

WOMEN'S DELAY IN REPORTING BREAST CANCER TO HOSPITALS: A PERCEPTION BY FEMALE STUDENTS OF SELECTED TERTIARY INSTITUTIONS IN KOGI STATE, NORTH-CENTRAL, NIGERIA

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Abstract

Breast cancer in women is a major public health problem in Nigeria. The reason for the increase in breast cancer in Nigeria is based on the delays by women, who suffer this ailment, in reporting to their health providers. This cross-sectional descriptive survey was carried out to identify reasons for women's delays in reporting to hospitals. The survey relied on the perception of 694 female students in four purposively selected tertiary educational institutions in Kogi State, North-central Nigeria. Data were gathered through a structured self-administered questionnaires designed by the researcher and complemented with an in-depth interview schedule. Simple percentage counts were used to analyse the socio-demographic data and the research questions. Findings from the study revealed that, majority (88.3%) of our respondents were aware of breast cancer, with majority who received their information from the mass media (32.6 %) and health care professionals (20.6%); only 5.9 % knew that the disease's aetiology is idiopathic, and more than half (51.2 %) and 21.6 % respectively, perceived ignorance and fear of getting the disease as the major reasons for breast cancer late presentation by women to hospitals. The study reveals that late presentation of breast cancer is a function of poor knowledge about the disease. Therefore, it is recommended that more aggressive campaigns be put in place by the various governments in Nigeria to enlighten the public, especially, women on the danger of late reporting of breast cancer symptoms. More so, health educators should endeavour to adequately inform women about their breast health at all times.

Key words: Breast cancer, Delay reporting, Female Students' Perception, Health education

RETARD DES FEMMES DANS LA SIGNALISATION DU CANCER DU SEIN AUX HÔPITAUX: PERCEPTION DES ÉTUDIANTES DE CERTAINES INSTITUTIONS TERTIAIRES DANS L'ÉTAT DE KOGI, DANS LE CENTRE-NORD, AU NIGÉRIA

Abstrait

Le cancer du sein chez les femmes est un problème de santé publique majeur au Nigéria. L'augmentation du nombre de cancers du sein au Nigéria s'explique par les retards des femmes qui souffrent de cette maladie à signaler leurs cas à leurs fournisseurs de soins de santé. Cette enquête descriptive transversale a été réalisée afin d'identifier les raisons du retard pris par les femmes dans leurs déclarations aux hôpitaux. L'enquête a été réalisée sur la base de la perception de 694 étudiantes dans quatre établissements d'enseignement supérieur

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sélectionnés à dessein dans l'État de Kogi, dans le centre-nord du Nigéria. Les données ont été recueillies au moyen de questionnaires auto-administrés structurés conçus par le chercheur et complétés par un calendrier d'entretiens approfondis. Des pourcentages simples ont été utilisés pour analyser les données sociodémographiques et les questions de recherche. Les résultats de l'étude ont révélé que la majorité (88,3%) de nos répondants étaient au courant du cancer du sein, la majorité ayant reçu leurs informations des médias (32,6%) et des professionnels de la santé (20,6%); 5,9% seulement savaient que l'étiologie de la maladie était idiopathique et plus de la moitié (51,2%) et 21,6% respectivement percevaient l'ignorance et la peur de contracter la maladie comme les principales causes de cancer tardif présenté par les femmes aux hôpitaux. L'étude révèle que la présentation tardive du cancer du sein est due à une connaissance insuffisante de la maladie. Par conséquent, il est recommandé aux différents gouvernements du Nigeria de mettre en place des campagnes plus agressives afin d'informer le public, en particulier les femmes, sur le danger de déclaration tardive des symptômes du cancer du sein. Plus encore, les éducateurs sanitaires doivent s'efforcer d'informer correctement les femmes de leur santé mammaire à tout moment.

Mots-clés: Cancer du sein, Signalement des retards, Perception des étudiantes, Éducation à la santé

Background to the study

Breast Cancer in women is a major public health issue globally, and its treatment constitutes a great physical, psycho-social and economic challenge in resource- limited societies in Africa (Adisa & Esson, 2007). Breast cancer is the common term for a cancerous(malignant) tumor that arises from uncontrolled growth of abnormal breast cells (Agboma, 2007; Hartmann & Loprinzi, 2012). Globally, breast cancer is currently the top-most cancer among women worldwide, claiming the lives of thousands of women, both in the developed and the developing worlds, and the majority of breast cancer deaths occur in low- and middle-income countries (LMICs), where most women are diagnosed in late stages due to lack of awareness and adequate access to health services.

According to the International Agency for Cancer Research, (IARC, 2010), breast cancer is by far the most frequent cancer among women with an estimated 1.38 million new cancer cases diagnosed in 2008 (23% of all cancers), and ranks second overall (10.9% of all cancers). The Agency further states that, breast cancer is now the most common cancer both in developed and developing regions with around 690,000 new cases estimated in each region (population ratio1:4) and that incidence rates vary from 19.3 per 100,000 women in Eastern Africa to 89.7 per 100,000 women in Western Europe, and are high (greater than 80 per 100,000) in developed regions of the world (except Japan) and low (less than 40 per 100,000) in most of the developing regions.

Further still, IARC states that the range of mortality rates is much less (approximately 6-19 per 100,000) because of the more favourable survival of breast cancer in (high-incidence) developed regions. As a result, breast cancer ranks as the fifth cause of death from cancer overall (458,000 deaths), but it is still the most frequent cause of cancer death in women in both developing (269,000 deaths, 12.7% of total) and developed regions, where the estimated 189, 000 deaths is almost equal to the estimated number of deaths from lung cancer (188,000 deaths).

Although, precise statistics are not available, breast cancer is on the increase in Nigeria. Incidence rate has increased from 13.8–15.3 per 100,000 in the 1980s, to 33.6 per 100,000 in 1992 and 116 per 100,000 in 2001 and as at 2008, the incidence and mortality are respectively estimated as 18,935 and 10,469 (IARC, 2010), and has overtaken carcinoma of the cervix in hospital incidence (Gwarzo, Sabitu and Idris, 2009). Note that, in the world breast cancer death rate by countries, Nigeria ranked 17 and has taken the lead in Africa, with 24.7 mortality rate.

The World Health Organisation (WHO), estimates that the incidence of cancer in Nigeria for women and men by 2020 will be 100.9/100,000 and 90.7/100,000 respectively while death rate is expected to increase to about 76,000/100,000 and 72.7/100,000 respectively (Ovuorie, 2012). Thus, breast cancer is not gender-specific, but more prevalent among women. The increasing incidence of breast cancer in Nigeria is partly due to the changing demographic profile, acquisition of 'Western lifestyle' and the changing socio-economic profile of the country (Adebamowo and Adekunle, 2002). As a significant public health problem across the globe, breast cancer is frequently undiagnosed due to late presentation to hospitals. In fact, Eferaro (2012) said experts' reports show that more than 83 to 87 percent of breast cancer are presented late; thus incurring unavoidable bills in the process.

From the foregoing, it is pertinent to say that, women can survive breast cancer if it is found and treated as early as possible. It is against this background that this study assessed the perception of female students in selected tertiary institutions in Kogi State on the reasons women delay in reporting breast cancer to the hospitals.

Statement of the problem

Studies have shown that many breast cancer cases are presented late in developing countries, including Nigeria. This delay in reporting breast cancer to hospitals portends danger to the victims (Odeyemi, Oyediran, 2002; Odusanya & Tayo, 2001; Kayode, Akande & Osagbemi, 2005; Olowookere, et al, 2012; Okobia, Bunker, Okonofua & Osime, 2006). This late presentation may be attributed to many factors such as ignorance, myths and misconceptions, fear of stigmatization, among others, in our society. These studies, therefore, focused on eliciting information from patients and health care providers concerning delay in seeking health care. This present study assesses reasons for late presentation of breast cancer by women as perceived by female students of tertiary educational institutions in Kogi State, North central, Nigeria with a view to finding solutions to reduce cases of breast cancer in the area.

Research questions

In an attempt to address the above stated problem, this study is designed to answer the underlisted questions:

- a) Are female students of Kogi State tertiary educational institutions aware of breast cancer?
- b) What are the first sources of information about Breast cancer by the respondents?
- c) What are the perceived causes of breast cancer?
- d) What are the reasons for women's late presentation of breast cancer to the hospital as perceived by female students in Kogi State tertiary institutions in Kogi State, North-central, Nigeria.

Literature review and theoretical framework

The World Health Organisation(2011), defined cancer as a generic term for a large group of diseases that can affect any part of the body. Other terms used are malignant tumours and neoplasms. Cancer of the breast, with the local names including among others: 'Jejere-omun'(Yoruba), 'Kete-Eya'(Igala), 'Dajin-nono'(Hausa), 'Oya-ara'(Igbo), 'Ukwu-inireva'(Ebira), 'Ochek-ame'(Idoma), and 'Kansa usha atumba' which means, a tree has grown in the breast in Tiv, is a type of cancer in which cells in the breast divide and grow without normal control and can then invade nearby tissues or spread throughout the body (Eferaro, 2012).

Delay presentation of breast cancer is the period between when a patient first observed her symptoms and decided to seek for health care. Unger-Saldina (2014) avered that traditionally, breast cancer delay has been defined as more than three months between symptom discovery and the beginning of cancer treatment which has been claimed in two types- patient delay and provider delay. According to Unger-Saldina (2014, patient delay refers to the lengthening of the interval between the discovery of symptoms and the first medical consultation and the most accepted threshold to establish it is three months. Anderson and Jakez (2008) noted that, the high breast cancer mortality rates in low-medium-income countries (with Nigeria ranking third) are thought to be due to diagnosis in advanced stages and access to medical care. A patient's prognosis and choice of treatment, thus, depends on the stage of cancer, certain characteristics of the cancer cells, age, weight, menopausal status, etc.

Breast Cancer risk-factors

The specific agent or agents that cause breast cancer remain unknown (Davis, et al, 1997). Thus, breast cancer is an idiopathic disease, because its cause(s) is/are unknown. From available literature, the precise etiology of breast cancer is unknown, however, like other types of cancer, it arises from one single cell. The transformation from a normal cell into tumour cell is a multistage process, typically a progression from a pre-cancerous lesion to malignant tumours; these changes are the result of the interaction between a person's genetic factors and other external agents" (Olotu, 2006; WHO, 2011). It is important to note that having a risk factor, or even several, does not necessarily suggests that a woman will develop breast cancer, however, since the specific agents which cause breast cancer have not been delineated and the risk factors have only a minimal contribution to development of the disease, early detection is a key to breast cancer survival (Rabon-Stith, 2001). Predisposing factors that can put women at risk of cancer of the breast can be either modified or non-modified (Olotu, 2006; Omar, et al, 2010). Thus, breast cancer risk-factors are categorised into biological, lifestyle, reproductive and other factors as found on table 1

Table 1. Classification of Risk- Factors associated with Breast Cancer

Biological factors	Lifestyle factors	Reproductive factors	Other factors
Age, Female Sex, Family history, Genetic abnormalities, Race.	Excess alcohol consumption, Tobacco smoking, High intake of animal fat-rich diet, Overweight/obesity, Physical inactivity, Sedentary behaviour	Age at menarche (first menstruation before 12), Late Age at menopause (after 55 years), Never having being, pregnant, Late age at first birth, Not Breastfeeding, Oral contraceptives, Abortions, Exposure to Diethylstilbestrol (DES)	Exposure to radiation, Previous benign disease, Cancer in the other breast, Hormonal Therapy for the menopause, Breast density, Certain breast changes, Cancer of the uterus and ovary

Sources: Omar, et al (2010); Breastcancer.org (2007); Olotu (2006); Infomedical (2011); WHO (2011)

Factors responsible for late presentation of breast cancer in Nigeria

In Nigeria, breast cancer carries a bleak prognosis of about 80 percent of cases present in advanced or terminal stages (Odeyemi & Odediran, 2002). Eferaro (2012), reported that ‘more than 83 percent to 87 percent of breast cancer cases are present too late, and thus involved unaffordable bills in the process. Delay in presenting breast cancer, therefore, poses serious danger for the victim (Okoliba, Bunker, Okonofua, & Osime, 2006). Several factors are associated with late presentation of breast cancer, especially, among women in Nigeria as in other sub-Saharan Africa. They include: lack of information, late symptoms identification, ignorance, lack of health personnel, poor healthcare facilities, myths and misconceptions, stigmatization, poor referral system, culture and beliefs, among others.

Lack of information about breast cancer and its risk factors constitutes a major problem for its late presentation in Nigeria, unlike in the advanced countries where carcinoma of the breast has been widely publicised (Ekanem & Aligbe, 2006). When people are informed about the danger involved in a particular health condition as in the case with breast cancer, the people are likely to take action that would cede them from being victims. It is against this background that Ekanem and Aligbe (2006) and Salaudeen, Akande and Musa (2009) recommended in their various studies on breast cancer in Edo and Kwara States of Nigeria respectively, that in order to reduce the late presentation of breast cancer, followed by appropriate treatment, the importance of early diagnosis is paramount.

Another factors that militates against early detection and subsequent presentation of breast cancer are myths and misconceptions, as well as poor information dissemination. It is obvious that a person’s perception of the risk of, or susceptibility to developing a disease (e.g, breast cancer), as assumed by the health belief model is an important determinant of health-related behaviour. Yet, myths and misconceptions may be fingered as barriers for detecting and presenting breast cancer for early treatment and management. Several studies have confirmed this assertion (Komen, 2012). The World Health Organization (WHO) captured the reasons for breast cancer late presentation when it says that ‘the problem of impeded access to health care, the exorbitant cost of care, ignorance of the disease, poverty, dis-empowerment of women and a general lack of health education complicate matters as incidences of cancer among women increase’ (Ovuorie, 2012).

According to Remennick (2006), early detection of breast cancer may be hindered by factors such as experiences of breast cancer survivor, fears of being diagnosed for breast cancer, taboos and beliefs about breast cancer that hinder awareness programmes and

treatment, and traditional cultures. These, however, account for the patterns of late-stage diagnosis. Availability, accessibility and utilisation of health information are factors that can help women to know about breast cancer, like any other health conditions, and subsequently, early presentation. However, lack of health information for the populace has been identified as one of the reasons for the upsurge of a number of preventable diseases, like breast cancer in Nigeria as in other countries in Africa (Osagbemi & Tariah, 2008).

Methods of research

Research design

The descriptive survey research method was utilised for this study. It linked breast cancer with screening practices among female students in tertiary educational institutions in Kogi State, North-central Nigeria. The survey method was favoured because it allowed the researcher to administer copies of the questionnaire to a large number of respondents at the same time, and therefore enabled the researcher to obtain the perception of a representative sample of the target population so as to generalise the findings.

Description of the study setting (area)

This study has Kogi State, one of the 36 States in the Federal Republic of Nigeria, as its locale. Kogi State, also known as the 'Confluence State' is in the middle-belt (North-central) zone of Nigeria, with Lokoja as its capital. The State is located between latitudes $7^{\circ} 30'$ and $8^{\circ} 10'$ north of the Equator and Longitudes $6^{\circ} 01'$ and $7^{\circ} 50'$ east of the Greenwich Meridian (Babatimehin, et al, 2010). There are twenty-one Local Government Councils in the State. The 1991 census figure shows that Kogi State has a population of 2,147,756, while the 2006 census estimated result puts the population at 3,314,043; 50.5 percent was made up of males, while 49.5 percent were females.

This study was specifically conducted among participants from four selected tertiary educational institutions, representing the three senatorial districts. They were: Kogi State University, Anyigba (Kogi East), Federal College of Education, Okene (Kogi Central), Kogi State Polytechnic, Lokoja, and School of Nursing and Midwifery, Egbe, (Kogi West), all representing the various categories of tertiary institutions in the state.

The study population and sample selection

The target population of the field survey, for quantitative data, consisted of female students, from ages 15 to 50 years old, and currently studying in the selected tertiary educational institutions, totalling 8,970. A multi-stage sampling method was used in selecting participants for this study. In the first selection, purposive sampling technique was used to choose four tertiary institutions, namely: Kogi State University (KSU), Anyigba; Kogi State Polytechnic (KSP), Lokoja; Federal College of Education (FCE), Okene, and ECWA School of Nursing (ESN), Egbe from the fifteen institutions across the state. The participating institutions were further categorised into Faculties and Schools. A simple random sampling method, without replacement, was used to select three (3) out of the six (6) Faculties from KSU, three (3) out of the five (5) schools each from KSP and FCE. Since ESN has neither Faculty nor School, as observed from the structure of the health educational institution, no selection was made; as such the school was categorised as a single entity (Faculty) for the purpose of this survey. The simple random sampling method was to ensure that each of the participating Faculties/Schools in the institutions has an equal chance of being selected using a lottery procedure devoid of human judgement.

In determining the sample size for the study from both the Kogi State University, Anyigba and Federal College of Education, Okene, the researcher relied on the published table for determining sample size by Israel (1992). The proportionate sampling technique was used to select the final sample size for this study. This was to give each department equal representation in the study. However, it is worthy to state that the entire female populations of both the KSP and ESN from the selected departments of the institutions were utilised due to their small size and ability to manage the population.

In-depth interviews were conducted by the researcher and his assistants among the different categories of health care providers (doctors, nurses and pharmacists) in the selected institutions' health centres. In all, sixteen interviews were undertaken on both the male and female genders. These respondents were interviewed due to their perceived knowledge about cancer generally, and breast cancer, in particular from their health and medical training perspectives.

Instruments for data collection

The primary data for the study were generated through the use of triangulation techniques. The self-administered questionnaire with the assistance of four trained researchers (undergraduates of KSU, Anyigba) were employed to elicit necessary primary data from female students in the various settings used for this study. The instrument, based on the research objectives, consisted of open and closed-ended questions, and was validated by two experts in Public Health and Medical Sociology. The questionnaire method was complemented with In-depth interview. Four (4) Health care providers in each of the study settings were interviewed to gain insights into certain issues surrounding breast cancer. Responses from these qualitative components boosted the strength of the quantitative instrument.

Methods of data analysis

Data generated through the questionnaire were scrutinized, coded and analysed with the use of Statistical Package for Social Sciences (SPSS) version 16 software. The descriptive statistics of frequency counts and percentages were used for analysing both the socio-demographic data and the research questions.

Ethical considerations

Throughout the field work, ethical considerations were emphasised; approvals were obtained from relevant authorities, and students' participation was based on informed and voluntary consent.

Results and discussion

Out of the 835 eligible respondents, 694 correctly completed the structured self-administered questionnaire, thus giving a response rate of 83.1 percent. This was used for analysis after editing.

Socio-demographic data

The first part of the results of the study presents findings with respect to the description of the respondents' personal data, which include age, marital status, religious affiliation and ethnic group. This is depicted in table

Table 2: Percentage Distribution of Respondents' by Socio-Demographic variable

Socio-Demographic Variables	Educational institutions				
	KSU N= 188 (%)	KSP N=181 (%)	FCE N =178(5)	ESN N=147 (%)	Total N=694(%)
Age					
15- 19	22 (11.7)	28 (15.5)	75 (42.1)	49 (33.3)	174 (25.1)
20 -24	96 (51.0)	80 (44.2)	88 (49.4)	80 (54.4)	344 (49.6)
25 - 29	52 (27.7)	45 (24.9)	11 (6.2)	7 (4.8)	115 (16.6)
30 - 34	6 (3.2)	8 (4.4)	2 (1.1)	7 (4.8)	23 (3.3)
35 - 39	5 (2.7)	10 (5.5)	2 (1.1)	1 (0.7)	18 (2.6)
40 - 44	5 (2.7)	8 (4.4)	-	-	13 (1.0)
45 – 49	-	2 (1.1)	-	3 (2.0)	5 (0.7)
≥ 50	2 (1.0)	-	-	-	2 (0.3)
Marital status					
Married	38(20.2)	73(40.3)	19(10.7)	34(20.7)	164 (23.6)
Single	150(79.8)	106(58.6)	159(89.30)	112(76.2)	527 (76.0)
Divorced	-	-	-	1(0.7)	1(0.10)
Widowed	-	2(1.1)	-	-	2 (0.3)
Religion					
Christianity	139(73.9)	92(50.8)	131(73.6)	134(91.2)	496(71.5)
Islam	47(25.0)	89(49.2)	47(26.4)	13(8.8)	196(28.2)
Traditioanlist	-	-	-	2(0.3)	2(0.3)

Source: Researcher's field work, 2013

Table 2 shows the sample distribution by socio-demographic profile. Respondents aged between 15-24 years were in the highest percentage (74.7 percent), followed by those in the age range of 25-29 with (16.6 percent). The mean age of the respondents was 23.02 years with the oldest being 50 years and the youngest, 15 years old. The distribution by marital status showed that more than three-quarters (76.0 percent) of the entire sample were never married, why less than a quarter, (23.6 percent) were married. The high level of single respondents, aged 15-29 years old, was due to the fact that the study was restricted to female students who are still preoccupied with academic activities in the tertiary educational institutions, rather than marital issues. It was also found that an overwhelming majority of the respondents (71.5 percent) were Christians, while over a quarter (28.2 percent) of the respondents practice the Islamic faith. Only 0.3 percent of the respondents were traditional worshippers.

Awareness of Breast Cancer by Female students of tertiary institutions in Kogi State

As shown in table 3, an overwhelming majority (88.3 percent) of the respondents were aware of breast cancer. The rest (11.7 percent) of them never heard of breast cancer as a disease.

Table 3: Percentage Distribution of Respondents' Awareness of Breast Cancer

Awareness of breast cancer	Frequency	%
Yes	613	88.3
No	81	11.7
Total	694	100.00

Sources of First Awareness about Breast Cancer

As shown in table 4, out of the total participants, 32.6 percent mentioned the mass media (radio, television, newspapers) and 20.6 percent reported health care professionals as their first source of information about breast cancer. This was followed by mothers (16.0%),

friends (13.8%) relations (10.2 %) and experience as in people who suffered it or had people who had suffered it (3.5%).

Table 4: Distribution of Respondents by first Sources of Information about breast cancer

Sources of Information	Frequency	Percentage
Health Professional	143	20.6
Mother	111	16.0
Relations	71	10.2
Friends	96	13.9
Mass Media	226	32.6
This Questionnaire	10	1.4
Family History	7	1.0
Cancer patients	24	3.5
Others	5	0.7
Total	693	100.0

Source: Researcher's Fieldwork, 2015

Perceived Causes of Breast Cancer

On the perceived causes of breast cancer (table 5), majority (47.7%) of the respondents mentioned infection, followed by putting money inside bra (18.8%), and evil spirit (11.7%) About 12 percent of respondents indicated lack of knowledge about breast cancer aetiology, while only 5.9 percent indicated that the cause of breast cancer is unknown. The least mentioned cause of breast cancer as perceived by respondents was wearing tight bra (4.3%)

Table 5: Distribution of Respondents by Perceived causes of Breast Cancer

Perceived causes of Breast Cancer	Frequency	Percentage
Infection	330	47.7
Evil Spirit	81	11.7
Putting Money in Bra	130	18.8
Wearing tight Bra	30	4.3
Unknown	41	5.9
Don't know	80	11.6
Total	692	100.0

Source: Researcher's Field work

Meanwhile, the general consensus of our interviewee-health practitioners on the cause of breast cancer in our study setting was that:

It is idiopathic, that is, no cause for breast cancer has been identified or confirmed across the globe. However, certain controlled and uncontrolled predisposing risk- factors such as, advance in age, alcohol consumption, poor diet, physical inactivity, not breast feeding a child, abortion, cigarette smoking (active and passive), genetic factor, and environmental exposure have been implicated.

Majority of the respondents (39.6 percent) viewed breast cancer as “worrisome”, followed by 18.9 percent who perceived it as “very worrisome”. Others saw the disease as dreadful (12.4 %), a death sentence (10.8%) and burdensome (6.0%). These findings suggest that the attitude of our respondents to breast cancer was negative.

Perceived Reasons for Women's late Presentation of Breast Cancer to the Hospital

Table 6 shows that more than a half (51.2%) perceived that women tend to present breast cancer cases late due to ignorance. This was followed by fear of getting the disease (21.6%), myths and misconceptions (7.5%), lack of necessary information (15.3%) and lack of screening services (4.5%).

Table 6: Distribution of Respondents by perceived reasons for women's late presentation of breast cancer to the hospital

Perceived reason for late presentation of breast cancer	Frequency	Percentage
Ignorance	355	51.2
Fear of getting breast cancer	150	21.6
Myths and Misconception	52	7.5
Lack of information	106	15.3
Lack of screening service	31	4.5
Total	694	100.0

Source: Researcher's Fieldwork, 2015

An interviewee in our study setting argued that:

The fear of getting breast cancer and stigmatization associated with it makes late presentation of the disease to the health facility for early diagnosis and prompt treatment inevitable (Female 32years, Kogi West). This could be the reason why breast cancer has been described as a death sentence by many people.

Another interviewee reported that:

One of the reasons for late presentation and consequently, late detection of breast cancer among women in Kogi is due to lack of awareness about the disease (Female, 26years, Kogi East). It is also the belief of many that breast cancer is a spiritual matter, hence, the common statement that, 'that will not be my portion, not even, my enemy.

Discussion of findings

This descriptive cross sectional study assessed the perceived reasons women present breast cancer late to the hospital using female students in four tertiary educational institutions (TEIs) in Kogi State, North-central Nigeria. A total of 694 female students participated in this study. From the study, the personal data showed the age range of the respondents from 15-50 years old. However, majority of the study samples were in the age range of 15-24 years old (74.7 percent) with a mean age of 23.02 years old.

In this study, 88.3 percent respondents had heard about the disease. This is similar to findings in previous studies among students, market women, and health care professionals where a large percentage of their study populations had heard about breast cancer as a disease (Odeyemi & Oyediran, 2002; Odusanya, 2002; Chioma & Asuzu (2007); Salaudeen, et al, (2009); Akpo, Akpo & Akhator, (2010); Gwarzo, et al, (2009); Obaji, Elom, Agwu, Nwigwe, Ezeonu & Umeora, 2013; and Lemlem, Snishaw, Halilu, Abebe, & Aregay, 2013).

From the above, awareness about breast cancer as a disease may be due to the emerging enlightenment programmes about breast cancer organised by government, non-governmental organisations, and other agencies, both national and international, in the society; especially during the yearly World Breast Cancer Day (every 4th October) or when an

important public figure was reported dead of the disease. Meanwhile, their major sources of information about breast cancer were the mass media and health care practitioners.

The study showed that the perception of respondents on the causes of breast cancer was poor. This was because, only 5.9 percent of opined that the cause of the non-communicable disease is unknown. This is in line with the various theoretical and empirical literature (Olotu, 2006; Agboma, 2007; Omar, et al, 2010) in which some authors agreed that the cause of breast cancer is idiopathic, that is, not really known, but a number of risk factors have been associated with the disease. Their low knowledge may be due to the myths and misconceptions associated with the disease. This implies that, in view of the unhealthy behaviour young people indulge in, they should be well educated on their health habits, so that they do not fall prey to the incurable, disease due to ignorance and care free attitude.

It has been observed from other studies that late presentation of breast cancer is a serious clinical problem with a minimal survival rate (Dogo, et al, 2006). Thus, early presentation to the hospital will enhance early detection and/or diagnosis for adequate and prompt treatment. In this study, ignorance, fear of getting breast cancer, myths and misconceptions, lack of information and lack of screening services were thought to be leading reasons implicated for reporting breast cancer cases in the hospitals among Nigerian women at advanced stage, with little or nothing to be done. This is consistent with the findings in the study conducted by The Macmillan Cancer Relief (2004), where it was found that one in every five women never checked their breasts clinically, and that their biggest concern was that they might actually find a cancer in them.

The implication of the study for breast health education

The knowledge of the public, especially, women about breast cancer, generally, has a lot of implication for the wellbeing of the women-folk. Health education is relevant to the extent that it would afford them necessary information needed to make positive choice concerning their breast health in terms of early detection, diagnosis, and treatment. The content of the health education would also include enlightenment on dangers associated with breast cancer risk factors. Health education, especially, health care practitioners should endeavour to embark on meaningful health education programmes.

Conclusion and recommendations

This study assessed the perceived reasons for late presentation of breast cancer by patients in Nigeria with focus on Kogi state. The findings revealed a high level of awareness regarding breast cancer. Respondents were adequately aware of the existence of breast cancer, but their attitude towards the disease was negative. Several factors were identified as the reasons for delay in women presentation to the hospital. Understanding these reasons for delay is very important in order to generate public health education programmes to motivate women to promptly seek healthcare in discovering abnormalities in their breasts as quickly as possible.

Recommendations

Arising from the study's findings and conclusions, the following recommendations and actions are suggested:

- a) The government, as a matter of priority, should provide more health care facilities, especially, screening services that are both accessible and affordable to Nigerian women. This will afford women of different ages to access health care when needed

with regard to their breast health, early detection, prompt diagnosis and effective cancer treatment and therapies.

- b) Massive breast health education should be put in place at all times by the various levels of governments or their agencies in the country to enlighten the public about the danger in breast cancer, so that they can make informed decisions on early screening for breast cancer.
- c) We also recommend that health educators, especially, health care practitioners should be encouraged to provide adequate and prompt education for their patients concerning their breast health from time to time.

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