Societal Perceptions of Breast Cancer among Elderly Women in Nigeria

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Abstract

The study examined the impact of the societal perceptions of breast cancer among elderly women on both its care and prevention in south-eastern Nigeria. A representative sample of adult members of the population was drawn in three local government areas in Enugu State. The study drew its rationale from the recognition that the societal perceptions of the causes, nature and management of breast cancer can make a major difference in whether aged women in Nigeria afflicted by breast cancer survive or not. The data were collected using a multistage sampling technique that consisted of a questionnaire and in-depth interviews. It was found that there is a need for more awareness creation, sensitivity workshops and the committed involvement of social workers, counsellors and allied professionals in providing care and counselling for elderly women, as they are often perceived as lying beyond reproductive health ailments in popular discourse.

Keywords: breast cancer; elderly women; treatment; perception

Introduction

The study was motivated by the objective to ascertain how breast cancer is perceived by the general public in Nigeria and the impact of this perception on the care of breast cancer and the health-seeking behaviour of the people with respect to breast cancer. In recent times, there has been an increase in cases of malignant breast cancer presentations to surgical out-patient departments in Nigeria (Agbo, Khalid, and Oboirien 2014). An older empirical study in Nigeria shows that breast cancer has become one of the commonest forms of cancer among women with an increasing mortality rate (Adebamowo and Ajayi 2000). Unfortunately, this mortality associated with the disease has been ascribed to late detection, the lack of knowledge and an inadequate medical response (Oluwatosin and Oladepo 2010).

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Agbo, Khalid, and Oboirien in their 2014 study reported that 99 per cent of presentations of breast cancer in teaching hospitals in northern Nigeria were late presentations. In concrete terms, the prevalence of breast cancer in Nigeria is put at a modest 116 cases per 1 000 women and an average of 27 840 new cases yearly (Adebamowo and Ajayi 2000). Akarolo-Anthony, Ogundiran and Adebamowo (2010), in their study of breast cancer incidence in south-western Nigeria, stated that the number of women at risk of breast cancer in Nigeria increased steadily from approximately 24.5 million in 1990 to approximately 40 million in 2010 and is projected to rise to over 50 million by 2020. A good number of these women are beyond the childbearing age.

Reproductive healthcare services, when provided, are tailored mainly to meet the needs of young people and childbearing women since the extant policies on healthcare delivery in this regard in Nigeria target only childbearing women (WHO 1999). Also, Oluwatosin and Oladepo (2010) showed that most cases of breast cancer among women in Nigeria occur within the mean age of 43–50 years. In other words, the incidence of cancer and its likelihood increase as women age. To buttress the above comment, Omotara et al. (2012) asserted that breast cancer affects women of any age range, but the risk increases as women advance in age.

Perceptions invariably affect an individual's attitude and response to social issues and are usually critically affected by the social attributes of the individual concerned. Therefore, social factors such as education, gender, income and age may be crucial to the perceptions of the reproductive health challenges of older women in Nigeria. Even where reproductive health diseases are detected in elderly women in the public healthcare sector, more attention is still given to the younger generation of women, as it is generally believed that their lives are more at risk than those of their older counterparts owing to pregnancies, menstruation, childbearing and breastfeeding.

It is in this regard that the author identified a need to examine perceptions of breast cancer among elderly women by the public and how these perceptions influence both healthcare provisioning and more crucially the health-seeking behaviour of the elderly women themselves. I undertook an empirical investigation into the dominant perceptions among the general population of breast cancer among elderly women and the influence that these perceptions have on the healthcare provisioning for these women.

In addition to the foregoing, studies indicated a low level of awareness of breast cancer among both women and the general populace as the foremost drive of the increase in and late presentations of breast cancer in Nigeria (Adotey and Jebbin 2004; Agbo, Khalid, and Oboirien 2014; Okobia et al. 2006; Olayide et al. 2017; Oluwatosin and Oladepo 2010). This affects the responses of both individuals and health establishments to the disease. Oluwatosin and Oladepo (2010) have called attention to the glaring incapacity of both healthcare practitioners and health facilities to offer adequate

response to the disease and the lack of clear public opinion to drive the needed change in the treatment and management of breast cancer in Nigeria.

In spite of the availability of health services, people make use of them only when the need arises and if they are aware of their existence and where they can be received. Societal perceptions of the causes, nature and management of breast cancer can be seen as making a major difference in whether older women afflicted by breast cancer survive. This is because the health needs of elderly women are not comprehensively covered given the lack of a clearly conceptualised social policy on healthcare of elderly members of the Nigerian population (Fasoranti 2000). Furthermore, less than 40 per cent of women aged over 80 with breast cancer receive treatment when compared to more than half of those aged 50–59 (NCIN 2011).

This paper is organised under five interrelated sections: the introduction which provides both the objective and overview of the research problem; the state of knowledge on breast cancer which engages with the extant literature on the subject; the methodology which outlines the procedures used in gathering data for the study; a section on the presentation and analysis of the data; and a final section on the discussion, conclusions and key recommendations.

Socio-cultural Factors in Prevention and Control of Breast Cancer: Overview of the State of Knowledge

According to the National Policy and Resource Centre on Women and Aging (1997), 75 per cent of women with breast cancer are over the age of 50. A more recent study reveals that only 39 per cent of older women in the UK receive treatment for breast cancer compared to 90 per cent of those under 50, though the older ones are more likely to have such health problems (Cancer Research UK 2012). Although the United Nations Congress in 1990 recommended that mammography screening be given to women biennially, physicians in Nigeria frequently do not refer older women for mammography as they often assume that elderly women are at less risk for breast cancer than younger women (De Graaf, Willemse, and Sleijfer 1994).

In a similar vein, Kmietowicz (2009) stated that half of the women who get breast cancer are aged over 65 and that of these women, 60 per cent die from the disease because their treatment is shrouded in myths and doctors who believe that a tumour is not a problem for older women because they are old and are going to die soon. On the contrary, Tew et al. (2014) revealed from their study that elderly patients present larger and more advanced tumours thereby needing extra care. The incidence of breast cancer starts to increase at about the age of 20 years and rises rapidly to about the age of 50 years when the rates slow down but continues until the age of 75 years when the incidences start to decline (Akarolo-Anthony, Ogundiran and Adebamowo 2010). This can be explained by the fact that ageing is a dominant risk factor for developing cancer (Rottenberg et al. 2018; Rowland and Bellizzi 2014).

Furthermore, apart from the genetic aspect of breast cancer, there are stigmas associated with breast cancer in many countries, such as the assumption that it happens to people who lived reckless lives, thereby constituting a major impediment to the progress in controlling the disease. It should therefore be of priority to reduce these stigmas and eventually eliminate them for the progress of the effective management of breast cancer (Brinker 2010). In spite of the above, it is likely that such beliefs are products of a lack of knowledge of the nature of the disease.

Older women believe that they will not contract breast cancer because of their age without knowing that the longer a woman lives, the more likely she is to develop breast cancer (Hooyman and Kiyak 1999; Rowland and Bellizzi 2014).

As a result of this, a good number of women die from breast cancer without ever coming in contact with health services. Without doubt, the issues of awareness and knowledge have emerged prominently in the literature on breast cancer in Nigeria. Adotey and Jebbin (2004), Agbo, Khalid, and Oboirien (2014), Okobia et al. (2006), Ajayi and Adebamowo (1999), Olayide et al. (2017), and Oluwatosin and Oladepo (2010) regard awareness and knowledge of breast cancer as critical to its early detection and management. Consequently, while breast cancer remains a health problem, its treatment and management are equally affected by socio-cultural factors.

Furthermore, financial constraints often inhibit the diagnostic screening for breast cancer preventive and control measures like mammography (Ashing-Giwa 1999; Olayide et al. 2017). Asing-Giwa (1999, 55) stated, “women who are living at or below the poverty level have to struggle with competing issues such as food, shelter, safety, and employment that take precedence over their own health and well-being”. Empirical studies indicate an increasing incidence of breast and other forms of cancer worldwide (Akarolo-Anthony, Ogundiran, and Adebamowo 2010; Ojewusi et al. 2016).

The WHO (2013) estimates that over 508 000 women died in 2011 due to breast cancer worldwide. Interestingly, though breast cancer is thought to be a disease of the developed world, almost 50 per cent of breast cancer cases and 58 per cent of deaths globally occur in less developed countries (Yakubu, Gadanya, and Sheshe 2014; WHO 2016). In addition, the incidence of breast cancer worldwide is expected to rise to 26.4 million with 17 million deaths by 2030 with most of the new cases expected to occur in the developing world. In fact, the WHO concludes that that cancer kills more people than HIV/AIDS, tuberculosis and malaria combined.

According to findings by Adebamowo and Ajayi (2000), medical records from Ibadan in south-western Nigeria between 2006 and 2009 showed that the peak of breast cancer in Nigeria is at the age of 43, while post-menopausal women account for about 20 per cent of all cases of breast cancer in the country. The above record agrees with the observation that the incidence of breast cancer starts at about 20 years of age, continues

or rises rapidly to 50 years, and no real decline shows up until 75 years of age (Akarolo-Anthony, Ogundiran and Adebamowo 2010).

According to the American Cancer Society (ACS 2009), 22 per cent of women diagnosed with breast cancer are over the age of 75, but younger women are given more attention when they are diagnosed with breast cancer. Some American doctors are reluctant to consider surgery for older women and resort to anticancer drugs such as tamoxifen because it is easier to administer. Several studies have proven that cancer will eventually grow and spread if a tumour is not removed surgically, even if the patient continues with treatment (ACS 2009). The issue of treatment is based on the belief that elderly women do not tolerate treatment such as chemotherapy and radiation therapy. It is reported among the Swiss and the Brits that many elderly women with breast cancer have died because they did not receive holistic or appropriate treatment for their diagnosis (Bouchardy et al. 2003; Cancer Research UK 2012). According to the above research, breast cancer patients over the age of 80, who did not receive adequate treatment had a much higher death rate from their cancer diagnosis than women who did receive proper treatment.

In elderly women, breast cancer is the most frequent malignancy. In an empirical study conducted in the Netherlands by De Graaf, Willemse and Sleijfer (1994), 30–50 per cent of women presenting with breast cancer are aged over 65 years. This notwithstanding, the authors stated that elderly patients with cancer have been offered less screening and received less staging (i.e. the process of determining the extent of the spread of the cancer to determine the best treatment option) than younger age groups. In an earlier study in the south-eastern Netherlands, 8 per cent of cancer patients between the ages of 45 and 59, 13 per cent of those between 60 and 64 years and as much as 23 per cent of those up to 75 years did not receive any kind of treatment (De Graaf, Willemse and Sleijfer 1994). This can be traced to what the authors had argued earlier that in choosing the optimal treatment for an elderly cancer patient, prejudice and stereotype opinions seem to prevail, as the elderly are regarded as a group known for having limited life expectancy, a decreased quality of life, cognitive impairment, functional problems and diminished social value.

Studies from the United States, Australia and Nigeria reported that women over 60 are more at risk of cancers of the reproductive system, but are less likely to have annual pap smears, chemotherapy, surgery or any form of treatment (Cancer Research UK 2012; National Policy and Resource Centre on Women and Aging 1997; NCIN 2011). In a study conducted in Nigeria by Fasoranti (2000) and further elaborated by Olayide et al. (2017), it was observed that diagnosis of breast cancer is usually late, because by the time most people are admitted to the hospital, the cancer is already so widespread that nothing medical or surgical can help. This is because treatment costs are exorbitant thereby hindering or limiting the amount of treatment and support the patient can receive.

Adebamowo and Ajayi (2000), in a study in south-western Nigeria, indicated that the peak occurrence of breast cancer in Nigeria is at the age of 42. Critically, they report that post-menopausal women account for 20 per cent of all cases of breast cancer in the country. In a recent study by Nwaneri et al. (2017) in Umuowa, in the Orlu Local Government Area in Imo State, and Oluwatosin and Oladepo (2010) in a previous one in the Akinyele Local Government Area of Ibadan, it was reported that rural women suffer the greatest lack of knowledge and awareness regarding breast cancer in society. Moreover, they inferred that health workers in Nigeria have yet to provide health information regarding breast cancer to women which could make the difference between life and death. In another empirical cross-sectional study in the Egor Local Government area in Edo State of Nigeria, Okobia et al. (2006) reported that social factors are critical to the disease and that knowledge generally influences attitude. On a similar note, in studies of attitudes to knowledge and practice of breast self-examination in Port Harcourt and other parts of the country, it was revealed that social circumstances play a very big role in the response of individuals, even where information is provided. In this case, one can see social variables such as education, income, age, gender, and even geographical location are implicated in the management of breast cancer in Nigeria (Adotey and Jebbin 2004; Bassey et al. 2011; Eguvbe, Akpede, and Arua 2014).

One critical gap in the literature which this study aims to deal with is the imprecise nature of the socio-cultural factors which determine attitudes to and behaviour towards breast cancer prevention and control. Therefore, while such authors as Bassey et al. (2011), DeVita, Hellman, and Rosenberg (1989), Eguvbe, Akpede, and Arua (2014), Kagawa-Singer (2000), and Spiegel, Bloom, and Yalom (1981) see socio-cultural factors like age, education, income, gender, beliefs, practices, values and perceptions as influential in cancer control and prevention, the precise nature of these factors and their relative impact have not been established in the extant literature. More crucial to our concern here is that the study of socio-cultural factors that have an impact on cancer control and prevention is still a rudimentary research concern in developing societies like Nigeria. The lack of awareness, misperception and narrow focus on chemotherapy treatment have all undermined the need to investigate the impact of socio-cultural factors on the prevention, diagnosis and treatment of breast cancer.

Consequently, it can be inferred that though there are technological advances in cancer screening, diagnosis and treatment which have resulted in unprecedented cancer survival, especially in developed countries, the reverse is the case in developing countries like Nigeria where much of government attention is on children and women of childbearing age (Anugwom 2015). According to the author, this is as a result of no free medical services for older adults suffering from different diseases especially those of the reproductive system, and where there is no proper understanding of the existence and prevalence of cancer among the elderly. Therefore, the present study aims to focus on these gaps and issues in existing knowledge on breast cancer.

Methodology

The study focused on Enugu State, a mainland state in south-eastern Nigeria. The study used three local government areas (LGAs) out of the 17 in the state: Nsukka, Udi and Enugu North. These LGAs are typical and representative of the state in terms of urbanisation and ruralisation. Enugu State has a population of 3 267 837 (NPC 2006). The study sample was drawn from the members of this population who are 18 years and older.

The sample size for the study was statistically determined using Cochran's (1963) formula which yielded a sample size of 1 159 people based on the latest census data of the state (NPC 2006). This sample size was considered adequate in view of the statistical manipulation intended in the work as well as the time and financial resources available to the researcher. The study made use of the multistage sampling technique in selecting its respondents. A combination of the simple random, systematic random and purposive sampling techniques was used in selecting the respondents. In the first place, simple random sampling was used through balloting to select five communities each from the LGAs and from these communities, simple random sampling was also used to select 10 residential quarters from each of the 15 communities. In the selected quarters, the researcher used systematic random sampling to choose the actual respondents from every tenth dwelling unit. The first dwelling unit selected was based on the criteria of availability, gender equity, age variation and population determined by the researcher. In each of these selected dwelling units or houses, the researcher used the purposive sampling method guided by the need to achieve gender equity and to cover the different age categories in selecting the respondents.

On the other hand, the in-depth interviews (IDIs) with 30 other respondents were also conducted by the researcher with the help of two research assistants who acted as note takers. The use of these notes, the questionnaire and IDIs enabled the researcher to gather both quantitative and qualitative data needed for the study. It must be stated here that there is no exact local name (vernacular term) for "breast cancer". This involved the use of lengthy explanations and illustrations in conveying the meaning to a few of the illiterate respondents especially since we found a tendency among such women to confuse breast cancer with "mastitis" (Anugwom 2015, 2016).

The questionnaire tried to elicit information on the societal perception of breast cancer among elderly women and issues and factors in the management of breast cancer among elderly women in Nigeria. The interview schedule also dealt with the same issues embodied in the questionnaire but deepened the questions through probing questions aimed at generating more in-depth opinions. The data were analysed using the Statistical Package for the Social Sciences (SPSS version 20).

The study received clearance from the ethics committee of the University of Nigeria, as it was part of a PhD thesis. In addition, the respondents were clearly informed about the nature and the goal of the study. They were also made to understand that their

participation is voluntary and that they can withdraw at any point of the process. They were also informed that they have the right to refute or not to respond to any question. Furthermore, they were assured of their confidentiality and anonymity in view of the fact that the study would not generate any direct or indirect harm to their reputation as required by the University of Nigeria Senate Research Ethics Committee (UNSREC). In the process before any section of the study, the respondents were given an informed consent form to sign or thumbprint.

Results

The findings of the study were captured under the following subheadings:

i. Perception of breast cancer among elderly women in south-eastern Nigeria: Insights from the field.

ii. Awareness of breast cancer among elderly women.

iii. Belief in unorthodox treatment of breast cancer and stigmas.

iv. Knowledge of counselling and intervention services (social work services).

v. Strategies for improving awareness of breast cancer among elderly women.

Perception of Breast Cancer among Elderly Women in South-eastern Nigeria: Insights from the Field

The respondents for the study are from varied socio-demographic backgrounds as shown in Table 1. The varied backgrounds of the respondents enabled the collection of robust body of information and perceptions that represent every strata of the typical Nigerian society.

Table 1: Respondents by socio-demographic characteristics

Socio-demographic Characteristic	*Frequency*	*Percentage (%)*
Age Range		
18–25 years	242	23.7
26–35 years	418	41
36–45 years	241	23.6
46–54 years	68	6.7
55–64 years	28	2.7
65 years and above	23	2.3
Total	**1020**	**100**

Socio-demographic Characteristic	*Frequency*	*Percentage (%)*
Gender		
Male	428	42.0
Female	592	58.0
Total	**1020**	**100**
Educational Qualification		
No formal education	37	3.6
First School Leaving Certificate (FSLC)	69	6.8
Senior Secondary School Certificate/WASC	303	29.7
Diploma/Equivalent	190	18.6
HND/First Degree/Equivalent	291	28.5
Master's Degree/Equivalent	115	11.3
PhD	15	1.5
Total	**1020**	**100**

Awareness of Breast Cancer among Elderly Women

The focus of this section is to ascertain the factors that influence the perceptions of breast cancer among elderly women in Enugu State. In other words, the study sought to find out what specific factors affect the perceptions of breast cancer as a disease suffered also by elderly women in society. First, we ascertained the number of those in our sample who are aware of breast cancer among elderly women.

Over half of those sampled in the study or 59.7 per cent of the respondents are aware of the occurrence of breast cancer among elderly women in Nigeria. However, a good percentage of those sampled (40.3%) are not aware of this fact. This means in effect that there is still a need for the creation of awareness on breast cancer as a disease that respects no demographic boundaries in Nigeria.

I sought to find out the specific effects of socio-demographic factors such as age, income and education on awareness of breast cancer among elderly women. The findings are presented in Table 2.

Table 2: Awareness by age of breast cancer among elderly women

Age	*Yes*	*No*	*Total*
Young (18–35)	322 (48.8%)	338 (51.2%)	660 (100%)
Middle (36–45)	189 (78.4%)	52 (21.6%)	241 (100%)
Old (46 and above)	98 (82.4%)	21 (17.6%)	119 (100%)
Total	**609 (59.7%)**	**411 (40.3%)**	**1 020 (100%)**

Table 2 shows that while only 48.8 per cent of the young respondents are aware of the occurrence of breast cancer among elderly women, 78.4 per cent and 82.4 per cent of middle-aged and older respondents are aware of it respectively. Generally, the risk of breast cancer increases with age and it is therefore not invalid that age is equally a factor in awareness of the disease among elderly women.

Table 3: Distribution of respondents by age and awareness of factors that are responsible for breast cancer in elderly women in Nigeria

Factors	*Age*		*Total*
	Younger	*Older*	
Heredity/genes	252 (28.0%)	25 (21.0%)	277 (27.2%)
Lifestyle	205 (22.8%)	22 (18.5%)	227 (22.3%)
Contraceptions	92 (10.2%)	22 (18.5%)	114 (11.2%)
Nutrition	331 (36.7%)	43 (36.1%)	374 (36.7%)
Infections	21 (2.3%)	7 (5.9%)	28 (2.7%)
Total	**901 (100.0%)**	**119 (100.0%)**	**1 020 (100.0%)**

$X^2 = 14.018$; df = 4, $p < .007$

Table 3 is a chi-square table confirming that the older respondents have a broader awareness of the factors that cause breast cancer in elderly women in Nigeria than the younger respondents. This is because, while the younger respondents saw the factors as just heredity, lifestyle and nutrition, a greater percentage of the older respondents were aware that other factors, like infection and the use of contraceptions can also result in breast cancer in elderly women.

Belief in Unorthodox Treatment of Breast Cancer and Stigmas

Generally, as ascertained through the IDIs, the majority of respondents expressed a low level of trust in public health institutions in the treatment and management of breast cancer. As a matter of fact, they saw the severity of the ailment as that beyond the capacity of public health institutions in Nigeria. In the views of an elderly female respondent in her late 60s in Enugu North:

> Our hospitals are actually for the treatment of malaria and typhoid and other smaller ailments; anybody with cancer who goes to these hospitals is either unserious about obtaining cure or so poor that she has no choice.

Another respondent from the Nsukka LGA answered in a very depressed tone that:

> Public hospitals are for those of us who cannot afford the big and well-equipped hospitals. They hardly have enough to treat us of malaria to talk of a serious disease like breast cancer. Our lives are in God's hands.

In view of the above sentiments, the respondents were asked in the questionnaire to state places that people who are confronted by breast cancer go for treatment apart from the public health institutions (see Table 4).

Table 4: Distribution of respondents by gender for other institutions women go to for breast cancer treatment apart from public health institutions

Institution	*Male*	*Female*	*Total*
Private hospitals	70 (21.5%)	135 (31.5%)	205 (27.2%)
Spiritual houses	47 (14.5%)	141 (32.9%)	188 (24.9%)
Herbalists	119 (36.6%)	52 (12.1%)	171 (22.8%)
Chemists	89 (27.4%)	101 (23.5%)	190 (25.1%)
Total	**325 (100%)**	**429 (100%)**	**754 (100%)**

Table 4 shows very interesting outcomes especially in terms of the perceptions of the respondents about the influence of gender on choice of institutions where elderly women seek treatment for breast cancer. As obvious from the table, the highest percentage of the male respondents (36.6%) think women with breast cancer would prefer to visit the herbalists, while the lowest percentage (14.5%) would visit spiritual houses. These findings among men contradict the case of the women, where the highest percentage (32.9%) think women with breast cancer would rely on spiritual houses, followed closely by private hospitals (31.5%), while the lowest percentage (12.1%) would patronise herbalists. The above outcome is truly in line with general Nigerian socio-cultural reality where women would find it difficult to patronise herbalists or native doctors but would eagerly solicit the help and solutions of churches and spiritual houses. It was revealed that 27.2 per cent and 25.1 per cent of the respondents believed that those who are affected by breast cancer prefer to go to private hospitals and chemists or pharmacists respectively. This underlines the lack of faith and trust of people in government hospitals. In the opinion of one of the IDI participants, a middle-aged mother of three in Enugu:

> ... when you go to these big teaching hospitals, it takes you days even weeks to see a doctor except you know someone who works there and sometimes before you get the chance to see a doctor, the patient in question either dies or his/her conditions gets out

> of hand unlike the private hospitals where both the doctors and the nurses are usually friendly and treat their patients with utmost care in order to retain their patients and the reputations of their hospitals as their continued stay in the business and daily bread depend on these. Therefore, even though private hospitals are usually more expensive, people still prefer to use them for their treatments or where the patient comes from a wealthy family, she is flown out of the country to such countries as India, Germany and the US for treatment.

In the words of another participant:

> We prefer going to prayer houses for these kinds of issues because our God is Almighty and there is nothing He cannot do. These big hospitals do not care about us, all they care about is the money they will extort from us.

Furthermore 24.9 per cent and 22.8 per cent of the respondents believe that people afflicted by breast cancer go to spiritual houses and herbalists respectively. This is understandable given that a reasonable number of respondents during the interview (including key persons in the interview) also believed that sometimes these diseases manifest as results of charms and spells cast on people through evil means. As they believe that God is omnipotent and can cure all sorts of diseases, they also believe that He can also destroy the evil effects of the spell and heal the patients of their diseases. As a matter of fact, the respondents while not clearly confessing to a tendency to stigmatise those afflicted by breast cancer, expressed the view that this ailment afflicts some people for one reason or the other. It is the belief that those who suffer from it either have spells cast on them or has offended nature (God) in one way or the other that makes seeking a solution through means such as herbalists and spiritualists quite common in cases like breast cancer.

Knowledge of Counselling and Intervention Services (Social Work Services)

The respondents were asked about their knowledge of professional counselling services or intervention by professionals, especially social workers, in the case of breast cancer. The responses in Table 5 reveal a low level of knowledge of such services. The question of whether there are social work services or other such professional services available to women suffering from breast cancer in the State was put to the respondents in a "Yes/No" manner and from Table 5 it can be seen that 37.9 per cent of the respondents are of the opinion that there are social work services available in the State to assist those affected by breast cancer while 62.1 per cent of the respondents are of the opinion that there are no such services in the State.

Table 5: Distribution of respondents' responses by availability of social work services

Social work services available	*Frequency*	*Percentage (%)*
Yes	387	37.9
No	633	62.1
Total	**1 020**	**100.0**

Source: Field survey 2013/14.

This shows that those who believe that there is no such help for women suffering from breast cancer are more in number than those who said there are such services. This finding reverberates with the opinion of one of the key persons, a senior nursing officer with a popular teaching hospital in Enugu interviewed in the study who said that:

> ... though there are services going on in the state to help women detect cancer early enough to make treatment easier and more effective, these services are usually provided by some other groups or associations but there is none known to be organised and delivered by social workers.

According to another respondent,

> ... social workers though not totally new in the country any more, are yet to gain the same level of recognition they have in the western societies both from the Nigerian government and the individuals who need their services. (See Anugwom 2015.)

Strategies for Improving Awareness of Breast Cancer among Elderly Women

This section sought to ascertain the various steps both government and public institutions can take to improve people's awareness of breast cancer among elderly women. It also sought to identify positive strategies that can be adopted for the prevention and effective management of breast cancer among elderly women in the State. The responses are presented below.

Table 6 shows that a good number of the respondents are of the opinion that government should put up posters or billboards (26.5%), and electronic media advertisements (32.7%), and should organise seminars or workshops (26.3%) as they are more effective ways of improving people's awareness of breast cancer, while 8.7 per cent and 5.8 per cent believe that free distribution of medications or free screening exercises and house-to-house counselling respectively are better ways of achieving the same goal.

Table 6: Distribution of respondents' responses by ways of improving awareness

Awareness ways/means	*Frequency*	*Percentage (%)*
Electronic media/newspapers	334	32.7
Posters/billboards	270	26.5
Seminars/workshops	268	26.3
Free distribution of medication/screening machines	89	8.7
House-to-house counselling	59	5.8
Total	**1 020**	**100**

The participants gave different reasons for their preference for billboards, electronic media and seminars over medical examinations. For some, there is no need to worry oneself or get involved with matters regarding the disease when there is no reason to believe one is at risk while for some others the trauma of knowing one has the disease will kill one even before the disease does. Some of the responses from these participants are captured below:

> People prefer to watch interesting adverts on the billboards, TVs or listen to them on the radios and be taught about health issues to subjecting themselves to regular medical examinations.

> Going for those examinations is as good as sentencing yourself to death; what if you are told you have one lump or the other? You end up dying even before the disease kills you given that you don't have the means to seek good medical assistance. Therefore, I prefer seeing those adverts of the television.

> Discussing a disease as serious as breast cancer or going for the screening when you are not feeling sick is a way of invoking the disease on oneself.

Discussion

Given that the disease of mastitis was often confused for breast cancer especially among the illiterate respondents, the glaring lack of an identified local name (vernacular term) for breast cancer became an interesting discovery in the study. Another remarkable discovery was that slightly over half of the respondents (59.7%) are aware of the occurrence of breast cancer. Furthermore, the study further discovered that men are slightly more aware of the disease than women (though the difference is not significant) which is rather surprising given that breast cancer is a disease that afflicts mostly women. Also revealing is the finding that there is a direct relationship between age and awareness of breast cancer among elderly women. This may be attributable to the fact that the risk of breast cancer increases with age and thus it may be expected that age also becomes a factor in awareness.

The above record is also in agreement with the observation that the incidence of breast cancer starts at about 20 years of age, continues or rises rapidly to 50 years, and no real decline shows up until 75 years of age. The study discovered an alarming low level of awareness about services available for breast cancer. While over 50 per cent of the respondents are aware of these services, almost 43 per cent are totally unaware of these services. Even among those who are aware of the services, most of them indicated surgery as a treatment option for breast cancer. Fewer participants indicated both screening and mammography, which are critical for detecting breast cancer as well as a treatment option. There was also the perception of a high reliance on traditional maybe rather than unorthodox or unscientific methods (traditional healers, prayer or spiritual houses, herbalists) for treatment and care of breast cancer. This obviously has to do with the popular perception, as evidenced by the interviews, that such ailments are supernatural in nature (caused by charms, magic spells, and witchcraft). It also mirrors a lack of trust in the conventional (public) health institutions. Equally interesting are the findings that an overwhelming number of respondents are unaware of available counselling, support or complementary services by professionals especially social workers in the case of breast cancer; the respondents generally regard such strategies as using posters or billboards, electronic media, and seminars or workshops as a means of improving people's awareness of breast cancer.

In conclusion, the study discovered that quite a good number of elderly women are affected by breast cancer with obvious inadequate care and serious mismanagement. One major reason for this is that there is no free or subsidised medicare available for cancer detection and management in the State. The above situation is even worse in the case of women with low socio-economic status. A reasonable number of the women in this category are still struggling to understand the disease and what exactly causes it owing to a lack of information or knowledge. In some cases, they are convinced that it is mastitis, which is locally referred to as "eshi era" in the Nsukka dialect, but this only affects nursing mothers and implies a collection of breast milk even though it does not flow and inflicts a lot of pain on the nursing mother (Anugwom 2016).

On the issue of professional counselling or intervention services in the State, a considerable number of the women do not even know what it means and those who claimed to know, stated categorically that there are no such professionals apart from the regular health workers with regard to cancer detection, management and treatment.

Therefore, it is recommended that rights-based and governance approaches be adopted as they may help the public health system in Nigeria to capture the peculiar needs of elderly women and deliver holistic health services to meet their needs. There is also a need for an evidence-based modification of public health delivery, to capture the needs of the public health sector in the country above the segment of the population in significant ways. Social workers on their part should try and help in the fight against breast cancer by creating awareness through seminars and workshops for women and other members of the public. Therefore, they can educate the public on the nature and

symptoms of breast cancer as well as show them the correct ways of carrying out breast self-examining, what chemotherapy and mammography are all about and when to start seeking such services.

Finally, as the study set out to determine the societal perceptions of breast cancer among elderly women in Nigeria, as this influences both healthcare provisioning and more crucially the health-seeking behaviour of the women themselves, it was seen that the incidence of breast cancer like other terminal diseases is on the increase. Unfortunately, the disease affects a reasonable number of elderly women who receive little or no treatment owing to a lack of finances and an absence of government programmes in Nigeria to assist them when confronted with such a disease. Furthermore, social workers who are mainstream service providers in hospitals in the developed societies do little or nothing to assist these women as a result of the non-professionalisation and unpopularity of the field of social work in Nigeria. Therefore, one will not be mistaking when one states that more attention should be given to the reproductive health of elderly women with special attention to breast cancer. Social work and social workers should also be given the recognition they deserve for them to step in for the effective treatment and management of breast cancer and other diseases in elderly women and the country at large.

References

ACS (American Cancer Society). 2009. "Adequate Treatment of Breast Cancer Deadly for Elderly Women." *Journal of Clinical Oncology* 21 (19): 3580–7.

Adebamowo, C. A., and O. O. Ajayi. 2000. "Breast Cancer in Nigeria." *West African Journal of Medicine* 19:179–191.

Adotey, J. M., and N. J. Jebbin. 2004. "Attitudes to Knowledge and Practice of Breast Self-Examination (BSE) in Port Harcourt." *Nigerian Journal of Medicine* 13 (2): 166–70.

Agbo, P. S., A. Khalid, and M. Oboirien. 2014. "Clinical Presentation, Prevalence and Management of Breast Cancer in Sokoto, Nigeria." *Journal of Women's Health Care* 3:149. https://doi.org/10:4172/2167-0420.1000149.

Akarolo-Anthony, S. N., T. O. Ogundiran, and C. A. Adebamowo. 2010. "Emerging Breast Cancer Epidemic: Evidence from Africa." *Breast Cancer Research* 12 (4): 3–9. https://doi.org/10.1186/bcr2737.

Anugwom, K. N. 2015. "Perception of Breast Cancer amongst Elderly Women in Southeastern Nigeria: Implications for Healthcare Provisioning and Care." Paper presented at the CODESRIEA International Conference on Governance of Public Health in Africa, Dakar, 19–20 November 2015.

Anugwom, K. N. 2016. "Societal Perception of Breast Cancer amongst Elderly Women in Enugu State." PhD dissertation, University of Nigeria.

Ashing-Giwa, K. 1999. “Health Behaviour Change Models and Their Socio-Cultural Relevance for Breast Cancer Screening in African American Women.” *Women and Health* 28 (4): 53–71. https://doi.org/10.1300/J013v28n04_04.

Bassey, R. B., N. K. Iruhe, M. A. Olowoyeye, A. A. Adeyomoye, and A. T. Onajole. 2011. “Knowledge, Attitude and Practice of Breast Self-Examination among Nursing Students in Lagos University Teaching Hospital, Nigeria.” *Educational Research* 2 (6): 1232–6.

Brinker, N. 2010. *Promise Me: How a Sister’s Love Launched the Global Movement to end Breast Cancer*. London: Crown Archetype.

Bouchardy, C., E. Rapiti, G. Fioretti, L. Paul, N. C. Isabelle, J. K. Schäfer, A. P. Sappino, and G. Vlastos. 2003. “Under Treatment Strongly Decreases Prognosis of Breast Cancer in Elderly Women.” *Journal of Clinical Oncology* 21:3580–7. https://doi.org/10.1200/JCO.2003.02.046.

Cancer Research UK. 2012. “Breast Cancer U.K. Mortality Statistics.” https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/breast-cancer.

Cochran, W. G. 1963. *Sampling Techniques*. 2nd ed. New York: John Wiley and Sons.

De Graaf, H., P. H. B. Willemse, and D. Sleijfer. 1994. “Review: Breast Cancer in Elderly Patients.” *Age and Ageing* 23 (5): 427–34. https://doi.org/10.1093/ageing/23.5.427.

DeVita, V., S. Hellman, and S. A. Rosenberg. 1989. *Cancer: Principles and Practice of Oncology*. Philadelphia: J.B. Lippincott.

Eguvbe, A. O., N. Akpede, and N. E. Arua. 2014. “Knowledge of Breast Cancer and Need for its Screening among Female Healthcare Workers in Oshimili South Local Government Area of Delta State, Nigeria.” *Afrimedic Journal* 5 (1): 59–64.

Fasoranti, T. 2000. “Combating Breast Cancer in Nigeria: The Need for Comprehensive Screening Programs.” Health and Welfare, 10 April 2001, Federal Ministry of Health. National Reproductive Health Policy and Strategy, Abuja: FMoH.

Hooyman, N. R., and H. A. Kiyak. 1999. *Social Gerontology: A Multidisciplinary Perspective*. New York: Allyn and Bacon.

Kagawa-Singer, M. 2000. “A Socio-Cultural Perspective on Cancer Control Issues for Asian Americans.” *Asian American Pacific Island Journal of Health* 8 (1): 12–17.

Kmietowicz, Z. 2009. “Rise in Obesity among Children in England may be Slowing.” *British Journal of Medicine* 339:b4568. https://doi.org/10.1136/bmj.b4568.

NPC (National Population Commission). 2006. *National Census Figures*. Abuja: NPC.

National Policy and Resource Centre on Women and Aging. 1997. “Cultural Context of Aging.” Accessed 10 July 2011. www.nia.nih.gov/national-policy-and-resource-on-women-&-aging.

NCIN (National Cancer Intelligence Network). 2011. *The Second All Breast Cancer Report*. Accessed 31 January 2019. http://www.ncin.org.uk/view.aspx?rid=612.

Nwaneri, A., E. O. Osuala, P. U. Okpala, A. C. Emesowum, and P. Iheanacho. 2017. “Knowledge and Awareness of Breast Cancer among Rural Women in Umuowa Orlu LGA, Imo State, South East Nigeria.” *Journal of Clinical Practice* 20 (4): 489–94.

Ojewusi, A. A., T. Obembe, O. S. Arulogun, and T. Olugbayela. 2016. “Breast Cancer Awareness, Attitude and Screening Practices in Nigeria: A Systematic Review.” *Academic Journal of Clinical Reviews and Options* 7 (2): 11–25.

Okobia, M. N., C. H. Bunker, F. E. Okonofua, and U. Osine. 2006. “Knowledge, Attitude and Practice of Nigerian Women towards Breast Cancer: A Cross-Sectional Survey.” *World Journal of Surgical Oncology* 4:1–9.

Olayide, A. S., H. Akande, S. Olatoke, G. Rahman, and S. A. Oguntola. 2017. “Level of Awareness and Knowledge of Breast Cancer in Nigeria: A Systematic Review.” *Ethiopian Journal of Health Science* 27 (2): 163–74. https://doi.org/10.4314/ejhs.v27i2.9.

Oluwatosin, O. A., and O. Oladepo. 2010. “Knowledge of Breast Cancer and its Early Detection Measures among Rural Women in Akinyele Local Government Area, Ibadan, Nigeria.” *BMC Cancer* 26 (6): 271. https://doi.org/10.1186/1471-2407-6-271.

Omotara, B., S. Yahya, M. Amodu, and J. Bimba. 2012. “Awareness, Attitudes and Practice of Rural Women regarding Breast Cancer in North East Nigeria.” *Journal of Community Medical Health Education* 2:148. https://doi.org/10.4172/2161-0711.1000148.

Rottenberg, Y., A. Naeim, B. Uziely, T. Peretz, and J. M. Jacobs. 2018. “Breast Cancer among Older Women: The Influence of Age and Cancer Stage on Survival.” *Archives of Gerontology and Geriatrics* 76:60–64. https://doi.org/10.1016/j.archger.2018.02.004.

Rowland, J. M., and K. M. Bellizzi. 2014. “Cancer Survivorship Issues: Life after Treatment and Implications for an Aging Population.” *Journal of Clinical Oncology* 32 (24): 2662–8. https://doi.org/10.1200/JCO.2014.55.8361.

Spiegel, D., J. R. Bloom, and I. Yalom. 1981. “Group Support for Patients with Metastatic Cancer: A Randomized Prospective Outcome Study.” *Archives of General Psychiatry* 38 (5): 527–33. https://doi.org/10.1001/archpsyc.1980.01780300039004.

Tew, W. D., H. B. Muss, G. G. Kimmick, V. E. von Gruenigen, and S. M. Litchman. 2014. “Breast and Ovarian Cancer in Older Women.” *Journal of Clinical Oncology* 32 (24): 2553–61. https://doi.org/10.1200/JCO.2014.55.3073.

WHO (World Health Organization). 1999. “Breast Cancer: Prevention and Control.” Accessed 11 July 2011. www.who.int/cancer/detection/breastcancer/en.

WHO (World Health Organization). 2013. “Global Health Estimates.” Accessed 15 March 2016. www.who.int/cancer/detection/breastcancer/en/.

WHO (World Health Organization). 2016. Breast Cancer: Prevention and Control. Accessed 2 April 2016. www.who.int/cancer/detection/breastcancer/en/.

Yakubu, A. A., M. A. Gadanya, and A. A. Sheshe. 2014. “Knowledge, Attitude and Practice of Breast Self-Examination among Female Nurses in Aminu Kano Teaching Hospital, Kano, Nigeria.” *Nigerian Journal of Basic and Clinical Sciences* 11 (2): 85–88. https://doi.org/10.4103/0331-8540.140344.