

Citation: Nsenga, M & Rutebemberwa, E. (2019). Knowledge, Attitudes and Practices of breast cancer screening among Rural women in Bubaare Subcounty, Rubanda District. *Journal of African Interdisciplinary Studies*. 3(8), 178 – 189.

Knowledge, Attitudes and Practices of breast cancer screening among Rural women in Bubaare Subcounty, Rubanda District

By

Marcella Nsenga and Elizeus Rutebemberwa

Abstract

The objectives of the study were to establish the level of knowledge of rural women on breast cancer; and to determine their attitudes and practices regarding breast cancer screening. A cross-sectional survey was conducted in Bubaare Sub-county, Rubanda District, among 241 rural women, aged 20 years and above. Data was collected using a structured questionnaire. Quantitative data was entered into Microsoft Excel 2010 and analyzed, using STATA Version 13.0 . Results showed that two thirds of rural women, 235 (97.5%) had heard about breast cancer. However, the overall knowledge was low among all age groups. The study considered the risk factors, signs and symptoms and screening methods. Concerning attitudes, 208 (90.5%) were willing to be screened for breast cancer. However, 60% were not worried about the disease since they had no history of cancer in their families and did not expect to suffer from it. As regards practice, 204 (84.7%) had never examined their breasts and did not know how to do it. In addition, 225 (93.4%) of the respondents had never gone to any health facility for breast cancer screening. Results from bivariate analysis showed that age of respondents was significantly associated with the level of knowledge on breast cancer for rural women ($p = 0.003$); heard about breast cancer ($p = 0.035$); information source ($p = 0.008$); respondents' knowledge about risk factors ($p = 0.000$); signs and symptoms ($p = 0.000$); methods of detecting breast cancer ($p = 0.000$); respondent's perception about breast cancer ($p = 0.000$). Concerning practice, whether taught how to examine her breasts ($p = 0.000$); how often breast examination was done ($p = 0.000$); ever examined her breasts ($p = 0.000$); ever gone for breast cancer screening ($p = 0.000$). The study concludes that knowledge about breast cancer among rural women in Bubaare Sub-county was low, majority with negative attitude towards breast cancer screening. The study recommended more health education sessions in the community, focusing on risk factors, signs and symptoms, prevention and dissemination of information through media, community health teams, religious leaders and health workers respectively.

Key words: Knowledge, attitudes, Breast self-examination, clinical Breast examination

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Introduction/Background

Globally, breast cancer is one of the leading causes of cancer related morbidity and mortality among women in both developed and developing countries (WHO, 2014). According to literature, out of 14.1 million new breast cancer cases and 8.2 million cancer deaths that occurred in 2012 worldwide, female breast cancer accounts for 1,626,600 new cases and 521,900 deaths (Jemal, Bray et al, 2012).

The disease is long term, therefore it affects the whole family in a way that a person ceases to be productive. Its treatment is expensive and all the resources that would benefit the family are spent on the patient, being a terminal illness, children are left orphans with all the challenges that may be encountered. In addition to pain, the patient gets psychologically tortured due to isolation with a lot of stigma. From previous studies, early detection of breast cancer plays an important role in reducing its morbidity and mortality (Noreen, Murad, Furqan & Bloodsworth, 2015).

In African countries women are twice as likely to die from breast cancer as women in high-income countries which are largely attributable to late diagnosis; 75% - 90% of women in Sub-Saharan Africa are diagnosed in stages III and IV, which significantly reduces their chances of survival (Akuoko, 2017). The aging and growth of the population as well as increased prevalence of risk factors associated with economic transition, such as smoking, obesity, physical inactivity have contributed to increased burden of breast cancer in Africa (Jemal, Bray et al. 2012). These changes would require the community to follow standard guidelines that help to promote health including early breast cancer screening.

In Sub-Saharan Africa, increased prevalence and risk factors are associated with economic transition such as smoking, obesity, physical inactivity among others (Chala, 2016). The media coverage is sporadic and health promotion issues are only highlighted during awareness days or weeks, which is not effective. Since breast cancer is the most common cancer among women, it is very important for women to be knowledgeable of breast cancer risk factors, symptoms and outcome of treatment. Therefore, efforts to promote early detection through screening continue to be a major focus in fighting breast cancer (Chala, 2016).

Statement of the Problem

In Uganda, the incidence rate for breast cancer is 6%, whereas the current mortality rate is 45 per 100,000 population (Wabinga, 2015). This could be associated with late reporting to the health units with symptoms of breast cancer, lack of necessary equipment or trained health providers. In spite of measures taken, women in rural areas have continued consulting traditional healers, delay in reporting cancer cases and belief in cultural ties and norms. In support of this (Siwila, 2016), states that illiteracy and ignorance among rural women may as well hinder their understanding of the seriousness of breast cancer information provided.

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Objectives

The objectives of the study were to establish the level of knowledge of rural women on breast cancer and to determine their attitudes and practices regarding breast cancer screening.

Methodology

A cross-sectional survey was conducted in Bubaare sub-county, Rubanda District, among 241 rural women, aged 20 years and above. Data was collected using a structured questionnaire. Quantitative data was entered into Microsoft Excel 2010 and analyzed, using STATA Version 13.0

Discussion of Results and Findings

Socio-demographic characteristics of the respondents

This section provides background information about the sample socio- demographic characteristics of the respondents in terms of age, marital status, education level, religion and occupation. Out of the 241 rural women aged 20 years and above who were interviewed, 121 (50.2%) were aged 20-35 years, 65 (27%) were 36 - 50 years, 33 (13.7%) aged 51 - 65 years, while 22 (9.1%) were 66 - 80 years respectively. This is the age group recommended for breast cancer screening by the World Health Organization. Majority of the respondents 121 (50.2%) were young 20 – 35 years, 189 (78.4%) married, 140 (58.1%) had obtained primary level of education, 136 (56.4%) were Catholics and the majority 179 (74.3%) practicing peasant farming. **Ref. (Annex 1)**

Univariate analysis of respondents' knowledge on breast cancer

At this level, data of different variables was described and later entered into a second level of analysis to check for any relationship with the dependent variables. Out of 241 respondents, 235 (97.5%) had heard about breast cancer, compared to 6 (2.5%) who had never heard about it. The main source of information was media 81(33.6%). However, some respondents who obtained information from the category of others had seen patients suffering from breast cancer, whereas others had got information from school.

Majority of the respondents 185 (36.8%) did not know the risk factors for breast cancer, while the minority 6 (2.5%) related it with age. While 217 (90%) of the respondents perceived that women were at greater risk of getting breast cancer than any other group of people. 7 (2.9%) of the respondents perceived that only old women were at risk of getting breast cancer, so such category of people could not be bothered to go for breast cancer screening.

Regarding signs and symptoms of breast cancer, swelling of the breast was mentioned by majority of the respondents 108 (44.8%), followed by breast or nipple pain 55 (22.8%). Other signs and symptoms were not well known. It was known by majority of the respondents 127 (52.7%) that breast cancer was incurable, compared to 84 (34.9%) who knew it as curable especially when women report early to the hospital. However, among the respondents, 24 (9.9%) could not answer any question about breast cancer. When asked about how breast cancer could be detected, majority of the respondents 210 (87.1%) talked of examination at the health facility, whereas breast self-examination was mentioned by only 8 (3.3%). In addition, 6 (2.5%) talked of traditional methods as a means of detecting breast cancer. **Ref. (Annex 2)**

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Level of Knowledge of Respondents about Breast Cancer

The level of knowledge of the respondents on breast cancer was categorized into two, that is; high and low knowledge based on a scale of 10. A person was taken to have high knowledge if she scored 5 and above and low knowledge if she scored below 5, in answering questions related to breast cancer.

Out of 241 respondents, majority 135 (56%), had low knowledge about breast cancer, compared to 106 (44%) that had high knowledge.

Distribution of breast cancer knowledge across the socio- demographic factors of respondents

Out of the 241 respondents who were interviewed, women aged 66 - 80 years had the highest proportion 19 (86.4%) of low knowledge, compared to those of 51- 65years 17 (51.5%).

Among the married, (53.9%) had low knowledge compared to (46.1%) who had high knowledge about breast cancer. For the respondents who were not married, (69.2%) had high knowledge while (30.8%) had low knowledge on breast cancer. There was little difference between the level of knowledge among the protestants and Catholics, that is, low (55.6%) and high 44.4%) for protestants, (low 54.4% and high 45.6%) for Catholics. Among peasants who were the majority, more than 50% had low knowledge and 43% had high knowledge about breast cancer. For the peasants who were the majority of the respondents, 57% had low and 43.0% had high knowledge about breast cancer. **Ref. (Annex 3)**

Bivariate analysis of level of knowledge and socio-demographic characteristics

The bivariate analysis of socio-demographic factors and the level of knowledge on breast cancer. At bivariate analysis, possible covariates were looked for that is, those independent variables that were likely to show significant relationship with the dependent variables. The dependent variable was the level of knowledge on breast cancer. The independent variables were: age of the respondent, marital status, level of education, religion and occupation.

From the results, age of the respondent was significantly associated with the level of knowledge on breast cancer ($p= 0.030$), while the marital status, education, religion and occupation had no significant association with the level of knowledge on breast cancer. This was shown by their p-values which are more than the threshold of 0.05.

Furthermore, the Chi-square test was carried out to determine the relationship between age of women and level of knowledge about breast cancer among the rural women. The results revealed that the model was better off with age as a predictor than not ($P < 0.001$), So there is a statistically significant relationship between age and knowledge of rural women about breast cancer.

Bivariate analysis of socio-demographic factors with the level of knowledge on breast cancer

Results from Chi square test, which was applied to other variables to determine the significance of relationship between those variables and the level of breast cancer knowledge, were indicated. Five factors were found to be significantly related to breast cancer knowledge considering $p < 0.05$ as statistically significant. This included whether the respondent had heard about breast cancer ($p= 0.027$), information source ($p= 0.012$), knowledge about risk factors for breast cancer ($p= 0.000$), signs and symptoms of breast cancer ($p= 0.000$), what respondent knew about breast cancer, that is whether curable or not ($p= 0.001$), how breast

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cancer could be detected ($p= 0.002$). These factors were later considered for multivariate analysis where logistic regression model was applied (**Ref Annex 4 & 5**)

Results from Multi-variate Analysis

At multivariate analysis, variables of p-value less than 0.05 at bivariate level of analysis were fitted in the logistic regression model to establish the relationship between covariates that had significant relationship at bivariate level. These were good predictors of the dependent variable of knowledge about breast cancer. According to the results, there was less likelihood of high knowledge in the age group of 66 - 80 than that of 20 – 35 years ($OR= 0.02$, $95\% CI: 0.00 - 0.23$). The odds of having high knowledge about breast cancer in the age group of 66 - 80 years were 0.02 times that of 20 – 35 years. There was less likelihood of high knowledge in the age group of 36 -50 than that of 20 -35 years ($OR=0.35$, $95\% CI: 0.15 - 0.79$). The odds of having high knowledge in the age group of 36 – 50 years are 0.35 times that of 20 – 35 years.

For knowledge about the signs and symptoms of breast cancer, there is less likelihood of high knowledge for breast nipple pain than swelling of all or part of the breast ($OR= 0.66$, $95\% CI: 0.29 - 1.47$). The odds of having high knowledge for breast nipple pain are 0.04 times that of swelling of all or part of the breast.

As regards knowledge about risk factors for breast cancer, there is less likelihood of high knowledge for other risk factors than age ($OR=0.01$, $95\% CI: 0.00 - 0.80$). The odds of having high knowledge of other risk factors are 0.01 times than that of age. (**Ref. Annex 6**)

Attitudes of respondents towards breast cancer screening

Univariate analysis

Investigation was made on 241 rural women from Bubaare sub-county, about the attitudes they had towards breast cancer screening. Majority of the respondents 179 (74.3%) were not worried of having their breasts examined, compared to 62 (25.7%) who were worried. Majority of those who gave responses and were not worried 117 (48.5%), did not suspect themselves to be at any risk of getting breast cancer, while others 28 (11.6%) because they had no history of cancer in their families. On the other hand, 58 (24.1%) of those who were worried, feared the results from examination that would be made, while 17 (7.1%) feared pain. However, 165 (68.5%) respondents did not give their reasons.

The interview results show that majority of the respondents 206 (90.5%) had a wish for breast cancer screening compared to 23 (9.5%) who were not bothered. Among the reasons given, were to know their health status 206 (85.5%), or seek for early assistance if there would be need 22 (9.1%). On the other hand, those who did not wish to be screened suspected the procedure to be painful 26 (10.8%), feared not to get married if they would be diagnosed with cancer 11 (4.6%), or fear of being isolated by their families or friends. In addition however, many others 195 (80.9%) were un- decided. For respondents' choice of place for breast examination, majority 164 (68.1%) wished to be examined in the hospital, at the nearby health center 68 (28.2%), because it's near their homes, with little transport costs; and the minority, others 9 (3.7%), wished to go wherever the services were provided.

The hospital was chosen by majority 178 (73.9%), as expected to have more equipment and skilled health providers than the health centers. However, 51 (21.2%) feared expenses in hospitals and could not therefore make it their choice. The rest 9 (3.7%) talked about waiting for too long at the hospitals, whereas 3 (1.3%) mentioned that the health

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workers were unfriendly so they prefer to go to traditional healers who would handle them differently and get concerned about them. (Ref. Annex 7)

Bivariate analysis for attitudes towards breast cancer screening

Results for bivariate analysis which was carried out to determine whether there was any significant relationship between independent and dependent variable or outcome, using a p-value of 0.05 at 95% confidence interval. The Chi-square test revealed no significant relationship between the factors tested and the attitudes of respondents towards breast cancer screening. This was indicated by P-values which were above 0.05. (Ref. Annex 8 & 9)

Practice of Respondents Regarding breast Cancer Screening

Univariate Analysis

The main concern was whether the respondent had been taught how to examine her breasts. Majority of the respondents 201 (83.4%) had never been taught how to examine their breasts compared to 40 (16.6%) who were taught. The source of teaching was for majority of the respondents 199 (82.6%) not specific, health workers 24 (9.9%), by VHT 14 (5.8%). The reasons highlighted by majority 91 (37.8%) of the respondents were that nobody had ever talked about it or encouraged them, others 83 (34.4%) claimed not to get informed health workers at the health facility, whereas the minority 17 (7.1%) did not know where and when to get information or teaching.

Practice of Respondent about Breast Self examination

Out of 241 respondents, majority 204 (84.6%) had never examined their breasts compared to 37 (15.4%) who had examined themselves. In addition, more than three quarters 205 (85.1%) had no idea on what to check for in the breasts, only 22 (9.1%) mentioned abnormalities or swellings in the breasts. The results show that the majority 191 (79.3%) did not know how often breast examination should be done and they had not done it. Whereas 23 (9.5%) did examine themselves anytime they felt like.

A greater number of respondents 225 (93.4%) had never gone for breast cancer screening compared to 16 (6.6%) who had gone. Majority of the respondents 115 (47.7%) gave reasons of having had no health facility that provided services for breast cancer screening, no equipment at the health facility 36 (14.9%) whereas the minority 8 (3.3%) said that they had no qualified health workers to carry out breast cancer screening (Ref. Annex 10)

Bivariate analysis for practice of respondents regarding breast cancer screening

At bivariate level Chi-square test was used to evaluate the relationship between independent variables and dependent variable which is practice of breast cancer screening. Four factors were found significantly related to breast cancer screening. These were how often self-breast examination was done ($p = 0.000$); ever been taught how to examine the breasts ($p = 0.000$); Whether the respondent had ever examined her breasts ($p < 0.001$); and whether respondent had ever gone for breast cancer screening ($p = 0.000$). They were later carried to multivariate level of analysis. Other factors were not found statistically significant. (Ref. Annex 11)

Multivariate analysis for practice of respondents regarding breast cancer screening

Multivariate logistic regression analysis (alpha 0.05), identified variables that predicted practice of breast cancer screening. In consideration of how often self-breast examination was

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carried out, the results revealed that there is less likelihood of carrying out self breast examination every two weeks than monthly ($OR= 0.011$, $95\% CI: 0.001 – 0.215$). The odds of carrying out self-breast examination every two weeks was 0.011 times less that of doing it monthly.

The results also showed that there is less probability of doing self breast examination, other times among the respondents than monthly ($OR= 0.002$, $95\% CI: 0.000 – 0.029$). The odds of self examination during other times among the respondents were 0.002 times that of monthly self-examination. (**Ref. Annex 12**)

Discussion

The study was conducted to generate information about knowledge, attitudes and practices of breast cancer screening among rural women in Bubaare Sub-county, Rubanda District. The results showed that the overall knowledge about breast cancer was low among rural women. Although more than three quarters had heard about breast cancer, a limited number of women had knowledge about the risk factors, symptoms and screening methods. The respondents' attitude towards breast cancer screening as well as practice were poor though a good number of them wished to be screened on condition that the services were made free of charge since their economic status is low (Hawley, 2017).

Respondents' knowledge about breast cancer

According to the findings of the study, majority of the respondents were young women below 50 years (77%), where most of them were between 20 - 35 years, married, with Primary level of education, 56.4% Catholics, 41.1% Protestants and majorly peasant farmers. In this study, age was an important predictor of knowledge about breast cancer among rural women in Bubaare Sub-county. Women who were young were more likely to have better knowledge on breast cancer than their counterparts who were more than 40 years. The results from the study showed that 52.9% of the respondents who had high knowledge of breast cancer, were in the age group of 20 – 35 years. This could be explained by the fact that young women could have heard the information from school, and were able to remember what they were taught than the women who were older, above 40 years.

The results were supported by a study conducted in South Africa, which reported age as the strongest risk factor for breast cancer since cancer risk in a woman increases as she grows older (Rhamathuba, 2015). According to the recommendation, those who are at risk should be made aware of personal risk factors of developing breast cancer. Similarly, the respondents in the older age group displayed low levels of knowledge regarding screening practices (Rhamathuba, 2015). In this study, most of young women in the age group of 20 - 35 years, were school drop-outs who had had lower primary education, whereas others were either orphans or from polygamous families where education of children only relied on their mothers' efforts with fewer fathers' support. Such category of women was more likely to have no transport to the health facility or pay for health services. In Uganda, inadequate knowledge about breast cancer is documented as an important factor in preventing women from visiting screening facilities, or engaging in breast self-examination (Wabinga, 2016). This further contributes to delayed treatment thus, high morbidity and mortality rates.

The highest education level for majority 140 (58%) of the respondents was Primary. Women of this level of education could easily be influenced by the peers, and have lack of awareness about many health seeking behaviours. According to Sharma et al (2013), women with higher level of education had significantly higher levels of breast cancer knowledge.

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Educated women are able to read information written in news papers or any other printed material and they are less dependent on their husbands for financial support more especially when they are employed.

According to the study findings, women lacked adequate information on breast cancer, risk factors, signs and symptoms and breast cancer screening methods. With reference to other previous scholars, studies done on breast cancer screening in Uganda and some other countries, reveal that in order to promote effectiveness of breast cancer control through early detection, rural women should possess relevant knowledge, as well as appropriate attitudes and practices concerning breast cancer and its early detection methods (Shankar et al, 2015). Education plays a vital role in modifying lifestyle behaviour, however health education and promotion are important in reinforcing breast cancer screening knowledge and practices, through community awareness campaigns so as to empower women to carry out preventive practices and utilize any screening services available.

The main source of information to the respondents about breast cancer screening in this study was media 33.6%, while health workers from health centers/ clinics and hospitals provided 26.5%. Information and knowledge are very important as they could influence health-seeking behaviour and change attitudes towards breast cancer. In agreement with this, a study in Jordan noted that the level of knowledge about breast cancer was limited in 80% of the subjects and only 13.3% reported to have good knowledge about breast cancer (Al Odwan, Khreisat et al, 2016).

In such areas, there is no electricity for use of television, some people cannot afford buying radios, while others are illiterate, and cannot read printed material or understand health messages communicated on radios especially in other languages different from what they know. Thus, health education should be intensified so as to enlighten women of all age groups on the risks of breast cancer, its symptoms and preventive measures.

In this study, more than 50% of the respondents understand breast cancer as a disease of no cure. As the incidence of breast cancer increases worldwide, understanding rural women's knowledge of, attitude toward and behaviours engaged in breast cancer screening is essential, because screening is the first step toward early detection (Houshian, 2017). Early detection of breast cancer plays the leading role in reducing mortality rates; (Al Odwan, Khreisat et al, 2016).

As regards detection of breast cancer, majority of the respondents 210 (87.1%) knew that breast cancer can be detected by examination at the health facility. However, only 8 (3.3%) of the respondents mentioned breast self-examination as a means of identifying some breast abnormalities like tumors.

Attitudes of Rural Women towards Breast Cancer Screening

In this study, 90.5% of respondents were willing to be screened for breast cancer. However, 60% of respondents were not worried about the disease since they did not have any history of cancer in their families nor expect themselves to be at risk. In concurrence with this, a study by Kyanjani et al (2012), reported poor attitude of the participants where they gave reasons for not going for breast cancer screening, since they were not feeling any problem with their breasts and did not therefore, find it necessary.

Some of the reasons expressed by the respondents for not screening for breast cancer, were fear of the outcome of examination 24.1%, and fear of pain 7.1%. In this regard, 68.5% could not give an explanation. While others feared to lose their jobs, not getting married or fear of isolation by their relatives and friends in case they would be diagnosed with cancer.

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However, some respondents' understanding of cancer as a death sentence is often determined by cancer experiences in some families or having had friends who suffered from the disease, thus, affecting their thinking (Kumar, 2017). This could therefore be modified by regular sensitization and explanation of the facts about the risk factors, their susceptibility to breast cancer and possibility of cure if early diagnosis could be made.

Customs and beliefs in the rural community where women first consult traditional healers for such complaints as related to breast cancer, are commonly observed to worsen women's condition when they develop breast tumors. In agreement with this, a study in South Africa reported that cultural values and ethnic diversity had an impact on health beliefs which influenced rural women's interaction with western medication especially with breast cancer (Lemlem, 2013).

In this study, some women reported delay in breast cancer screening or seeking treatment because of fear of stigma concerning their daughters, as it was believed that they also might be affected by breast cancer and thus, not be considered for a good marriage. Furthermore, it was believed that cancer is a death sentence from God. In addition, some respondents feared the procedure of screening, whereas others feared to be isolated by their relatives or friends in case they were found with breast tumors or cancer.

Practices of rural women regarding breast cancer screening

The study findings show that 84.7% of the respondents had never examined their breasts nor did they know how to do it and what to check for. Thus, an increased risk for under-utilizing screening services like mammography. In addition, 93.4% had never gone to any health facility for breast cancer screening. In agreement with this, some scholars have reported that rural women, who are at low income and educational levels, are at a higher risk for late stage detection of breast cancer (Trupe, Rositch et al. 2017). Hence, the impact of low rates of breast cancer screening is well documented and of concern.

The results show that majority of the respondents (83.4%) had never been taught how to examine their breasts (BSE). The possibilities of these women going for screening is limited if the information is not available or services are limited (Pace and Shulman, 2016). Breast self-examination encourages women to appreciate any changes in their bodies and would therefore ably seek for health assistance or advice in time, before progression of the disease.

In this study, 47.7% of the respondents reported that there were no screening services for breast cancer provided at their nearest health facilities, whereas 3.3% reported having no qualified health workers to provide the screening services. This could contribute to late reporting to the health facility where the services were provided especially if the distance was long.

Socioeconomic status may determine the variety of life styles and dietary practices that might affect breast cancer risk, as well as possibly influencing the health-seeking behaviour of the respondents (Ameer, Abdulie et al. 2014). The results of the study revealed that 0.8% of the respondents were employed. Some previous studies have shown that low socio-economic status is correlated with the incidence and mortality of various malignancies, such as breast cancer, as well as poorer breast cancer outcomes worldwide (Younis, Al-Rubaye et al. 2016). In agreement with this, poor women are more likely to use other sources of health care, like traditional or herbal medicine than going to health institutions (Omotara, 2012). Lack of basic knowledge and an effective information delivery system for breast cancer, further threatens the life and wellbeing of rural women (Gueye et al., 2017). This may

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be associated with poverty, poor health seeking behaviours where the community is biased on the health services provided, or easily influenced by cultural practices. There was strong association between age of respondents and knowledge about breast cancer. Young women between 20 and 35 years were more likely to be knowledgeable about breast cancer than old women, for example 50 years and above. The literature from developed countries indicates that breast cancer risk increases with increased age at diagnosis (Al Odwan, 2016). Other strong associations were between knowledge of breast cancer risk factors, signs and symptoms as well as preventive methods of breast cancer and practice of breast cancer screening. Knowledge of the risk factors and signs and symptoms seemed to be motivational to practice, probably because it helps people to estimate to what extent they are vulnerable.

Previous studies have also identified relationship between knowledge and practice of preventive measures (Oladimeji, 2015). Information source however, has also been identified to have strong relationship with breast cancer knowledge. This concerned majorly the media through radio and television messages. This requires health workers to embrace their role of educating the public since their information may be consistent and more reliable.

Conclusion and Recommendations

Conclusion

The study concludes that the overall knowledge about breast cancer among rural women of Bubaare Sub-county was low, majority with negative attitude towards breast cancer screening.

Recommendations

The study recommended more health education sessions in the community, focusing on risk factors, signs and symptoms, prevention and dissemination of information through media, community health teams, Religious leaders and health workers respectively.

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