

Knowledge of B C

Interviewer: Is there anybody you know that has had breast cancer?

Interviewee (Linda): There is nobody that I know of that has had breast cancer.

Interviewer: Do you think that culture plays a role in understating breast cancer?

Interviewee (Linda): Yes I do think culture plays big a role in your understanding of breast cancer.

Interviewer: How does it play a role?

Interviewee (Linda): When we grow up around our families and society, I have never heard of breast cancer even being spoken of until I was in high school; even then I had to learn about it through television and social peers. In my culture, breast cancer is mostly associated with White people more so than Black people because it is something they did not know nor understand. Thus it influences the behaviour around it. In my culture nobody actually thinks about breast cancer as a life threatening disease or illness because it is not something they

BC
educatio
n and
culture

encountered more often. Those who have encountered it have not spoken openly about it. It is only now that people are becoming aware of breast cancer and how serious it is.

Seriousness of
breast cancer

Interviewer: Are you aware of the methods used in breast cancer screening, if so can you please describe them?

-Interviewee (Linda): Well not entirely, I can only talk from my experience from the little that I remember of it. About three years back I had lump on my breast of which I had suspected to be breast cancer, so the process was that the doctor felt the breast to have a clue what kind of a lump it was. The doctor had to take some blood from the lump to test what kind of lump it was then I also had to do an x-ray scan. From all that process they could tell that the lump was not cancer.

Screening
method

Interviewer: Does culture and traditional views influence the screening of breast cancer?

Interviewee (Linda): Some cultures do not believe in scientific ways of dealing with diseases and illnesses; they believe in more traditional ways of dealing with it. Therefore, in some cultures some people might end up not even going to a doctor for the screening of breast cancer.

Interviewer: What are your thoughts of breast screening in relation to cancer and traditional medicine?

Interviewee (Linda): I am not a person who believes in traditional medicine, so I would see modern scientific breast screening as the best option due to updated technology and knowledge of the disease, compared to traditional medicine.

Interviewer: What is your understanding of treatment for breast cancer?

Interviewee (Linda): I have heard of surgery. I am not sure what kind of surgeries are undertaken, and I have also heard of chemotherapy; still not sure if it applies to breast cancer.

Interview

Demographics: Uyanda, 35 year old

Interviewer: From the briefing we had prior to your participation in this study, I just want to remind you that the title of my research project is a qualitative study on Black African female postgraduate students' beliefs and understanding of breast cancer. Okay, so I am basically interested in your views and your own personal understanding of the illness.

Interviewer: What is your understanding of breast cancer?

-Interviewee (Uyanda): my understanding is that, you get an infection which develops into a cancer over the period of time. It can be diagnosed both men and women but women are more prone. If a member of a family, a mother, grandmother has been diagnosed you are more likely to be diagnosed. It is genetic but not always. Younger women are not as likely to be diagnosed as compared to older women. Early diagnoses means more chances of being cured and late diagnosis mean one can die, treatment comes through chemotherapy which is dependent on the severity of the cancer, which is diagnosed in stages, but I don't know how many stages.....uhm what else, some women have had their breast removed to stop the cancer from spreading on the whole body.yah..

Knowledge of
BC

Interviewer: Is there anybody you know that has had breast cancer?

-Interviewee (Uyanda): I know two ladies (relatives) who passed away due to breast cancer and I have heard of two people who are survivors.

Seriousness of
death

Interviewer: How did that influence your understanding of breast cancer?

Interviewee (Uyanda): It made me understand that one needs to constantly screen themselves, that it can be a long painful process to have breast cancer, that even Black people are highly susceptible to breast cancer, that it can be traumatic for the people close to the victim.

Interviewer: Do you think that culture plays a role in understating breast cancer?

Interviewee (Uyanda): I don't think culture as such, just socio-economic class. Unfortunately the poor people are likely to be uninformed about breast cancer and majority of those people are Black, hence the number reflects a certain cultural group.

Interviewer: Are you aware of the methods used in breast cancer screening? If so, can you please describe them?

-Interviewee (Uyanda): I know how to screen myself, early mornings, after a bath. Lay down with my back, lift my arm above my head, with the opposite hand I feel my boob using the tip of my fingers, I touch around the base of my boob feeling for lumps and pain that...I try to do this at least once a month... I once thought I had a lump but it was an abscess... that's the cheapest and most convenient because you know your body better and you easily feel any difference.

Screening
Method

Well yes, I know there are other scans that professionals use, I don't know what they are called, how much they cost or how to book for them.

Interviewer: How does culture and traditional views influence the screening of breast cancer?

Seriousness
of BC and
influence of
culture

Interviewee (Uyanda): I would say in terms of diagnosis and culture. Some people might ignore early signs claiming its ancestral reasons, witchcraft etc. But I am not really sure how that works... so culture might be a barrier in seeking cure. (Modifying variable)

Interviewer: What are your thoughts of breast screening in relation to cancer and traditional medicine?

Interviewee (Uyanda): Well I think if people want to go the traditional medicine route, it's their right, however, that could lead to problems especially if that route is not helping. If you think about it, the longer breast cancer is left undiagnosed, the more terminal it is. If someone believes that a traditional healer will help and time goes on, they might waste thousands of rands and still die. For people who find out late that they have breast cancer and are at the last stage, I don't think using traditional medicine would do any harm than already done. They will die anyway and if consulting a traditional healer gives them comfort, why not?

Interviewer: What is your understanding of treatment for breast cancer?

Uyanda: Well I think I mentioned this in the beginning, the only treatment I know is chemotherapy.

Interview

Demographics: Zinzi, 22 years old

Interviewer: From the briefing we had prior to your participation in this study, I just want to remind you that the title of my research project is a qualitative study on Black African female postgraduate students' beliefs and understanding of breast cancer. Okay, so I am basically interested in your views and your own personal understanding of the illness.

Interviewee (Zinzi): Ready when you are.

Interviewer: What is your understanding of breast cancer?

Interviewee (Zinzi): Well breast cancer is diseases that occurs in women and in a later stage, depending on how it has spread in the tissues in the breast, the breast or breasts are amputated.

Interviewer: Is there anybody you know that has had breast cancer?

Interviewee (Zinzi): No

Interviewer: Do you think that culture plays a role in understating breast cancer?

-Interviewee (Zinzi): I can say fairly; nowadays we find our traditional healers highlighting this disease and the 'myth' causes of it, and seem to address it as a danger and in relation we should do away with unforbidden non-cultural acts so that we don't fall unfortunate. So culture understands that this illness or disease is in turn of the wrongful acts women take or challenge, therefore this is seemingly the price for their burdens, if not sins. So culture doesn't understand breast cancer or the depth of it. In turn, so many deaths are witnessed because of ignorance and myth cultural beliefs. The reaction or the behaviour in regards to breast cancer is misinterpreted.

Role of
culture

Interviewer: Are you aware of the methods used in breast cancer screening, if so please name and describe them?

Interviewee (Zinzi): This is embarrassing... I have no idea of the whole process or the first stages or anything that takes place after one has been told and has this confirmed by the doctor that they have the disease, except that they have to start treatment and go through dialysis; something like that. #hides#

Interviewer: How does culture and traditional views influence the screening of breast cancer?

Interviewee (Zinzi): I have no idea. All I know is culture will have this disease blamed on one's passed actions.

Interviewer: What are your thoughts of breast screening in relation to cancer and traditional medicine?

Interviewee (Zinzi): Perhaps if I firstly understand what breast cancer and the screening process is, then maybe I would know what's going on. This is just a neglect of one of the most dangerous diseases, yet I don't know what it is properly and in depth. Eish! #hides#.

Interviewer: What is your understanding of treatment for breast cancer?

Interviewee (Zinzi): The treatment is done to prolong the illness and numb the pain or the possible chances of pre-death, whilst we really know that they hasn't been a cure for this. But the treatment is set to start immediately once the patient has been diagnosed with breast cancer.

APPENDIX SIX: REFLECTION PAGE

Conducting and writing up this thesis has been a very challenging, exciting and yet frustrating learning experience. The time it took for me to get clearance from the Ethics office was one of the most frustrating points of this process, not only because there were some documents missing from my application, but because learning, two months after submitting my ethical clearance application, that it never reached the Ethics office due to circumstances not mentioned here, was very frustrating. Finally receiving the clearance after such a long time was not as exciting as I imagined it would be.

Collecting the data and interacting with the study participants was fun and I enjoyed it. The problem came with analysing, writing up and integrating the data critically. I think this is where I had the biggest problem, which I think began in my honours year. During my year as an honours student, we were unfortunate in that we were not given the opportunity to do a complete research study but rather a proposal only. We were therefore not properly trained or prepared for the master's programme, in terms of research. Of course at the time when we were told that we would not be conducting research at the honours level I was happy, just as any student would be, but I failed to realise that this decision would affect my progress as a postgraduate student.

There were times during the write up of this thesis where I felt that I was not good enough and felt like quitting, but the tremendous support from my supervisor kept me going. Supervision is one of the things I valued the most; the feedback received from my supervisor made me become a better individual and a critical thinker. I believe that I was able to finish this thesis because of the supervision received, and by believing that God had brought me this

far, not to fail me but to make me a stronger person. Being a strong believer in God and His word, I believe that I have made it this far because of Him; He was with me throughout my struggles during my training years.

Ms Lucinda Johns, thank you so much for the guidance and support, it was very much appreciated. May you do for other students what you did for me, and may the good Lord bless you abundantly!